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Defining and costing a comprehensive package of services for survivors of gender-based violence

Primary Research - Final Report

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EXECUTIVE SUMMARY

The 2016 *Report on Diagnostic Review of the State Response to Violence against Women and Children* found services providing care and support in the aftermath of violence to be limited in scope, too few in number and inadequately funded, especially when provided by the non-profit sector.[1] It thus recommended that the *'Department of Social Development to lead in comprehensively defining psychosocial response services for victims of VAWC, establishing minimum core services and funding implications for their implementation'*.[2] This research was commissioned in response to this recommendation with the broad overall purpose being to identify and cost a set of core services responding to gender-based violence, to be accomplished through three activities: Production of a literature review; primary research informed by the literature review's findings and recommendations; and a costing based on these core services and policy brief. Building on the literature review, this report presents the findings from the primary research, including an expenditure analysis of the service areas. This will inform the parameters of the costing and policy brief concluding the project.

Review of the existing legislative and policy framework confirmed that the courts have ruled that care and support services are a socio-economic right,[3] with the National Development Plan also recognising that such services are part of the social protection floor beneath which no member of society should slip.[4] In addition, care, support and healing' is one of six pillars identified as key to the country's *National Strategic Plan on Gender-based Violence and Femicide*.[5] Laws such as the 1998 Domestic Violence Act (DVA), the 2007 Criminal Law (Sexual Offences and Related Matters) Amendment Act, and the 2005 Children's Act are also in place (see annexure 1 for full legislative and policy framework). However, the literature review found that the policy architecture underpinning the content and substance of the services remains incomplete, with some services being expressly provided for in supporting legislation and policy (i.e. VFR, court preparation and support, and PEP); and others which must be inferred from legislation and policy (i.e. shelter, counselling and emotional support).

The literature review completed for the first phase of the research looked into the extent of GBV and implications for women's use of services in South Africa. Administrative data from DoJCS and SAPS, reveal high levels of domestic violence, sexual offences and rape amongst women and children. However, none of the figures are a true reflection of the extent of GBV, as various studies have shown that most victims elect not to bring their experiences to the attention of state officials. Access to services therefore, cannot be made dependent upon engagement with either the courts or the police. If it is, then a substantial portion of victims will be excluded from help. Whilst many women experience GBV, the limited number of studies available on women's use of services have shown that they do not all prioritise the same services, there is limited cross-use of services for domestic violence, and survivors of rape do not always seek counselling services.

Survivors show high levels of psychological distress following an incident of GBV with PTSD being the dominant lens through which this has been conceptualised. When used as a measure of emotional suffering, it has shown rape, of all forms of violence, to have the strongest association with PTSD among South African women.[6] According to the national South African Stress and Health (SASH) survey, PTSD affected 6% of those who identified as having been raped, with only experiences of political torture matching or exceeding the severity of rape's effects.[7] However, due to its frequency, IPV was associated with the greatest number of PTSD cases amongst women at population level.[8]

[1] KPMG, 2016
[2] KPMG 2016.
[3] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2014] ZAFSHC 127 (28 August 2014)
[4] Department of Social Development, 2016.
[5] Interim Steering Committee, 2020
[6] Kaminer et al., 2008.
[7] ibid
[8] ibid.

Victims' emotional and psychological difficulties can be thought of as existing on a continuum involving stress, trauma and crisis. Care and support interventions thus need to be oriented both towards processes of change in victims' response to violence, as well as the depth and complexity of those responses. Given the range of different kinds of professional and para-professional staff required to apply this framework of care and support, the study explored the human and material resources actually available to services.

GBV survivor's access and use of quality care and support services is further affected by the limited human and material resources allocated to such services which have historically been provided through partnerships between the state and the non-profit private sector (including faith-based organisations). This partnership takes concrete form in the subsidy allocated to NGOs by the DSD towards the provision of social care services. However, there is considerable variation in the amounts paid to organisations both within the same province, as well as across provinces which significantly affects the allocation towards post subsidies. While subsidies towards NPO social and social auxiliary worker posts have always been less than that paid to an entry-level social or social auxiliary worker employed by the DSD, the relative gap has increased over time.. Furthermore, analysis of the combined national and provincial budget allocations for social welfare services reveals that the allocations to the Victim Empowerment Programme (VEP) (which is where the budgets for GBV services will overwhelmingly be drawn) was very small, with only the social relief of distress, at 1%, receiving less.

The research rationale informed the objectives, method and sample of the primary research. In an ideal world all the various services would have been evaluated, enabling us to identify and cost the most effective of these. This is not the case. While many services bear a nominal and superficial resemblance to each other they also differ in important ways. In some instances, variation may be the necessary consequence of local context and need but in others it may reflect unequal and different access to human and material resources. In response to these challenges, and in keeping with realist evaluation methods[9], we placed a strong emphasis on the theories of change underpinning particular types of service. This research included received Ethics Clearance of HSRC Research Ethics Committee in October 2019 and included extensive stakeholder consultation throughout the research process. Data was collected using in-depth, face-to-face interviews and focus groups with the latter being the primary method of defining services. A total of 39 interviews and 34 focus group discussions were held with a wide range of government and NGO stakeholders and beneficiaries at national, provincial (North West, Eastern Cape, Gauteng and Western Cape) and local level. The report also included expenditure analysis on services where current expenditure figures were made available by various implementers or where information was available in the public domain. There were two dimensions to our analysis of the field and documentary material. One sought to discern in each service the various elements comprising a complete theory of change (TOC). The second dimension of analysis involved assessing services in terms of their availability, accessibility, acceptability and quality (AAAQ).

Presentation of study findings begin with a discussion of services' infrastructure. This is followed by discussion of findings on services which are organised according to the following four elements which dictates its form, namely: 1) **Beneficiaries**, or the service users that provide the rationale for the service's existence; 2) **service modalities**, or the set of techniques, practices and methods thought to enable change; 3) **a medium of service**, referring to communication that is in-person, telephonic or text; and 4) **a physical setting** which both housed the service and organized it in relation to the processes and procedures associated with that setting.

In relation to **material infrastructure for care and support services**, the interviews and focus groups identified material resources as being particularly vital to services' operations. Those raised most frequently were: transport funds for beneficiaries, maintenance and availability of facilities, and security costs to prevent office break-ins. In relation to staffing, training and supervision it was found that services are provided by different types of staff that typically fall into one of two categories: those with formal qualifications and those without formal qualifications. Both have an important role to play in service provision and should be accompanied by training, supervision and support to avoid vicarious trauma and burn-out. The study found significant gaps here including the shortage and uneven distribution of psychologists and psychiatrists in the public health sector and an over-reliance on under-paying particular categories of staff. Ultimately this is to the detriment

9 Pawson et al., 2004.

of both beneficiaries and communities. Investing in staff not only increases the quality and effectiveness of services but values women's work in this sector. In summary the following recommendations are made: Applying the term 'volunteer' only to those who genuinely work without recompense; creation of a qualification and occupational category, possibly termed a 'support worker' which recognises prior learning and ensuring that this process is fast-tracked; include training and supervision in costing of services; standardise care and support staff descriptions and allocations across provinces; increase NGO subsidies.

Analysis of **beneficiary** access to care and support services found that, certain groups are excluded from GBV services for reasons that are discriminatory (e.g. LGBTQ+ individuals, migrants and refugees) whilst people with disabilities experienced no less a lack of acceptance. Standard forms of communication, the physical design of spaces, and the rigid application of fixed processes and procedures, coupled to stigmatising attitudes towards disability, all functioned to exclude. The report focuses on a specialised, beneficiary-focused service: court support to people with ID. The overall objective of the SAVE programme (Cape Mental Health) and the TTBC's programme of assistance to children with ID is to offer children and adults with intellectual disabilities who are victims of sexual abuse the same access to justice as the general population and to ensure conviction of the perpetrators. Services include a series of psycho-legal assessments, court support and expert testimony to the court on their behalf. There is high demand for the service with long waiting lists and funding is limited with only Western Cape DSD funding the SAVE service whilst other national and provincial departments have acknowledged a need for such services. A key finding of the expenditure analysis is that these programmes are specialised and cannot function without psychological assessments. However, the pervasive problem underlying the costing of such services is that of economies of scale where it is held that the more beneficiaries a service assists with fewer or less costly staff, the lower its unit cost (inputs vs outputs). But thinking about services in terms of their *efficiencies* only is mistaken. Psychologists cannot be replaced by SAW, for example, without fundamentally altering the service and its effectiveness. The study concludes that people with ID have important legal claims to justice, dignity and freedom from violence and thus there is a legal obligation to include care and support to people with ID in the core package of services.

Telephonic helplines are examples of services organised around a particular **medium** or avenue of communication. The theory of change is informed by three features of telephonic communication which distinguish it from in-person communication, namely: immediacy, convenience and anonymity. The service serves a variety of purposes to callers, providing information and referrals, a reliable listening ear to those who may be lonely and isolated, a route to urgent help, and offering ongoing emotional support and assistance to those who have no other access to services, or who prefer the anonymity of telephone lines. Comparison of telephonic helplines of Lifeline, Childline and the DSD GBV Command Centre found that, despite the similarities in their work, each service has very different resources at its disposal. Only the Command Centre can afford a staff complement entirely composed of social workers, making it a very expensive service relative to the number of callers helped. On the other hand both Childline Gauteng and Lifeline utilise counsellors (although their supervisory staff are a combination of social workers, social auxiliary workers and psychologists). Analysis of data on calls provided by the three services found that while telephone helplines manage a high volume of calls only a fraction of these ultimately result in counselling cases which are a more meaningful measure of a helpline's service than calls. Using the data on cases, the expenditure analysis found that Childline's total expenditure per case is 14 times less that of the Command Centre, dealing with double the number of cases and less than half the staff complement. Based on the analysis we recommend the following: Firstly, a cost-benefit analysis of the three services, which are sufficiently similar to allow for valid comparison. Secondly, a review of the value and necessity of the digital component of the Command Centre, as it is unclear whether the benefits of these tools outweigh the financial costs. The digital component of the Command Centre should also be put out to tender. Rationalising the number of services may need to be considered once these various recommendations have been completed.

The **National Emergency Response Team (NERT)** is an example of a service organised around a particular **modality** – that of short term psychosocial support. The NERT's approach to GBV adopts the same methods as those utilised in responding to emergencies, disasters and traumatic events. As the NERT cannot respond to all traumatic events, given their sheer number, its focus is cases prominent in the media, as well as cases referred to it by state officials. Analysis of NERT intervention registers found that the great majority of cases take the

form of a single contact with the victim and/or their families. The NERT was initially created as a response to disasters or humanitarian emergencies – singular events directly affecting many people simultaneously because concentrated in space and time. Incidents of GBV, by contrast, are everyday, distributed across space and time, with effects confined to a single victim (very occasionally, more) and their immediate circle. For that reason and because an emergency-style response is not cost-effective, it is recommended to prioritise first responder services at health facilities over NERT-style interventions.

Community-based care and support is a core service, especially for those who do not engage with legal systems. The desired outcome is an empowered individual able to function effectively with the overarching mechanism of change being the relationship between the helper and beneficiary in the form of speech. The GBV care and support services in the study sample were a mix of the specialised, general and dedicated and the most ill-defined category of service was the White Doors. It was found that most community based counselling services are provided by NGOs which are amongst the most disparate and their effects most uneven and mixed. This is largely due to limited funding and absence of practice guidelines. Here it was found that these services are weakened by the way the VEP theorises crime, violence and victimisation, concentrates its efforts around the criminal justice system, and provides inadequate guidance around the standardisation of services. Care and support services, as currently provided, thus demonstrate multiple inequalities affecting those who provide the service, as well as those who receive the service. Indeed, it is possible that the weaknesses in the conceptualization of the VEP are contributing to the conflicting, parallel processes of deskilling and professionalization of NGO services observed by this study. The following recommendations are suggested: A comprehensive review of the VEP including a revision of its theory of change to include a) the socio-economic conditions that facilitate violence and limit victims' chances of escape; and b) recognition of the more complex emotional and psychological consequences of violence. Comprehensive practice guidelines and norms and standards must be developed to support the implementation of the VEP across a range of dimensions.

Shelters are considered a core service fulfilling GBV survivors' socio-economic rights. The theory of change underpinning shelters is that they break the cycle of violence through the provision of a range of services, including temporary safe accommodation, basic necessities, job skills training, childcare and psychological support. These interventions enable women to leave their abusive partners which contribute to reducing women's future use of health facilities, as well as their use of court and policing services. By limiting children's exposure to violence, shelters also help reduce the likelihood of children growing up to either perpetrate or experience violence as adults. A key study finding is that shelters are delinked from the broader package of social benefits such as housing, health and education that are a necessary component of their care and support services. It was also found that children's services at shelters are inadequately funded. The following recommendations are thus made: Firstly, that a wide-ranging policy response is required, one which must become more intersectoral in order to embed shelters' care and support services within the broader network of social benefits, including employment, job skills and training programmes. The opportunity to do so presents itself now with the DSD currently developing a new framework for shelter policy, with the need for this framework also recognised by the National Strategic Plan on Gender-based Violence and Femicide 2020 – 2030.[10] The policy should include the following: 1) adapt the current theory of change to acknowledge the wider range of women accommodated by shelters and provide clear guidance around the admission of transgender women; 2) provide a clear description of the different services, along with their parameters including the use of the term safe house to refer to emergency short-term assistance and to distinguish it from longer-stay shelters; 3) provide a clear description of shelter services for children; 4) Set out a comprehensive framework for an intersectoral approach to the sheltering, housing and employment of women who have experienced crime and violence; and 5) Provide direction on a shelter enrichment grant allowing for the repair and renovation of shelters, including ensuring they are accessible to women with physical disabilities.

The study included an analysis of one health sector response to GBV that is currently available: post-rape care provided by health facilities, concentrating on care and support services in the **Thuthuzela Care Centres (TCCs) and the Kgomotso Care Centres (KCCs)**. The KCC focuses on both rape and IPV equally. The TOC underpinning

[10] Interim Steering Committee, 2020.

these services is that good supportive care is crucial during the acute stage of trauma to prevent further harm to the victim, will prevent unnecessary infections of HIV and other sexually transmitted diseases, and limit unwanted pregnancies. It also prevents the development of more serious mental health disorders; and will limit defaulting on PEP treatment. The study findings confirmed that the **health sector's** response to GBV has lagged well behind that of other sectors and is skewed towards the medical management and forensic examination of rape complainants. In addition, the identification and management of IPV in health settings is currently missing from the set of core services as well as access to mental health services. There is also reliance of these services on external funding, resulting in unstable care and support services subject to the changing winds of donor preferences and interests. It was also found that specialised post-rape care is also affected by economies of scale. In the context of the under-staffing of health facilities it is difficult to motivate for specialised staff dedicated exclusively to these services if they are not constantly occupied. From that perspective specialised services are more feasible and cost-effective when located in facilities treating a large number of rape survivors. But this approach then limits what can be offered by facilities serving smaller, less-populated parts of the country. To address these gaps in services the following is recommended: 1) the DSD should recognise that first responder services offered at health facilities form part of the VEP, integrate these within the programme and fund them accordingly; 2) context-sensitive norms and standards are necessary to ensure that all rape complainants receive a minimum standard of care, regardless of whether they report at a TCC or a small rural hospital; 3) develop a comprehensive policy response to intimate partner violence that will also guide the sensitive and responsible identification and referral of survivors of IPV.

First responder services at the police station victim friendly room (VFR) is a core service given that SAPS, through its local police stations are a first point of contact for many victims of GBV. The SAPS National Instruction 2/2012 on Victim Empowerment provides for the establishment of VFRs at all police stations. Two TOCs underpinning this service emerged from the research. The first being that the provision of an appropriate environment, will provide an opportunity for victims of GBV to make their statements in a conducive environment and have improved access to relevant support services. This will result in a better-quality statement, which will enhance the investigation. The second TOC holds that that police stations are often the only 24/7 services in many parts of South Africa. For many survivors reporting a crime will also be the only time they will seek out and receive psycho-social support services. The VFR at a police station can thus act as a gateway to a more expanded package of psycho-social services for GBV survivors, inclusive of family intervention, often in partnership with DSD. The study findings reveal that first responder services at VFRs are either volunteer-driven or NGO-driven structures. Structures reliant on volunteers do not particularly benefit lower-income areas with far less access to resources and as a consequence they have come to reflect existing underlying inequities. It is thus recommended that their theory of change be revised and adapted to address this, which must include the further development of policy as VFRs have expanded in scope and purpose and not in ways that reflect the SAPS National Instruction. The study proposes three variations. Variation one applies to areas that are relatively affluent and whose CPF and volunteer profile is largely professional. Variation two includes VFRs being managed strictly in accordance with the SAPS National Instruction, with NGOs responsible for the training, debriefing and supervision of first responders; and variation three includes VFRs acting as a hub for a range of psycho-social services, with this role specific to areas that are very under-serviced.

Two types of **court services** have emerged, namely court preparation and court support. While no policy directives are available to define the court support offered to those seeking protection orders, the Regulations on Sexual Offences Courts set out the clear distinction between court preparation and court support. Ke Bona Lesedi (KBL) is the court preparation programme first developed by the National Prosecuting Service (NPS) of the NPA in 2001, with Norms and Standards guiding the functioning of the programme approved in 2010. The theory of change is distilled as follows: Understanding how the court works and the witness' role in its procedures lessens stress and increases confidence, resulting in responses that are more accurate and complete. Maximising witness' ability to respond effectively in court increases the likelihood of their being perceived as credible and their testimony capable of sustaining a conviction. Court preparation also effects change beyond individual matters. If prosecutors are given more time to concentrate on the legal issues and concerns affecting their matters, this may manifest in a higher conviction rate generally which will ultimately

contribute to enhancing the credibility of the criminal justice system.[11] KBL has developed a comprehensive set of guidelines to systematise and standardise the various tasks of Court Preparation Officers (CPOs) and make court preparation an imperative for every sexual offences court; and KBL's training programme is accredited with the HWSETA. In terms of the KBL norms and standards 160 CPO and five court managers ought to have been filled. However, only 121 CPOs and four court preparation mangers were employed at the end of the first quarter of the 2019/20 financial year, leaving vacant one court preparation manager and 38 CPO positions vacant (largely due to budgetary constraints). With 96 sexual offences courts having been established it is possible that some courts may not currently have access to CPOs. Government services are thus affected by limited budgets too, with the insufficient number of CPOs considered to significantly limit KBL's availability to witnesses.

The various court-related programmes offered by NGOs enhance and complement court preparation services to complainants. Further, court preparation is offered only in relation to criminal matters and thus cannot be extended to applicants seeking to obtain protection orders from the civil courts. **Court support services** are either stand-alone programmes situated directly at the court; or they operate independently from the courts, usually off-site. Whilst there are variations in the court support offering, common to all are the following elements: supportive presence and accompaniment; simplification and explication of procedures, processes and language; and the imparting of techniques aimed at enabling complainants to emotionally prepare for these procedures. The outcomes they aim to achieve are increased convictions and psychological harm being reduced. Figures provided by three organisations on the number of people using court support services reveal a constant and high demand for their services in dealing with domestic violence cases. The study concluded that court preparation and court support are core to assisting survivors navigate the courts. Both are relatively well-delineated services in relation to supporting rape complainants through criminal trials. KBL's theory of change is a complete one that is also institutionalised in policy. While court support is also institutionalised, it exhibits somewhat greater diversity in method through the use of both individual counselling, as well as group support. Both sets of services described, because relatively well-delineated, are good candidates for studies examining their comparative effectiveness.

The report concludes that care and support services embody the vision of the Constitution of the Republic of South Africa which guarantees rights to equality, dignity and freedom and security of the person and anticipates the realisation of different socio-economic rights, from health care, to housing and social security. It further concludes that there is a duty on the state to make these services both increasingly available, as well as to a wider range of people. To support the realisation of this goal the study reviewed seven kinds of services and recommended six as core, with these being: telephonic helplines; community-based counselling services; safe houses and shelters; containment and first responder services based in health facilities; containment and first responder services based at the SAPS' victim-friendly rooms; and support with navigating both the criminal and civil courts through court preparation and court support programmes. While there may be a place for rapid response emergency team interventions, we have not prioritised these as a core service.

Based on the study findings, four strategies are suggested to consolidate and strengthen these core services, namely: 1) investing in the staff who provide services; 2) reviewing and refining the VEP and associated policies; 3) Ensuring equitable access to services; and 4) planning for the progressive realisation of services. In addition there needs to be a system to plan for the equitable rollout of services which needs to be informed by the prevalence of GBV in each province / district, the size of the provincial population and key population centres; measures of poverty in a province and district; and the volume of cases dealt with by individual police station stations, courts and designated facilities. From one service flows the potential of many benefits that both contain the original harm and prevent new and compounding difficulties from seeping into their beneficiaries' lives. These include ending repeat victimisation; limiting children's exposure to violence and its repetition and re-enactment in their (adult) lives; and linking to livelihoods, income, social security and housing.

11 National Prosecuting Authority 2015: 17-18

ACRONYMS

Availability, Accessibility, Acceptability and Quality	AAAQ
Cape Mental Health	CMH
Commission for Gender Equality	CGE
Community health centres	CHC
Community policing forums	CPF
Criminal Law (Sexual Offences and Related Matters) Amendment Act	SOA
Court preparation officer	CPO
Criminal justice system	CJS
Department of Health	DoH
Department of Justice and Constitutional Development	DoJCD
Department of Planning, Monitoring and Evaluation	DPME
Department of Social Development	DSD
Domestic Violence Act	DVA
Early childhood development	ECD
Eastern Cape	EC
Family Violence Child Protection and Sexual Offences	FCS
Focus group discussion	FGD
Gauteng Department of Community Safety	GDoCS
Gender-based violence	GBV
Intellectual disabilities	ID
Investigating Officers	IO
Ke Bona Lesedi	KBL
Kgomotso Care Centres	KCC
Lesbian, gay, bisexual, transgender, queer	LGBTQ+
Medecins sans Frontieres	MSF
National Emergency Response Team	NERT
National Institute for Community Development and Management	NICDAM
National Prosecuting Authority	NPA
National Prosecuting Service	NPS
National Strategic Plan	NSP
North West	NW
Office of the Premier	OoP
People Opposing Women Abuse	POWA
Post-exposure prophylaxis	PEP
Post-traumatic stress disorder	PTSD
Psychological first aid	PFA
Reception, assessment and referral	RAR
Service level agreement	SLA
Sexual Assault Victims Empowerment Programme	SAVE
Short message services	sms
Social auxiliary worker	SAW
South African Demographic and Health Survey	SADHS
South African Police Service	SAPS
South African Stress and Health survey	SASH
Thuthuzela Care Centre	TCC
Unstructured Supplementary Service Data	USSD

Victim Empowerment Programme	VEP
Victim-friendly rooms	VFR
Victim impact statement	VIS

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SECTION ONE: BACKGROUND, APPROACH AND METHOD

1 INTRODUCTION

Services providing care and support in the aftermath of violence are an expression of social solidarity, their very existence testament to both the recognition of violence as harmful and the attempt to undo its many wrongs. At their best, such services offer refuge in times of emergency, limit further harm, and enable a return to the everyday – one where individuals are altered by their experiences but nonetheless able to take pleasure in and meaning from life once more. Yet the 2016 *Report on Diagnostic Review of the State Response to Violence against Women and Children* observed there to be an insufficient number of services, which were also being eroded by inadequate funding – especially the services provided by the non-profit sector.[12] The consequences of this are visible everywhere: in services whose on-going survival is precarious and working conditions poor;[13] in victims' ongoing exposure to violence that can also escalate over time[14]; in the development of chains of secondary consequences, such as participation in multiple other forms of violence and worsening mental health that intensifies social isolation and patterns of self-destructive behaviour; in diminished physical health, including disability; and mistrust of the state and its institutions.[15]

At least some of the policy architecture required to support effective social care services is in place. The courts have ruled that care and support services are an aspect of socio-economic rights,[16] while the National Development Plan treats services as part of the social protection floor beneath which no member of society should slip.[17] Laws such as the 1998 Domestic Violence Act (DVA), the 2007 Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA), and the 2005 Children's Act have been promulgated and 'Response, care, support and healing' identified by the *National Strategic Plan on Gender-based Violence and Femicide* (NSP) as one of six strategies essential to the combating of such violence in the country.[18] But while these various policy statements underscore the necessity of services and begin sketching the form these should take, they do not detail how services ought to be provided. These questions of substance and method must instead be teased out from the patchwork of services provided by the state and non-profit sector. Gathering and consolidating these various parts into a minimum set of core services, supported by costed estimates of their operations, is the purpose of this study.

The task is neither simple nor straightforward. Most care and support services are not packaged, pre-tested and approved service offerings designed in a laboratory, or developed by clinician-researchers from elsewhere. Instead, they tend to be practitioner-developed, localised and small-scale in setting, and often implemented by staff and volunteers with mixed educational/professional backgrounds. Their models, or interventions, are seldom formalised or institutionalised in policy and they are rarely evaluated – let alone made the basis of randomised control trial testing, the gold standard of credible efficacy.[19] In a world committed to a particular notion of evidence-based programming they can seem unconvincing – and perhaps even inferior to 'what works.' But the absence of evidence for the effectiveness of services is not evidence of services' ineffectiveness. Efficacy trials are also not the only way to evaluate a programme's workings. For this study we have adopted a realist or pragmatic approach to the evaluation of care and support services. this is one which focuses on the theory and logic behind particular interventions on the assumption that these interventions ought to be able to explain why and how they able to bring about change. For if a particular service cannot justify itself, or offer a clear and logical basis for its workings, then it is unlikely to be particularly effective.[20]

[12] KPMG, 2016
[13] Vetten, 2019
[14] The most extreme example of this is intimate femicide. Data for 1999 and 2009 show a history of domestic violence to have preceded over 30% of women's deaths at the hands of their intimate male partners (Abrahams et al., 2013)
[15] The under-reporting by women of crimes committed against them is a widespread example of this (see Jewkes, Penn-Kekana and Rose-Junius, 2005)
[16] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2014] ZAFSHC 127 (28 August 2014)
[17] Department of Social Development, 2016
[18] Interim Steering Committee, 2020
[19] Ghate, 2018
[20] Pawson et al., 2004 ; Ghate, 2018.

1.1 Background and purpose of the research project

This project is the outcome of a recommendation made by the 2016 *Report on Diagnostic Review of the State Response to Violence against Women and Children* commissioned by the Department of Planning, Monitoring and Evaluation (DPME) and the Department of Social Development (DSD). In concluding its assessment of the South African government's response to violence against women and children to date, the report made six recommendations, one of which was for the *'Department of Social Development to lead in comprehensively defining psychosocial response services for victims of VAWC, establishing minimum core services and funding implications for their implementation'*.[21] On the strength of that recommendation this project was commissioned by the DPME, under the Technical Cooperation Facility funded by the European Union in partnership with the National Treasury.

As a whole, the project consisted of three activities (captured in Figure 1):

1) Review of existing literature around care and support services;
2) Primary research informed by the literature review's findings and recommendations;
3) Finalisation of a policy brief detailing and costing core services to victims of GBV.

The findings from the primary research are the focus of this report, which also lays the ground for the final policy brief costing those services identified as core. The finalisation of these project outputs has since been identified as a key activity[22] for pillar four of the NSP – response, care, healing and support. This pillar has as its goal: "Victim-centred and survivor-focused accessible, equitable and quality services that are readily available across the criminal justice system, health system, education system and social support system at all respective levels."[23]

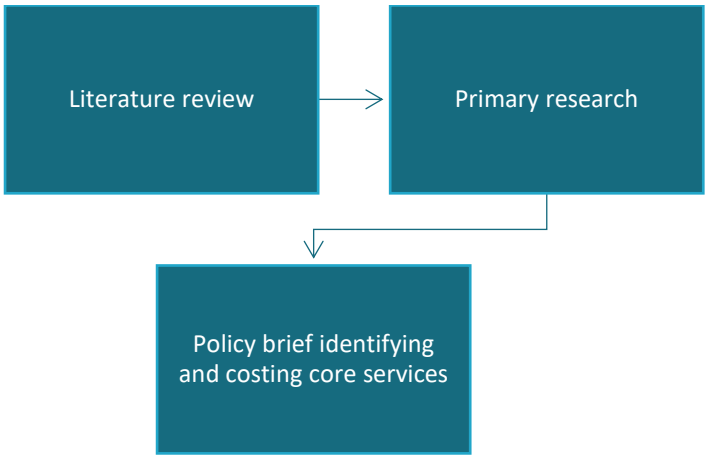

Figure 1 Research project process flow

1.2 Scope of the report

Gender-based violence (GBV) is an umbrella term covering a range of different forms of violence whose manifestation varies according to cultural and historical context. What unites these various forms of violence is the way they reflect and reinforce both gendered social norms around appropriate conduct and behaviour, as well as a social hierarchy ordered in gendered ways. For the purposes of this report we have focused on the

[21] KPMG 2016.

[22] This was phrased as "[D]evelopment of a minimum core package of services and related costing for GBVF survivors" in the NSP (Interim Steering Committee 2020: 75).

[23] Interim Steering Committee 2020: 75

forms of GBV most prevalent in South Africa: domestic or intimate partner violence (IPV), as well as sexualised violence perpetrated by non-partners. While the report also addresses services to children who have experienced related forms of violence, this does not comprise a major part of the study. Unlike for adults, a comprehensive legal and policy framework already exists to guide services to children. The Children's Act, for example, mandates a continuum of care for those who have been victims of violence which ranges from prevention and early intervention, to therapeutic services. In their entirety, these measures to prevent and respond to violence, abuse, exploitation and neglect affecting children constitute the country's child protection system. These services are statutorily determined, while the norms and standards for the child protection system have also been the subject of extensive consultation. Evaluating and revising these does not fall within the scope of the study. Furthermore, a government-commissioned costing of the Children's Bill was published in 2006, which provided estimates of the real cost of implementing the Children's Act, as well as a yardstick against which the government's budgets can be measured.[24] Our research therefore seeks only to examine where clear gaps were identified by the literature review completed in the first part of the project, such as programmes for children in shelters and, on the advice of our reference group (which includes children's organisations), focus groups with care-givers.

It is also beyond the scope of the report to engage with the various debates around different theoretical approaches to counselling, psychotherapy or social development. While noting these, our focus is on services, their type, organisation and workings.

Throughout the report we refer to those who have experienced, or are experiencing, GBV as both victims and survivors. Using both terms acknowledges the all-too real fact of victimisation, as well as the agency of women and girls in seeking essential services.[25]

1.3 Structure of the report

Designating any care and support service as core must begin with an analysis of what is mandated by law and further substantiated in regulations, directives and policy. We set this out in the next section of the paper which also highlights those services which have been insufficiently formalised and so made vulnerable to discretionary, inadequate support. A brief overview of the extent of GBV in the country, as well as its psycho-social effects, follows next, with this discussion beginning to point to the kinds of services required. The report then briefly outlines the human and material services currently available to care and support services. Description of the study objectives, method and sample concludes the section.

Part two of the report builds on this overview by examining the logic behind services and how this translates into their day-to-day operations. Here we draw on the primary research undertaken with government officials and NGO workers, including an expenditure analysis of each service area. Much of what we describe here is not ideal and points towards the kind of normative framework needing to be developed in support of services. , supported by appropriate models of costing. This is set out in the discussion and recommendations concluding the report.

2 EXISTING LEGISLATIVE AND POLICY FRAMEWORK

Services to survivors of GBV are located within the broader framework of social care, or welfare, services in South Africa and form part of the bundle of socio-economic rights to which all citizens are entitled.[26] As such,

[24] Barberton, 2006. See also the budget monitoring reports produced by the Children's Institute at http://www.ci.uct.ac.za/ci/law-reform/childrens-act/budget-monitoring

[25] The 2006 United Nations Secretary-General's In-depth Study on Violence Against Women A/61/122/Add.1 notes the ongoing debate the terms victim and survivor. Some suggest that the term "victim" should be avoided because it implies passivity, weakness and inherent vulnerability and fails to recognize the reality of women's resilience and agency. For others the term "survivor" is problematic because it denies the sense of victimization experienced by women who have been the target of violent crime". Therefore, these guidelines use the term "victim/survivor".

[26] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC for Social Development, Free State and Others (1719/2010) [2013] ZAFSHC 49 (28 August 2014)

these services must be provided and where they are not in existence, the state is obliged to make them increasingly available over time both to more people, as well as a wider range of people.

In addition to being a right, certain care and support services are also essential. In section 213 of the 1995 Labour Relations Act an "essential service" is defined as one whose interruption endangers the life, personal safety or health of the whole or any part of the population. In 2018 the Essential Services Committee designated "Services rendered by mental and related institutions" part of this category.[27] These services included the following:

- Mental health care
- Psychological assessment
- Therapeutic counselling services and any other form of counselling
- Mental health crisis management
- Court preparation and assistance for victims who are users
- Treatment (including assistance with adherence to medication).

Any service defined as 'essential' is effectively a core service.

What has locally been designated essential is congruent with the proposals made by the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence.[28] The Joint Global Programme recommends an integrated response to violence by governments' health, justice and police, and social services departments whose services must, at a minimum, secure the rights, safety and well-being of any woman or girl who experiences GBV. Services across these sectors should be available, accessible, acceptable and of quality, with information regarding all processes routinely available and referral networks, systems and standards the norm.[29] The care and support services forming part of the Joint Global Programme's framework include:

- Crisis counselling
- Basic psychosocial support
- Mental health assessment and care
- Victim and witness support services
- Participation of survivors in sentencing hearings
- Toll-free telephonic helplines available on a 24/7 basis
- Alternative accommodation including safe houses and shelters
- Services to children affected by violence
- Assistance towards economic independence, recovery and autonomy
- Material and financial aid.[30]

The literature review completed for the first phase of the research suggested that almost all of these services already exist in South Africa – although not to the extent required. Some of these services have also been institutionalised through laws and policies, as Table 1 shows. The table also distinguishes between what is expressly provided for and what must be inferred. The DVA, for example, is explicit about the obligations of the police towards complainants of domestic violence, making it their duty to assist victims find shelter from their abusive partners, as well as obtain counselling and medical care. Although no reciprocal legal obligation is placed upon the DSD to make shelter and counselling services available, it can be inferred from the fact of their reference in law that such services ought to exist. (Readers interested in the domestic, regional and international framework principles guiding the provision of care and support services will find these summarised in Annexure 1 of the report.)

Table 1: GBV service type and supporting legislation and policy

Service	Supporting legislation and policy

[27] Government Gazette, 11 May 2018: 36 – 37
[28] UN Women, UNFPA, WHO & UNDP, UNODC, 2015.
[29] ibid
[30] ibid

Expressly provided for:	
Victim friendly room	▪ South African Police Service National Instruction 2/2012 Victim Empowerment
Court preparation and court support	▪ Department of Justice and Constitutional Development Regulation 108 of 2020
Post-exposure prophylaxis to prevent HIV	▪ Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 ▪ National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Act
Implicit in legislation:	
Shelter	▪ Domestic Violence Act, 116 of 1998 ▪ South African Police Service National Instruction 7/1999 Domestic Violence ▪ Children's Act (2005) ▪ National Norms and Standards for Child Protection
Counselling and emotional support	▪ Domestic Violence Act, 116 of 1998
Health care following an incident of domestic violence	▪ Domestic Violence Act, 116 of 1998
Supported by policy:	
Counselling and emotional support	▪ The Victims Charter and Minimum Standards (2004) ▪ National Policy Guidelines for Victim Empowerment (2009) ▪ National Mental Health Policy Framework and Strategic Plan 2013-2020 ▪ Department of Social Development Norms and Minimum Standards for Service Delivery in Victim Empowerment (2013)

But while the policy architecture in support of care and support services is emergent, the substantive content of most services is under-developed. By outlining the extent of GBV in South Africa the next section starts sketching the number of services required, as well as how they ought to be distributed, while the section dealing with the effects of violence highlights the type and nature of care and support services required.

3 EXTENT OF GBV AND IMPLICATIONS FOR WOMEN'S USE OF SERVICES IN SOUTH AFRICA

The Department of Justice and Constitutional Development (DoJCD) noted that approximately 208 591 criminal charges relating to domestic violence had been registered during the 2018/19 financial year.[31] Statistics supplied by the South African Police Service (SAPS) for the same 12-month period recorded 60 984 reports of sexual offences, with adult women reporting 36 597 of these crimes. Rape accounted for 30 626 of these matters. Children reported a further 24 387 sexual offences, with 18 586 of these matters registered as rapes.[32] While these figures offer a useful guide to victims' recourse to the justice system, they are not a reliable guide to the true extent of GBV, as a 2010 research report demonstrated in relation to Gauteng:

- Between April 2008 to March 2009 a total of 12 093 women in Gauteng, or 0.3% of the adult female population, reported an assault by an intimate partner to the police in the province. By contrast, 18.1% of women in the province told researchers they had experienced violence at the hands of their intimate male partners during this same time period.[33] Overall, 33.1% of women had experienced physical violence at the hands of a partner in the course of their lifetimes.[34]

[31] DoJCD 2019: 46
[32] SAPS, 2019.
[33] Machisa et al., 2010.
[34] ibid

- While one in four (25.3%) women interviewed had experienced rape in their lifetimes, only one in 25 women had ever reported their experience to the police.[35]

These data demonstrate that while violence is widespread, most victims elect not to bring their experiences to the attention of state officials. Access to care and support services therefore, cannot be made dependent upon engagement with either the courts or the police.

A further point can be made about the distribution of services. The 2016 national South African Demographic and Health (SADHS) survey reported that one in five (21%) ever-partnered women had experienced physical violence from a partner in the course of their lifetimes, with 8% having experienced such violence in the 12 months preceding the survey.[36] However, these reports of violence were not evenly distributed throughout the country, KwaZulu-Natal recording the lowest proportion of women reporting physical violence (13.7%) and the Eastern Cape the highest (31.6%). Physical violence in the past 12 months was also reported most frequently by women in the Eastern Cape (10.1%) but least often by women in Limpopo (0.9%).[37] These data suggest that some provinces may require a greater number of services responding to intimate partner violence than others. (No equivalent data are available for rape unfortunately.)

3.1 Women's use of services

All women do not prioritise the same services, as use of the Thuthuzela Care Centres (TCC) illustrates. According to the National Prosecuting Authority's (NPA) 2017/18 Annual Report, 33 973 sexual offences were attended to by the TCCs during that 12-month period. However, in 35% of adults' matters the victim did not wish to pursue a criminal charge and wanted TCC health and counselling services only.[38] (Data were not provided in 2018/19).

A case study conducted in one locality in Mpumalanga further illustrates differences between women in their use of services. Drawing on official records compiled by the local courts, police station and hospital, researchers identified 942 women as having sought assistance with domestic violence between 1 January 2006 to 31 July 2007.[39] Four hundred and sixteen women in this group had sought police assistance, a further 322 had approached the courts and 204 had sought healthcare. When cross-referenced these three sets of data showed only three women to have used all three government services during the eighteen-month period under study, with a further 12 both applying for protection orders and reporting the violence done to them to the police. Outside of the three women who had used all three services, none of the women who turned to the courts had also utilised healthcare services. There was somewhat more overlap in use of police and health care services, with 28 police dockets containing the forms required for a medico-legal examination but only five women's cases captured in hospital records.[40]

The findings of this case study may be pointing to weak systems of referral between the various services. But they may also be highlighting the fact that the three institutions were not necessarily responding to the same forms of domestic violence. Because emotional abuse is rarely treated as a crime the case study found few such reports in police records. The DVA, by contrast, specifically allows for protection from emotional and psychological abuse and was thus frequently mentioned in court records.[41] Different institutions are thus seeing different populations of women experiencing abuse. The same point can be made in relation to sexual offences.

In their 2018/19 Annual Report the DoJCD stated that 208 591 criminal charges relating to domestic violence had been registered that financial year, along with 60 984 sexual offences matters. This shows the police to have far more contact with victims of domestic violence than victims of sexual offences. However, the vast majority of these reports did not translate into trials. According to the same 2018/19 data provided by the

[35] ibid
[36] Statistics South Africa, 2016
[37] Statistics South Africa 2016: 55
[38] National Director of Public Prosecutions 2018: 73-74.
[39] Vetten et al., 2009a
[40] ibid
[41] Vetten et al., 2009b.

DoJCD, 13 211 domestic violence-related matters were dealt with by the courts, of which 2 365 cases were finalised with a verdict.[42] By contrast, more than double the number of sexual offences were finalised – 6 341[43] versus 2 365. Proportionally more rape complainants will thus have contact with the criminal courts, than complainants of domestic violence. In relation to domestic violence it is the civil, rather than criminal, courts that are women's chief port of call. In 2015/16[44] the DoJCD reported 275 536 applications for protection from domestic violence to have been lodged with the courts.[45] It follows then, that services based at the criminal courts will benefit a very small proportion of survivors of domestic violence but proportionally more survivors of sexual offences.

What of women's use of counselling services? While the literature does suggest that women value counselling services for rape,[46] in practice, for reasons that are unclear, they do not always turn to them, as a small-scale study[47] of 64 rape survivors seen at one TCC in the Western Cape showed. Of the sample, 71.7% met the criteria for a diagnosis of post-traumatic stress disorder (PTSD) at four weeks post-rape. At six months more than half the group (56.8%) still met a diagnosis of PTSD, with only about one-fifth of the group having sought further counselling. The four reasons most frequently given by women for not obtaining counselling included being unaware of such services; difficulty getting to services; feeling ashamed and embarrassed; and having no need of counselling.[48]

Victims' use of services is thus shaped by factors both institutional (such as the type of assistance offered), as well as personal to the individual (such as shame).

3.2 Forms and extent of psychological distress following an incident of GBV

Most of the psychological distress resulting from GBV has been conceptualised through the lens of PTSD. When used as a measure of emotional suffering it has shown rape, of all forms of violence, to have the strongest association with PTSD among South African women.[49] However, due to its frequency, IPV has been associated with the greatest number of PTSD cases amongst women at population level.[50] According to the national South African Stress and Health (SASH) survey, PTSD affected 6% of those who identified as having been raped, with only experiences of political torture matching or exceeding the severity of rape's effects.[51] Higher rates of PTSD were reported by a Gauteng-based study, its symptoms evident in 28.1% of women raped by non-partners and 15.4% of women either sexually or physically abused by their partners.[52]

PTSD is not the only psychological difficulty affecting women, the same Gauteng study reporting depressive symptoms, including suicide attempts as well as suicidal ideation, in just over one-third (34.2%) of women reporting experiences of sexual or physical IPV.[53] Analyses of shelter case files[54] reported that between 20% and 32% of women had been diagnosed with disorders that included schizophrenia, psychosis, bipolar disorder and borderline personality disorder, as well as PTSD. Anxiety, depression and suicidal ideation (or attempts), as well as difficulties with substance abuse had also been noted by shelter staff.[55] Even though these proportions

[42] Department of Justice and Constitutional Development 2019: 46
[43] NPA 2019: 41.
[44] Department of Justice and Constitutional Development, 2016.
[45] Data for 2016/17 are deliberately not used in this report because calculations for this period are based on the number of reports of particular types of abuse, rather than the number of applications made for protection orders. Using this method, the DoJCD reported 395 628 instances of abusive conduct ranging from physical abuse, to unauthorised entry into someone's residence (2017: 43). This represents a 43.6% increase on the previous year. Given how frequently different forms of abuse co-occur (eg physical and emotional abuse), such a significant increase is more likely the result of double-counting than an increase in the number of individual applications made.
[46] Christofides et al., 2005a.
[47] Maw, 2013
[48] Ibid
[49] Kaminer et al., 2008.
[50]ibid.
[51] ibid
[52] Machisa et al., 2010.
[53] ibid
[54] Vetten, 2018; Vetten and Lopes, 2018.
[55] Abused women's greater reliance on substances is also evident from SASH data which indicated that abused women were nearly twice as likely to report ever drinking and 2.4 times more likely to report regular drinking and non-medical use

were crudely estimated they are suggestive of a higher level of psychological distress among abused women than the general population where the 12-month prevalence for any disorder has been estimated to be 16.5%.[56] Violence, therefore, likely contributes to the higher rates of mood and anxiety disorders reported by women in the SASH survey, which also took a more severe form than men's did.[57]

Other factors thought to detrimentally affect women's mental health include HIV, motherhood (the peri-natal period in particular) and women's higher rates of poverty.[58] The last is very evident in women accommodated by shelters, with approximately two-thirds found to be unemployed and their future prospects limited further still by incomplete levels of education – only 16% of shelter residents were in possession of a matric certificate.[59] Thus, while women's difficulties may appear individual and psychological, they are clearly compounded and mediated by social and structural disadvantage that is both gendered and racialised. Poverty, unemployment and incomplete schooling are not evenly distributed throughout the population but disproportionately concentrated in groups of women racialised as 'coloured' or 'black African'[60] (to utilise apartheid classifications).

4 DESCRIBING CARE AND SUPPORT SERVICES

An important goal of care and support services is the prevention and/or amelioration of victims' distress, which should also include measures to address victims' social disadvantage, given how this interacts with their emotional suffering. What does this mean in practical terms?

4.1 The continuum of care and support service interventions

As the previous section highlighted, victims are not all affected by violence in the same way, nor to the same extent. The forms of their distress vary in manifestation, severity and duration and are influenced by individuals' resilience, as well as the social support and material resources available to them – be these in the form of family and friends, or access to helping services (which includes the ability to pay for transport to these facilities, as well as food to take with medication[61]). Given this, a spectrum of assistance, rather than a single kind of intervention, needs to be made available to survivors. This spectrum also needs to be designed around a dynamic understanding of human responses to difficulty, one which treats these not as static but as altering over time.

One such approach is to understand victims' difficulties as existing on a continuum involving stress, trauma and crisis. While each one of the three is prompted by an external event, it is the individual's appraisal of the event which largely determines how they respond to the event. Thus, what some individuals experience as stress may be experienced as a crisis by others.

At the risk of simplifying contested and complex debates, stress, trauma and crisis may be conceptualised as follows[62]:

- Stress refers to situations where external events are perceived to place demands on individuals in a way that challenges or taxes their personal resources. Stress may be experienced as mild or severe and may emerge following a single event (such as rape) or in situations where difficult events are the chronic condition of someone's life (such as domestic violence). In the case of the latter the stress will likely be cumulative in effect.

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of sedatives, than non-abused women. Lifetime and past-year non-medical use of analgesics was almost double for abused women (Gass et al., 2010).

[56] Herman et al., 2009.

[57] Herman et al., 2009.

[58] Moultrie and Kleintjes, 2006.

[59] Vetten, 2018

[60] See Statistics South Africa 2017 and 2020

[61] Vetten and Haffejee, 2005.

[62] Dulmus and Hilarski, 2003.

- Trauma is a response to an event resulting in physical injury, or one perceived to have caused psychological injury or wounding. A central element of this perception is the sense that one's worldview has been shattered and life itself irrevocably altered. Traumatic events are experienced both psychologically (in the way individuals experience themselves as powerless, or to have been stripped of the capacity to make and sustain meaningful human connections) and physiologically, in the form of somatic aches and pains and an elevated heart rate.
- Crisis presents itself when people perceive their stress or trauma to have reached a point where their ability to cope has been progressively overwhelmed. The outcome is a state of instability and disorganization.

Experiencing events as stresses, traumas or crises is not evidence of a psychological disorder. However, if people are left to struggle with difficult events alone on an on-going basis, this may lead to the development of disorders (although this is not guaranteed either). The conceptualisation of PTSD illustrates this.

Violent events typically result in post-traumatic *stress*, characterised by the following cluster of reactions:

- The presence of intrusive symptoms associated with the event (such as nightmares and flashbacks);
- Persistent avoidance of stimuli associated with the event;
- Negative alterations in cognition and mood associated with the event; and
- Marked alterations in arousal and reactivity associated with the event.

These stress reactions are generally at their worst in the first month following a violent incident and decline in severity over time. However, when all four sets of reactions are still in evidence four weeks after the traumatic event, then a diagnosis of post-traumatic stress *disorder* may be warranted. A traumatic *crisis* may be precipitated when someone feels they have no control over their reactions, are entirely isolated and unable to turn to others for help and can no longer see any purpose to their continued existence. In this state of crisis, suicide may come to seem the only way to resolve the situation. Care and support interventions thus need to be oriented both towards processes of change in victims' response to violence, as well as the depth and complexity of those responses:

- Helping interventions in the immediate aftermath of a violent incident should establish the victim's safety and provide practical, stabilising assistance in the form of psychological first aid (PFA) which can be utilised by professionals and lay counsellors alike.[63] The goal of PFA is to encourage people's ability to cope and function adaptively in the short and long-term by restoring their sense of safety, as well as providing various forms of practical assistance.
- Containment is a necessary aspect of helping during periods of stress, trauma or crisis. As the name suggests, containment refers to the ability to 'hold', or not be overwhelmed by, the strong emotions of fear, anger and rage, or intense anxiety often experienced by victims.
- Counselling, whether short or medium-term, may be offered to help people through difficult periods, including crises.
- Where people's difficulties have become entrenched ways of being that cause significant difficulty and disruption to their lives, then specialised, professional assistance and, in some instances, psychotropic medication, may be necessary.

This spectrum of help requires a range of different kinds of professional and para-professional staff. We detail next the human and material resources actually available to services.

4.2 Resources available to services

The care and support services focused on by this report fall within the category of care work; that is, to activities undertaken within the context of particular kinds of relations (such as mother and baby, nurse and patient, social worker and service beneficiary, or son and frail father) and whose purpose it is to meet the

[63] Allen et al, 2010

physical, psychological and emotional needs of children and adults, young and old, frail and able-bodied.[64] In the case of the care and support services focused on by the research, this healing relationship is bound by a particular ethical framework and its effectiveness reliant upon the fit between beneficiary and counsellor, as well as the use of distinctive techniques.

Care work challenges conventional understandings of the relationship between cost and productivity. While increasing output by reducing input is typically understood as producing the desired goal of efficiency, in the case of care, decreasing the number of social workers or counsellors while increasing the number of beneficiaries only succeeds in compromising both its quality and availability. This is because care's effectiveness is dependent upon a personalised form of concerned and attentive relating which cannot be spread over too many people at the same time; once numbers increase beyond a certain threshold the quality of this relationship is diminished. Employing sufficient numbers of the appropriate staff, at a rate commensurate with the value of their work, is one of the sector's greatest challenges, as we discuss next.

Budgeting for social care/welfare services

Social welfare services in South Africa have never been the exclusive preserve of the state. Since the establishment of the first department of welfare in 1937, these services have been provided through a partnership between the state and the non-profit private sector (including faith-based organisations).[65] This partnership takes material form in the subsidy allocated to NGOs by the DSD. Because a subsidy represents only partial payment, NGOs are expected to source the balance of their costs elsewhere, including other government departments; donor organisations; corporate social responsibility programmes from the private business sector; trusts and foundations; and the proceeds from lotteries. This supplementation has, however, become increasingly difficult[66] - so much so that in 2010 organisations in the Free State turned to the courts to determine the DSD's financial responsibility for these services.

At the heart of the dispute was the extent to which the department should cover organisations' costs of operation. Part of the judgement's significance lies in the importance it accords to human and material resources in the provision of care and support services of an acceptable standard. According to the court these 'core costs' were always to be factored into the funding of any service by the DSD and included the following:

- The salaries of the number of each staff type necessary to providing the service
- Training and staff development
- Water and electricity
- Food supplies
- Clothing
- Lease of premises
- Telephone and other communication costs
- Stationery
- Equipment hire
- Office insurance
- Security guards
- Transport.[67]

But while the court may have determined these costs as core, policy guiding the quantum of funding to each service type, as well as how it is to be calculated, remains outstanding. Instead, the amount of subsidy paid to any particular organisation is chiefly determined by their particular province's department of social development which, in turn, obtains its budget via the Provincial Equitable Share.[68] The amounts allocated to each province are not identical but differentiated according to a formula. Although the extent of poverty in

[64] International Labour Organisation 2018: 6.

[65] While the for-profit private sector also provides some social welfare services these are not discussed here as they are not subsidised by the DSD.

[66] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2010] ZAFSHC 73 (5 August 2010)

[67] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2014] ZAFSHC 127 (28 August 2014)

[68] See the comprehensive discussion in the 2016 review of the DSD's White Paper, particularly proposals three to five (pages 356 – 359)

each province is taken into account, population size is ultimately more decisive in determining a province's quantum of funding. Gauteng thus receives the largest allocation of budget and the Northern Cape the least. But while it may receive the least, the Northern Cape DSD makes the highest per capita allocation towards welfare services for the poorest 40% of its population than the other provinces[69]. In 2014 the Northern Cape was shown to have spent R1 009 per person in this category per year, as opposed to the R299 spent per year by the least generous province, KwaZulu-Natal. The national average was R463 per year.[70]

The provincial budgets for social welfare services are divided between a set of core services areas. Table 2 taken from an August 2018 presentation[71] to parliament's Portfolio Committee on Social Development demonstrates how the combined national and provincial budget for social welfare services is broken down. At 3%, the allocation to the Victim Empowerment Programme (VEP) (which is where the budgets for GBV services will overwhelmingly be drawn) was very small, with only the social relief of distress, at 1%, receiving less. The VEP budget also grew very little over this period and, at 2.7%, was well below inflation. Again, at 2.3%, only social relief of distress showed lower growth.

Table 2: National and provincial budget allocations to social welfare services for the period 2017/18 to 2019/2072

Sub-programme	2017/18 Budget	%	2018/19 MTEF	%	2019/20 MTEF	%	% increase
Care and services to families	499 782	4%	530 644	4%	560 343	4%	7.3%
Child and Youth care centres	1 176 559	9%	1 813 897	13%	1 951 290	14%	5.5%
Child care and protection	1 813 897	14%	1 951 290	14%	1 300 736	14%	5.3%
Community-based care services for children	770 738	6%	815 444	6%	865 466	6%	5.3%
ECD and partial care	2 711 571	22%	2 908 973	21%	3 030 922	22%	8.3%
Crime prevention and support	1 066 885	8%	1 126 772	8%	1 194 379	9%	4.2%
Substance abuse, prevention and rehabilitation	874 251	7%	1 020 279	7%	1095473	8%	11.8%
Victim empowerment	387 775	3%	410 837	3%	443 142	3%	2.7%
Services to older persons	1 312 934	10%	1 382 981	10%	1458857	10%	5.7%
HIV and AIDS	1 109 195	9%	1 102 226	8%	1 165 961	8%	10.1%
Services to persons with disabilities	777 103	6%	810 664	6%	851 859	6%	4.5%
Social relief of distress	98 107	1%	99 834	1%	105 229	1%	2.3%
TOTAL	**12 598 797**		**13 973 841**		**14 023 657**		

The significant variation in subsidies discussed next must be understood against this backdrop.

Provincial post subsidies for social workers

Because the size of subsidies is at the discretion of provinces, rather than standardised through national policy, there is considerable variation in the amounts paid to organisations both within the same province, as well as across provinces. This is very evident in the subsidies allocated towards posts. According to data collected nationally subsidies towards social worker posts varied between as little as R5 415 per month in the North West Province, to as much as R14 536 per month in the Western Cape in the 2016/17 financial year.[73] Social auxiliary workers (SAW) in the Eastern Cape received a post subsidy of R2 981 per month (an amount not

[69] Budlender and Francis 2014: 12-13
[70] ibid
[71] DSD, 22 August 2018.
[72] Table sourced from same presentation of 22 August 2018.
[73] ibid

increased since 2005) while the lowest subsidy in 2016/17 for a SAW in Gauteng was R8 060 per month.[74] The contributions made to staff without formal qualifications have been found to be even lower. For example, counsellors based in the TCCs were reported to receive subsidies of R1 250 per month[75], while shelter studies noted subsidies of R2 500 per month being allocated towards house mothers in domestic violence shelters.[76]

Even though subsidies towards NPO social and social auxiliary worker posts have always been less than that paid to an entry-level social or social auxiliary worker employed by the DSD, the relative gap has increased over time. In 2012/13 the subsidy for a NGO SAW was 86% of the equivalent entry-level post in the DSD.[77] By 2016/17 this had fallen to 61%. Subsidies towards social work posts decreased from 70% to 65% over the same period. For social work supervisors the percentage declined from 66% to 57%.[78] The salary increases awarded to departmental officials also eroded the portion of budget towards NGO services. In 2012/13, 74% of provincial departments' budgets for victim empowerment services were transferred to NGOs, decreasing to 68% in 2013/14.[79] Salaries in the NGO sector are therefore well below the market standard, which has two effects: a high turnover of staff who migrate from the NGO sector in search of the higher salaries and benefits paid by government and the private sector;[80] and NGO posts that either remain empty for months, or are filled by inexperienced staff.[81] The overall result is a care economy characterised by self-exploitation and low-wage, high-turnover labour strategies – all of which compromise the quality of care and the availability of personnel to NGOs.

Mental health services in the public health sector are also compromised by their unavailability. The mental health human resources available to the Department of Health and NGOs was estimated to total 9.3 per 100 000[82] of the population by the 2013 *National Mental Health Policy Framework and Strategic Plan 2013-2020*.[83] Disaggregated, this amounted to 0.28 psychiatrists; 0.45 other medical doctors (not specialized in psychiatry); 7.45 nurses; 0.32 psychologists; 0.4 social workers; 0.13 occupational therapists; and 0.28 other health or mental health workers per 100 000 of the population.[84] Rural areas had even less access to specialised, professional skills. Psychiatrists were represented at a rate of 0.03 per 100 000 of the population in the country's public sector rural health settings, with Mpumalanga and the Eastern, Western and Northern Cape reported to employ no full-time psychiatrists in rural public sector health settings at all.[85]

This research project represents one attempt to address this under-resourcing of services. How we sought to do so is described next.

5 PRIMARY RESEARCH OBJECTIVES, METHOD AND SAMPLE

5.1 Rationale

In an ideal world all the various care and support services would have been evaluated, enabling us to identify and cost the most effective of these. This is not the case. As Table 3 demonstrates, the day-to-day workings of the vast majority of services have been little-researched and their costing almost never attempted.

Table 3: Summary of results of literature review by service type

Service type	Description of	Evaluation of	Costing of service

[74] ibid
[75] Vetten, 2015.
[76] Vetten and Lopes, 2018.
[77] Budlender, 2018
[78] ibid
[79] Budlender and Francis 2014: 42
[80] Lund, 2010
[81] Patel, 2014.
[82] Department of Health n.d: 16
[83] Department of Health n.d.
[84] WHO and Department of Psychiatry and Mental Health, University of Cape Town,2007
[85] De Kock and Pillay, 2017

	service	service	
Emergency/short-term shelter	No	No	No
Medium-term shelter	Yes	Partly	Yes
First responder - Thuthuzela Care Centre	Yes	Partly	No
First responder – victim-friendly room	No	No	No
Telephonic helpline	No	No	No
Court preparation	No	No	No
Court support	Some	No	No
Community-based counselling and support	No	No	No

While these services may reflect consensus around what victims of GBV broadly need, they generally operate in the absence of a policy framework determining their minimum requirements. In practice this means that while many services bear a nominal and superficial resemblance to each other, they also differ in important ways. In some instances, variation may be the necessary consequence of local context and need but in others it may reflect unequal and different access to human and material resources. Thus, interviewing only a handful of services ran the risk of their coming to establish the norm – and potentially entrenching whatever shortcomings and idiosyncrasies existed in those services. Second, if all the services are different, we would have no way of knowing which approach is ultimately to be recommended; the sample will have been too small to provide acceptable, generalisable parameters for the calculation of costs.

To address these challenges, and in keeping with realist evaluation methods, we placed a strong emphasis on the theories of change underpinning particular types of service.[86] Admittedly, theories of change are hypotheses and not evidence of effect. But if explicitly formulated, they may help identify shortcomings in programmes that can be addressed and lay the basis for future evaluation of their effect.

5.2 Primary research objectives

The overall objective of the primary research was to define the elements of the following services:

- First responder services including those based at police stations or telephonic helplines;
- Court preparation;
- Court support;
- Emergency/short-term sheltering;
- Community-based services offering short- and medium-term emotional support and counseling;
- Services for children in shelters.

The study's sub-objectives were to:

- Define the purpose of each service (or what need(s) it is responding to);
- Define the theory of change determining each service (or how the service is assumed to change, for the better, the problem it has identified);
- Describe the different techniques and practices relied upon to provide the service, their order of sequence and the time taken for each step;
- Contrast and compare variations in the way services are provided;
- Identify the number and type of staff required to provide the service and their level of skill/qualification;
- Determine training and supervision needs for those providing the service;
- Describe the referral systems and coordination mechanisms relied upon for service delivery;
- Determine the infrastructure required to support the service (equipment, space, communications, travel costs);
- Understand the availability and demand for the service;
- Determine the extent of monitoring and evaluation required to support service delivery.

For government officials:

- To understand the accessibility and availability of services;

[86] Pawson et al., 2004.

- To understand the factors affecting implementation of services in provinces;
- To identify gaps in policies, norms and standards for service delivery;
- To gain insight into factors affecting utilization of this research study.

5.3 Data collection methods

Focus groups were selected as the primary method of defining services. These not only increased the number of services participating in the study, but also allowed both for more comprehensive description of the different practices, processes and forms that a particular service took, as well as surfacing important variations in the way services were offered. By asking organisations to contrast and compare their services with each other, as well as the logic informing these variations, we were in a better position to distinguish between differences that were the result of insufficient resources and those that reflected necessary contextual adaptation. This enabled clearer identification of those elements of a service that can be standardised, so strengthening the generalisability of each service's costing.

In-depth face-to-face or telephonic interviews were used when particular organisations were considered to demonstrate good practice that could form the basis of standardised recommendations. In these cases, senior staff were interviewed about the organisation's costs and operations. Interviews were also utilised when there were too few services to allow for a meaningful focus group discussion. A further set of interviews was conducted with key informants in government to better understand elements of service provision and implementation.

Document reviews were used to analyse policies, statements of expenditure, as well as use of services, their design and purpose.

5.4 Sample

The sample was drawn from four provinces, two urban and well-resourced (Gauteng and Western Cape) and two predominantly rural and less-resourced (Eastern Cape and North West). A total of 39 interviews and 34 focus group discussions were held with a wide range of government and NGO stakeholders and beneficiaries at national, provincial and local level. The tables below provide a summary of the interviews and focus groups conducted.

5.4.1 National and provincial government officials

A total of 16 interviews and one focus group discussion was conducted with national and provincial government officials. Government departments included the DSD, National Treasury, SAPS, the Department of Health (DoH), the DoJCD and the Gauteng Department of Community Safety (GDoCS).

Table 2: Summary of national and provincial government interviews

Level of government	Total interviews	Total FGDs	Departments covered
National	8		National Treasury, DSD, DoJCD, SAPS, NPA (5)
		1	DoH (1)
Provincial – North West, Gauteng, Eastern Cape	8		DSD, NPA, SAPS, DoH, GDoCS (5)

5.4.2 Implementer focus groups and interviews

A total of 23 interviews and 21 focus group discussions were held across seven service types with 57 organisations/departments.[87]

Table 3: Summary of implementer focus groups and interviews

\Service type	Total	Total FGDs	Provinces	Total NGOs /

[87] The departments include: DSD, NPA, GDoCS

	interviews			Departments
First responder – victim friendly room, telephonic helpline, emergency response	5	7	North West; Eastern Cape Gauteng; Western Cape	15
Emergency short term shelter[88]	3	-	North West; Eastern Cape	3
Community based counselling[89]	12	8	North West; Eastern Cape Gauteng; Western Cape	23
Court preparation (Ke Bona Lesedi)	-	2	North West; Gauteng	1
Court support	3	2	Gauteng; Western Cape	8
Children's programmes at shelters	-	1	Western Cape	3
One stop centre (Khusuleka and Ikhaya Lethemba)	-	1	North West; Eastern Cape Gauteng; Limpopo	4

5.4.3 Beneficiary focus groups

A total of 12 focus group discussions with 58 participants was held with 11 organisations across three services types.

Table 4: Summary of beneficiary interviews

Service type	Total FGDs	Total participants	Provinces	Total NGOs
Emergency short term shelter	2	14	North West; Eastern Cape	2
Community based counselling	9	39	North West; Eastern Cape; Gauteng; Western Cape	8
Community based counselling - marginalised groups	1	5	Western Cape	1

5.5 Analysis of data

There were three elements to our analysis of the field and documentary material. The first focused on the service's theory of change, or the pathway charted for beneficiaries to follow in bringing about the hoped-for, positive change in their lives. A complete theory of change was understood to comprise the following elements:[90]

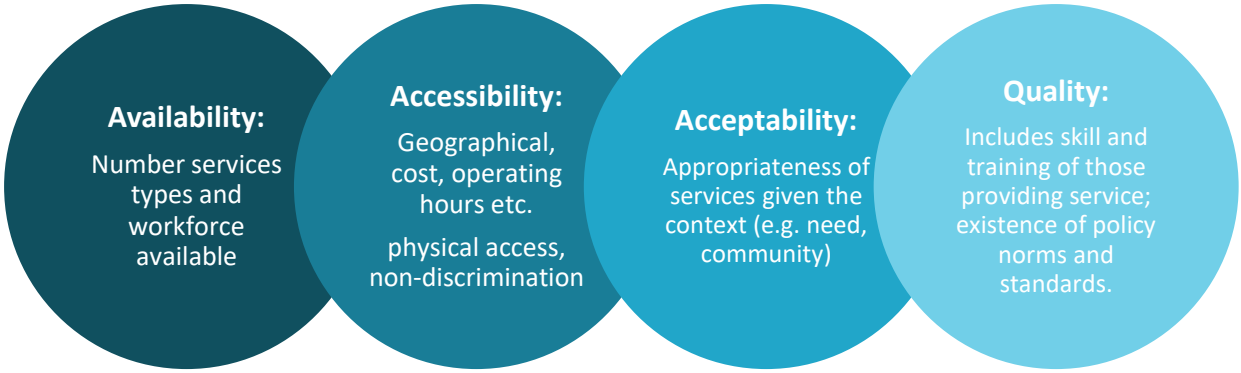
- A formulation of the problem or need the programme seeks to address
- Key parameters specifying, for example, who the intervention is (not) intended for and the setting in which it is to be located
- The resources (or inputs) required to apply the intervention
- The activities (or outputs) to be undertaken in pursuit of the programme outcome
- Specification of implementation outcomes – referring to the changes needing to be made by implementing bodies in relation to interventions that are collaborative or require referral.
- Identification of the mechanism of change, or the factor(s) mediating the programme and its outcome(s). This is key to understanding causality, or the contribution of the intervention to bringing about change.

[88] Many of the planned focus groups and interviews which were allocated to emergency short term shelter service area were re-allocated under first responder services. The Green Doors in Gauteng are no longer functional.
[89] DSD was included in the sample of stakeholders providing community-based counselling.
[90] Drawn from Ghate, 2018

- The desired changes, or outcomes of the intervention – referring to ultimate outcomes, or the overall change intended

The second dimension of analysis involved assessing services in terms of their availability, accessibility, acceptability and quality (AAAQ) (see figure below). As the study progressed, it became very evident that equity needed to be added as a fifth principle.

Figure 2: AAAQ approach to assessing services



The third focus of analysis was expenditure on the various services. This aimed to identify current cost pressures, as well as what would be required to deliver the service in the future. Much of the data obtained for this exercise were not precisely comparable because they were collected in different ways, with varying degrees of precision, and for different purposes by the organisations and departments included in the study.

5.6 Research ethics

The research received ethics approval from the Human Sciences Research Council's Research Ethics Committee in October 2019 and fieldwork was conducted in accordance with the principles of respect and protection, transparency, scientific and academic professionalism, and accountability.

All study participants received a comprehensive study information note in advance inviting them to take part in the research. This assisted them in providing informed, written consent around their participation in either a focus group discussion, or interview. Furthermore, the following was adhered to during the research:

- No individual was named in the report, while the default position for NGOs is anonymity. However, in some instances the service is the only one of its kind and publicly identified with a specific agency. In these cases, identification of the organization or department has been unavoidable. Where this is not the case, organisations remain anonymous. The same approach has been taken with government departments;
- All interviewees were informed of the confidentiality of the information collected, and this was maintained;
- Respondents were guaranteed autonomy that they have the right to freely decide to participate in the study without fear of coercion; and anonymity of participants in the study was preserved at all times.

5.7 Stakeholder consultation

Extensive stakeholder consultation was undertaken throughout the research process and included a series of meetings with the Research Reference Committee during the inception phase and prior to the fieldwork. Before commencing fieldwork, multi-stakeholder workshops were conducted from 23 to 30 July 2019 in

Pretoria (Gauteng), Rustenburg (North West) and East London (Eastern Cape). Finally, the draft report was presented in a series of virtual workshops to the Reference Committee and study participants from 15-26 June 2020 and comments integrated into the final version of this report.[91]

[91] Reports were produced for each of these stakeholder consultation processes.

SECTION TWO: STUDY FINDINGS

This section of the report details and analyses the various kinds of care and support services studied by the research. It begins with a discussion of services' infrastructure, services being neither possible nor sustainable in the absence of human and material resources. Indeed, we found far too many services in the study to have been made a function of their funding and their logic dictated by under-resourcing, rather than a workable theory of change. This is not a recipe for effectiveness and while it is not expected that all services be given unlimited access to every and any possible resource, services also cannot be reduced to their costs alone. Other elements are no less key to determining their design and operation. Based on the different forms taken by the services in the study, we identified the following four elements as being instrumental to the ways services were organised:

- Beneficiaries, or the service users that provide the rationale for the service's existence
- Service modalities, or the set of techniques, practices and methods thought to enable change
- A medium of service, referring to communication that is in-person, telephonic or text
- A physical setting which both housed the service and organized it in relation to the processes and procedures associated with that setting.

We discuss the remainder of the findings in relation to these different features of services, highlighting how the element acting as the service's primary organizing principle influences its form. Court support for people with intellectual disabilities illustrates a service whose design is explicitly intended to ensure its beneficiaries' inclusion within the protections of the law. This discussion is followed by a focus on telephonic helplines where the medium of service acts as the primary principle of design. Modality as organising principle is exemplified by the National Emergency Response Team (NERT), while the section on setting focuses on community-based counselling services, along with services located at health facilities, police stations and the courts.

Each form of service is introduced with a brief background to its establishment, including the extent to which it is formalized in policy. Critical discussion of the various theories of change informing its operations follows next. Here we found that while some services operated within the fully-worked out parameters of a complete theory of change, others lacked such definition – from the conceptualization of the service, to its activities and outcomes. At times, the service's theory was also not formally and explicitly articulated and had to be inferred from existing policy and the field material. The next part of the discussion examines the availability, accessibility, acceptability and quality of the service and how it works, with some of the observed permutations in operation explained by the expenditure analyses that follow. The discussion concludes with an assessment of the service, including how it could be strengthened.

1 CARE AND SUPPORT SERVICES AND THEIR INFRASTRUCTURE: CORE COSTS

Care and support services work with human beings who are typically under stress, have been traumatised or are in a state of crisis. Central to the effectiveness of any assistance at this time is the quality of the relationship between helper and beneficiary. Staff, their skills, training, support and supervision provide some indication of this quality.

1.1 Staffing, training and supervision

Services in the sample were overwhelmingly feminised, meaning they were largely provided to women by other women either formally qualified through professional training – such as social workers, SAW, registered counsellors, psychologists – or more informally qualified through experience – support workers, caregivers, house mothers and lay counsellors. Two new occupational qualifications – court preparation official and court preparation manager – were also in the process of being registered. For reasons both of cost and principle, informally qualified staff were more characteristic of NGO services than government services.

Staff without formal qualifications were often classified as volunteers rather than employees. This distinction is important to understanding their remuneration, for while volunteers receive stipends, employees earn salaries or wages. In fact, it may well be a misnomer to term these staff 'volunteers' once their working conditions are scrutinised more closely.

The 2013 Norms and Minimum Standards on Service Delivery in Victim Empowerment[92] stipulate that volunteers must be managed, trained and supervised by organisations; and some organisations' service level agreements (SLA) show a good portion of the service to be provided by volunteers working more than 40 hours over a three-month period. The extent of control exercised over these staff, as well as the hours they work, are the hallmarks of an employer-employee relationship[93] that ought to result in payment of a salary, rather than the more minimal amount associated with a stipend. The stipends provided by DSD to NGOs in this study ranged from R2 152 to R2 300 per month, which was below the minimum wage for 2019. But even employees could be allocated subsidies below the minimum wage; information provided by one shelter showed the housemothers to be earning R2 750 per month. Organisations dealt with these minimal payments in two ways: either by restricting staff hours to ensure that staff never earned less than the minimum wage (thus reducing the number of staff hours available to the service) or by having staff work full-time – but at rates below the minimum wage. Notably, the one organisation whose staff without formal qualifications earned the most – R6 945 per month – were being supported by an external donor, rather than DSD.

This reliance on volunteers is one reason NGO services cost less than those of government. The second contributor to the greater cost of government services is the wage premium enjoyed by public sector employees, calculated at 23.5% in 2015.[94] Just as was reported in the literature review, so the analyses of services' expenditure showed significant disparities in pay for what is essentially the same work. Table 5 presents the minimum and maximum paid to social workers and SAW by government and NGOs, together with the difference and percentage difference between the two. These calculations show the payment of some NGO social workers to be less than that of a government-employed SAW. Indeed, the lowest-paid NGO social worker earned 91% less than an entry-level government social worker. While the difference between NGO and government SAW was not quite as stark as that between social workers, the lowest-paid NGO SAW was earning less than the cleaner employed by a government service – R115 191 versus R121 320 per annum.[95]

Table 5: Comparison of pay – NGOs and government (as determined by the Department of Public Service Administration)

	NGO rates (in this study)		DPSA rates (2019)		Difference between DPSA and NGO rates		% difference between DPSA and NGO rates	
	Min	Max	Min	Max	Min	Max	Min	Max
Social worker	R135 192	R226 686	R257 592	R581 178	R122 400	R354 492	91%	156%
Social Auxiliary worker	R115 191	R156 600	R148 215	R265 320	R33 024	R108 720	29%	69%

Training, supervision and debriefing

Provincial offices of the DSD were engaging in two contradictory processes in relation to services staffed by individuals without informal qualifications. The first was evident from the allocation of post subsidies to organisations based in rural areas of the Eastern Cape and North West. In what effectively amounted to deskilling, organisations were not receiving subsidies for social workers' posts but expected to refer to DSD social workers instead, especially where children were concerned. This arrangement was not optimal, as the discussion in section 5.1.4 shows. It also meant that women admitted to shelters in peri-urban and rural areas were not offered the same levels of expertise and skills as women in urban areas, and also did not have the benefit of as many services.[96] The Western Cape and Gauteng provincial offices of the DSD, by contrast, were pursuing a strategy of professionalisation. In these provinces NGOs were being required to employ staff at the

[92] DSD, 2013.

[93] See the *Code of Good Practice: Who is an Employee?* Published under GN 1774 in Government Gazette 29455, 1 December 2006.

[94] Bhorat et al., 2015.

[95] Details of the cleaning staff's salaries were provided by a government one-stop centre.

[96] Lopes et al., 2018

level of SAW or more – a process seen as pushing the more experienced workers out of services. If provincial offices of the DSD nonetheless insisted on allocating post subsidies to a SAW or social worker alone, then this required organisations to consider retrenching their existing counsellors.

It is reasonable to ask questions about the quality of service provided to beneficiaries and staff referred to as counsellors illustrate how widely this quality can diverge. In one organisation 'counsellor' referred to staff who had completed a three-year degree and were registered with a professional body; in another, to staff who had attended a three month training course, worked on probation until considered competent, and then continued their counselling under close supervision; while in a third case, to staff whose training had consisted in observing others, whose competence had not been tested and who received no supervision or on-going training. Defining what qualifies someone as a counsellor is clearly in need of standardisation. At the same time, the demand for professionalisation of a particular kind both clashes with principles of community development – which would treat the inclusion of less formally qualified staff as building the capacity of local community members – and ignores how little funding organisations received for training. Indeed, it is one of the first activities to fall by the wayside when there is an insufficiency of funds. Organisations which had investigated further training for their counsellors described the SAW course as expensive and lengthy, with some individuals also unable to comply with study entry criteria. Other training cited as unaffordable was play therapy for children – a necessary skill in shelter services. According to study participants options for accredited training ranged from short certificate courses, to diploma and Master's-level courses, with costs being between R5 000 and R35 000 (depending on the service provider).

Regular supervision, which offers practical and technical advice on complex cases, issues and referrals, would also support informally qualified staff, as well as those with formal qualifications. Supervision is typically offered by another more experienced practitioner who may also have a higher degree of qualification (thus lay counsellors could be supervised and supported by a social worker) and enables staff at all levels to provide counselling services. But here too limited funding was compromising a necessary function. Organisations either did not receive funds to employ social work staff or did not receive funds to obtain supervision from outside the organisation (necessary for senior staff, as well as more complex cases).

In addition to training and supervision, staff require debriefing to prevent and address vicarious trauma, burn-out or tension and stress.

> *Crying on your way home doesn't work. We need to shake it off before you go home.*
> (Interview, Western Cape)

'Shaking it off' enables staff to share and release the immediate emotional impact of particularly difficult or distressing cases and needs, therefore, to be available on a flexible basis. Time constraints – typically the result of too few staff – was another reason why debriefing or supervision was often unavailable. And while psychological support might sometimes be required, few organisations had access to such services – either for themselves or their beneficiaries. One organisation's medical aid scheme covered up to six sessions with a psychologist, while another had a relationship with a NGO that offered affordable, individual therapeutic services. Without this support organisations reported absenteeism among staff, signs of depression and late-coming.

1.2 The material infrastructure supporting services

Across services the same set of material resources emerged as particularly indispensable.

Transport, food and clothing

Because there are too few social care services in South Africa generally, especially in rural areas, informal settlements and many townships,[97] beneficiaries often incur multiple and recurrent travel costs. These are for meetings and counselling at organisations' offices; health and medical care; court proceedings; or to obtain

[97] DSD, 2016

documents provided by the Department of Home Affairs. Services such as counselling frequently require more than one session, while child victims may need to be accompanied by an adult, which doubles the cost of transport. Many beneficiaries cannot afford these costs, especially in households marked by food insecurity. The lack of food security also meant that when organisations did contribute towards their beneficiaries' transport costs, some took to walking to organisations' offices to save the money they were given to buy food instead.

Food is also required for those who attend support groups (which tend to be longer than counselling sessions), or who have travelled long distances to spend a day at court, or to be examined at a health facility. It may also be required to support those completing a regimen of post-exposure prophylaxis (PEP) to prevent infection with HIV.

Clothing is needed when complainants are required to hand over items of wear for evidentiary purposes, or when they have been evicted from the household, or forced to escape its premises.

The maintenance, accessibility and availability of facilities

NGOs do not receive funds for maintenance of their facilities. Either government departments are unwilling to invest money in properties they do not own, or donors are unwilling to invest their funds in properties that organisations – and shelters in particular – do not own.[98] Some shelters are also in a state of disrepair, as well as having no access to running water or bath or shower facilities. This applies to both NGO and government premises.[99]

Both NGO and government offices are not always adequately maintained either:

> *We pay a rental, a minimal amount, and the rest of the building is empty because the city staff has moved out* [due to safety concerns]*. The building is not maintained although we have asked the city to help. There are holes in our ceilings, and boys crawl through the roof to steal. As a space where the client needs to be nurtured, it is not good.*
> (Focus group discussion, Western Cape)

Ramps, lifts and toilet facilities adapted to the needs of people with disabilities were also not in evidence at all NGO and government facilities.

Government facilities also face space constraints, which is particularly evident at courts and police stations. In some instances, it is simply not possible to provide the service until infrastructure such as a park home has been obtained. The procurement process is a lengthy one and the criteria used to prioritise some areas over others is reportedly unclear:

> *One police station has not had a structure for 10 years but then another station is prioritised – I am not sure how they do this but hopefully it is done according to statistics.*
> (Interview, Gauteng)

Security

Office break-ins were a concern for most service providers and alarm systems, burglar proofing and security gates a corresponding necessity. Shelters, however, may need more than this, as do organisations based in areas plagued by high levels of crime where armed robberies have occurred on organisations' premises.

> *In our communities it is not just counselling with beneficiaries, but we get exposed to gang violence. There is stone throwing and roads are blocked. There is danger in the area where I work and I am not sure if is going to affect me and my life. I cannot leave when I want to. People are shot in front of you sometimes. Some beneficiaries' partners threaten you. I sometimes have to hide my car so nobody knows I am there.*
> (Focus group discussion, Western Cape)

[98] Lopes et al., 2018
[99] CGE, 2019; Lopes et al., 2018

At the time of the fieldwork parts of the Cape Flats had been declared red zones and the army stationed in the area. The security of equipment, vehicles, staff and beneficiaries was of major concern, while movement across zones sometimes required a police escort. Attention to the broader context in which services are located is clearly necessary when determining the extent and type of security required.

1.3 Concluding commentary

An over-reliance on under-paying particular categories of staff was the norm in too many of the care and support services in this sample. This constitutes a set of inequities along multiple lines: between volunteer and employee; the formally and informally qualified; rural and urban organisations; government and NGO staff; and NGOs reliant upon DSD, versus those funded by other donors. Ultimately this is to the detriment of both beneficiaries and communities. Investing in staff not only increases the quality and effectiveness of services but values women's work in this sector.

We recommend the following:

- Applying the term 'volunteer' only to those who genuinely work without recompense. All other staff involved in providing the service should be recognized as employees and, at the very least, paid in accordance with the National Minimum Wage Act.
- As the literature review made clear, some survivors' distress is of a serious nature and requires specialist intervention. But this is not true of all survivors, some of whose difficulties fall on the mild to moderate end of the spectrum. These are limits within which NGO care and support services can operate if trained and supervised – as the National Mental Health Policy Framework and Strategic Plan 2013-2020 recognises.[100] We thus suggest that the deskilling and professionalization observed here be addressed through the creation of a qualification and occupational category, possibly termed a 'support worker'. Their scope of practice may include PFA and containment, crisis counselling and support, and social assistance - referring to forms of practical assistance such as applying for grants and court orders or developing beneficiaries' ability to generate an income. Recognition of prior learning should be built into the process. Additionally, ways must be found to fast-track this process. Previous attempts at accreditation were reported to involve processes so convoluted, difficult and time-consuming that they had been abandoned by many organisations.
- The costing of services must include regular training and allow for both internal and external supervision.
- All service descriptions should list the type of staff required to provide the service, with the amounts of subsidy paid to each staff type specified and standardised across provinces.
- In addition to being standardized, NGO subsidies should be significantly increased. Given the wage premium that public sector employees enjoy, it would be inappropriate to peg NGO subsidies at the same rate. We would suggest calculating subsidies at 80% of the public sector rate.

2 BENEFICIARY AS ORGANISING PRINCIPLE: COURT SUPPORT FOR PEOPLE WITH INTELLECTUAL DISABILITIES

All care and support services are, in principle, designed with beneficiaries in mind, with this design based on a set of assumptions about who will use the service, what their needs and difficulties are likely to be, and the nature of their capacities and capabilities. But if not critically examined, these assumptions can become barriers to services. In some instances, inattentiveness to particular beneficiaries' needs is likely deliberate; their use of the service is not desired. Migrants and refugees, focus group participants said, were prominent among this category, with many afraid of approaching the police even when legally resident – and even more so if undocumented. But 'foreignness', we found, could also be extended to cover South African whose customs were unfamiliar to those managing the service:

[100] DoH, n.d.

> *We find the Islamic culture very difficult to deal with – due to cultural norms that we don't understand.* (Interview, Eastern Cape)

It is not likely that Muslim beneficiaries would have found this service welcoming.

Prejudice, as well as service staff's lack of familiarity with their needs and circumstances, also deterred LGBTQ+ individuals from seeking help. The quote below, in which a focus group participant expressed their appreciation of the service offered by a local health clinic, points to some of the features of valued, welcoming services:

> *You can feel the support and you feel it is confidential. At this facility they help with trans people and MSM* [men who have sex with men]*. There is no judgement about your sexuality. They don't ask for papers. You fill in a form and they ask for your nickname.*
> (LGBTQ+ focus group discussion, Western Cape*)*

The necessity of recognising and accepting transgender individuals' personal identity and gender expression also came to the fore in residential facilities that insisted on placing trans women in men's facilities on the basis that they were classified male at birth[101] (dealt with further in section 5.2). The problem is more than one of appropriate placement in, or admission to, residential facilities, however; it also a question of the way IPV is conceptualised. Much violence within intimate relations is framed as something cisgender, heterosexual men inflict upon cisgender, heterosexual women. Because seldom thought beyond heterosexual and binary gender categories IPV is generally not recognised in same-sex, queer or trans individuals' relationships.[102] Counsellors, in turn, may not be aware of the unique aspects of abuse in LGBTQ+ relationships, nor how to assist in ways that are not heteronormative.[103]

People with disabilities experienced no less a lack of acceptance. Standard forms of communication, the physical design of spaces, and the rigid application of fixed processes and procedures, coupled to stigmatising attitudes towards disability, all functioned to exclude. People whose disabilities required non-standard forms of communication, such as sign-language interpretation or Braille, for example, were not effectively assisted by agencies who had neither the training, nor the means, to communicate differently. Mothers of children with multiple disabilities who required specialised care, or children with significant mental health disorders, struggled to find shelters capable of accommodating their needs. And court procedures were ill-suited to children and people with intellectual disabilities (ID) because they presumed a certain level of cognitive ability and style of reasoning.

These various forms of exclusion, stigmatisation and lack of acceptance left people uncertain about whose services could be trusted. The consequence was to create new categories and kinds of beneficiaries which, in turn, gave rise to new services whose explicit rationale is the correction of their beneficiaries' exclusion from existing services. Depending on their beneficiary population, these services typically incorporated either migrants and refugees among their staff, or LGBTQ+ individuals. In the next section we focus on one such specialised, beneficiary-focused service: court support to people with ID.

2.1 Purpose of the service and associated theory of change

The needs of people with ID are little-recognised and the services to them accorded low priority[104] - including services addressing violence.[105] This is despite the fact that women and girls with ID are at greater risk of sexual violence than the general population.[106] Aspects of this vulnerability are addressed by Chapter 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA) which introduced new offences

[101] CGE, 2019.
[102] See Lynch and Sanger, 2016; and Moodley, 2013.
[103] Padmanabhanunni and Edwards, 2013.
[104] Adnams, 2010
[105] Meer and Combrinck, 2017
[106] See Phasha (2012) for a summary also attentive to the South African context.

against people with mental disabilities, in addition to the crimes of general applicability contained in Chapter 2. Further, in terms of section 54, any person who knows, suspects or reasonably believes that a sexual offence has been committed against a person with mental disabilities is obliged to report this to a police official. Finally, Chapter 6 of the SOA introduced a National Register for Sex Offenders intended to record the names and particulars of all those convicted of any sexual offence against a child or person with mental disabilities. Anyone convicted of such offences must not be permitted to care for persons with mental disabilities nor have access to facilities where they are likely to live or congregate.

However, the protections offered by these provisions are dependent on the police effectively assisting complainants with ID and the courts successfully prosecuting their matters. This is not the case. Analysis of the attrition of rape cases through the criminal justice system in 2012 found that the cases of people with disabilities – 88.2% of these being intellectual disabilities – were less likely to proceed to trial than the cases of their non-disabled counterparts.[107] The problem is not new. In 1990 it had been estimated that no more than one or two of the sexual offences reported annually by victims with ID were considered for prosecution in Cape Town. In the hope of altering this situation the police and prosecution services approached Cape Mental Health (CMH) for assistance. The Sexual Assault Victims Empowerment Programme (SAVE) was the result.[108]

The goals of the SAVE programme are simple: to offer people with intellectual disabilities who are victims of sexual abuse the same access to justice as the general population and to ensure the conviction of perpetrators. Their theory of change identifies three conditions necessary to securing these outcomes:

> Complainants with ID can participate in legal proceedings and their matters result in convictions when there is a network of referrals in place across the criminal justice system; psychosocial support to the complainant and their family is made available before and during the trial; and expert evaluation reports detailing the complainant's capacities and capabilities are compiled and presented to the court.

SAVE's theory appears to have been borne out in practice. Analysis of their programme records for the decade between 1990 to 2000 found a similar rate of conviction to that of the general population (25%),[109] meaning that complainants with ID who had been through the programme had as much chance of their cases resulting in conviction should the case go to trial, as non-disabled complainants.[110] Further, approximately three-quarters (74%) of the service's beneficiaries expressed satisfaction with the service, with the social worker's active assistance and support, including their presence in court during trial testimony, being especially valued.[111]

2.2 Description and parameters of the service

All complainants with ID and their families who report allegations of sexual abuse to CMH receive social work services intended to assist the victim over the trauma and help the families prevent further abuse. However, only complainants whose matters are likely to go to trial are included in the SAVE programme due to both its costs and the demands placed on its support.

The centrepiece of the SAVE programme is its psychological evaluations which are key to assisting the courts to understand individual complainants' capacity to consent to sexual acts, especially as ID is not uniform and exists on a spectrum ranging from mild, to moderate and severe. These reports can only be obtained from an expert (a psychologist or psychiatrist) and must explain the nature and extent of the mental disability. In addition to these psycho-legal assessments, the SAVE programme also offers court support, as well as expert testimony on the contents of their report.[112] Other components of the programme include social worker follow-up, support and risk review to both victims and their families, and accompaniment to court.

[107] Machisa et al., 2017.
[108] Dickman and Swartz, 2005.
[109] This figure was derived from an analysis of conviction rates prepared by the South African Law Commission.
[110] Dickman and Swartz, 2005.
[111] Dickman et al., 2006.
[112] ibid.

Part of the SAVE programme also focuses on helping the legal system to understand and effectively assist people with ID. Their training aims to assist police officers and prosecutors to identify and refer complainants, adapt their questioning appropriately, and understand and respond to behaviour that seems unfamiliar or 'strange.' When funding is available, and as a way of extending the program nationally, CMH provides training and ongoing technical support to mental health societies, clinical psychologists, and related professionals across South Africa. These training activities are under-funded and not as frequent as they ought to be. As a result, it has been difficult to expand the network of referrals, particularly in rural areas. Also unfunded is the training psychologists require in psycho-legal content and interpretation of the law, with CMH relying on the current group of psychologists to provide this.

2.3 Availability and demand for the service

By 2005, the one or two cases prepared for court in 1990 by CMH had grown to about 45 annually.[113] At the time of the interview in early 2020 this number had further increased to approximately 120 assessments. However, there is a waiting list for these as the number of psychologists willing to work at a discounted rate is limited, which constrains the availability of the service. Only the Western Cape DSD currently funds the service (and only fairly recently at that), with the national office of the SAPS at an advanced stage of discussion with CMH to also contribute to the costs of SAVE assessments. While other national and provincial departments (Justice and DSD) have acknowledged the need for such a programme, funding to support its establishment has not been forthcoming.

The number of beneficiaries with active, open files at the time of the interview is captured in the table below.

Table 6: Beneficiaries of the SAVE programme

Race	Female	Male	Total
African	73	8	**81**
Coloured	120	26	**146**
White	5	2	**7**
Other	1		**1**
TOTAL	**199**	**36**	**235**

Outside of the SAVE programme, which continues to be available in the Western Cape only, there is also a service to children with ID offered by the Teddybear Clinic in Gauteng. However, the number of children with ID assisted by the Teddybear Clinic is small, with 35 assessments and court support interventions undertaken between 2015 and 2019. While other research suggests that more than these two services may exist in Gauteng, Western Cape and KwaZulu-Natal,[114] no description of any of these other services could be found.

2.4 Service process flow

> *Sometimes the FCS* [Family Violence Child Protection and Sexual Offences] *officer can pick up the possibility of ID or the caregiver says that they are diagnosed, or it is picked up by the Prosecutor during their first consultation. It is difficult – sometimes a person is not answering because they don't understand, or are scared, or they might just be anxious or traumatised*
> *(*Interview, Western Cape*)*

Investigating Officers and other members of SAPS are the main source of referral to CMH, followed by prosecutors. Referrals are also made by DSD, intermediaries and court preparation officers. Once these are received appointments are set with individual beneficiaries for a screening and intake assessment which typically takes a social worker about a day to complete. When a matter is referred from one of the surrounding

[113] Dickman and Swartz, 2005.
[114] Meer and Combrinck, 2017

rural areas the case review will be telephonic in form. CMH will also pay for the complainant's travel to Cape Town with a caregiver, overnight accommodation for two nights if necessary, meals and a small stipend.

Once the intake and assessment process has been completed a clinical psychologist administers a set of psychometric tests to determine the complainant's level of intellectual functioning; their competence to testify; and their level of understanding of sexuality, as well as their ability to consent to sexual activity. On average, two days or 16 hours of a psychologist's time is required for the assessment, preparation of the report and testifying in court.

During this period a field social worker will also be undertaking home visits, coupled with individual and family sessions, aimed at preparing the complainant for their appearance in court. The social worker will also attend the case to support the complainant and her or his family. This aspect of the service cannot be extended to rural areas however and beneficiaries are referred to local DSD or NGO social workers instead. This sometimes results in files being closed if neither DSD nor the NGO is able to follow up.

The following staff are required to provide the programme:

Table 7: SAVE court support programme - number and type of staff

Number and type of staff	Role description	Notes
1 Project manager	Follow up, engage with beneficiaries, manages and oversees steps, planning	
1 Receptionist	Supports beneficiaries on assessment days, explains what's going on, shows them facilities, makes comfortable.	Works across all 22 programmes at CMH.
5 Psychologists	Each works 1 day per week to undertake a psychological assessment and be a credible expert witness.	Without this, the chances of a conviction are very small. They are fully occupied and salaried for 49 days a year.
3 Intake Social Workers	Initial assessment with client and caregiver	
4 Social worker managers	Supervise, monitor, support	
19 Field staff (17 SW, 2 SAW)	Court preparation, counselling and on-going support to victims and families. Training of prosecutors, SAPS and other professionals (funding dependent).	Requires a thorough understanding of statutory responsibilities and the criminal justice system.

The Teddybear Clinic's assistance includes up to seven hours of psychological assessment and report writing, as well as a minimum of 10 one-on-one sessions with a court preparation counsellor. A social worker will also compile a report for the court assessing the child's ability to testify.

2.5 Service expenditure analysis

The SAVE programme is specialised and cannot function without psychological assessments, which also cannot be performed by those not qualified as such. It therefore should not be compared to the court support programmes discussed later.

Total staff costs amount to R1.2 million per year (with no breakdown of number of staff for this analysis).

Table 8: Court support expenditure for people with intellectual disabilities, CMH

	Total cost Annual
Recurring cost	**R 1,577,109**
Staff	
Management	
Social Worker	
Social Auxiliary Worker	R1,200,843
House mother	
Unpaid volunteers	
Operating expenditure	
Transport	R49,500
Training of staff	R600
Food and refreshments	R10,600
Other	R315,566
Once off cost	**R17,681**
Equipment	R3,000
Computer expenses	R14,681
Community based care (vehicle)	
% of once off cost (20%)	**R3,536**
Total cost of service	**R1,580,645**
Number of beneficiaries	**235**
Service cost per beneficiaries	R6,726

The organisation assists 235 beneficiaries per year, where 60% of them are carry-over from the previous year. This equates to a cost of R6 726 per beneficiary per year. This is cost-effective, taking into account that it includes 16 hours of a psychologist's time, one day of assessment by a social worker and further social work and support to the complainant's family. To put this in context: If the expenditure of R6 726 is apportioned to the psychologist's time alone, then this amounts to a cost of R370 per hour. By contrast, the hourly rate in 2019 for a psychologist in the private sector ranged from R951.40 to R1 285.00.[115]

The Teddybear Clinic receives no additional funding for their service to children with ID and relies entirely on any money received that is not tied to pre-defined use. While expenditure on their programme is somewhat lower it must be remembered that they are offering an add-on to a children's programme, while CMH is offering a comprehensive programme to people with ID.

Table 9: Court support expenditure for people with intellectual disabilities, Teddybear Clinic

[115] See table available at http://www.clairenewton.co.za/images/psychologist/Medical_Aid_Rates_for_Psychologists_2019.pdf

	Unit	Total
Intake appointment - primary caregiver	R95.88	R95.88
Psychologist - interview primary caregiver	R458.00	R458.00
Psychologist sessions - interview child - 2 to 4 sessions	R458.00	R1,832.00
Psychologist report for court	R458.00	R916.00
Court preparation intake	R95.88	R95.88
Court prep counsellor - minimum 10 sessions	R97.83	R978.30
Court prep readiness report by social worker	R97.83	R195.66
VAT		*R685.76*
Total cost of service per beneficiary		**R5,257**

2.6 Concluding commentary

This section has outlined the ways in which different beneficiaries' service needs are neglected – not only as a result of prejudice, or lack of information but also as a matter of funding. Different strategies will therefore need to be pursued to enable services to embrace a wider range of beneficiaries. In the case of people with mobility-related disabilities or sight impairments, this entails ensuring that the built environment is accessible: people are able to gain entry into buildings, move between different levels and use toilet facilities. Addressing other barriers will require service providers to be trained around the various forms of disability, sexual orientation and gender identity, as well as ways of working that are not heteronormative. Information materials about services should also reflect a wide diversity of users, while organisations should seek to increase the acceptability of their services by employing staff reflective of a diversity of backgrounds, including in relation to ability, sexual orientation and gender identity.

Care and support services to people with ID are a legal obligation and must be included in the core package of services. Indeed, as the SOA recognises, they are entitled to additional protections given their greater vulnerability to sexual offences. CMH's particular approach shows how people with ID can enjoy access to justice, as well as the full protection of the law. That they remain largely excluded from these processes is a function of the specialised services they require and the cost of these. They are thus illustrative of a more pervasive problem affecting the provision of services generally: economies of scale.

According to Census 2011, 3.2% of the population had a mild intellectual disability, with a further 1% having severe intellectual disabilities.[116] Three points can be made in relation to these percentages. First (and most obviously) the number of people with ID is small, inevitably ensuring that the skills required to work with this population are specialised. Second, and following on from the previous point, if services to people with ID are mainstreamed, this will be at the expense of their specialised nature. Specialisation arises when knowledge and experience are concentrated in a particular field, rather than being distributed generally, and can only be maintained by on-going exposure to the area of focus. Third, specialised capacity is expensive. However, it cannot be shifted down; psychologists cannot be replaced by SAW, for example, without fundamentally altering the service and its effectiveness. These are arguments not against the provision of specialised services, but in support of their taking a particular form. To ensure the cost-effective provision of services, we recommend the establishment of a limited number of shared and centralised specialised services. These shared specialised services offices should be established in each province to extend care and support to all those who need it, using a combination of:

a) **contracting service providers as and when needed** – government departments or NGOs apply to make use of a specialist service and contract accordingly once this is approved.

b) **sharing staff across services** – specialized staff are based at one central office on a full-time basis but serve several individual agencies (for example, one psychologist could provide their services to five different organisations).

[116] Cited in Meer and Combrinck, 2017.

Shared specialised services would not only provide access to psychological services for people with ID. Such services would also be available to any shelter or community-based counselling service requiring psychological assistance for their beneficiaries. Other specialised services to be offered would include sign language interpreters for Deaf beneficiaries, as well as language interpreters to assist those whose first language may not be in wide use in a particular locality. Shared specialised services should also offer training to equip care and support services to assist migrants and refugees, LGBTQ+ individuals, and people with disabilities. Finally, as centralisation has the effect increasing a range of transport-related costs – so placing the service out of reach – we recommend that a budget for travel be included within the costs of these shared specialised services.

3 MEDIUM AS ORGANISING PRINCIPLE: TELEPHONIC HELPLINES

Services relied on text, the telephone, and in-person presence as their medium of communication. In-person communication was most frequently utilised by services in the study sample and text least often. This section focuses on care and support services organised around the provision of telephonic assistance, showing how, as a medium, it alters the ways people use services and ask for help. The examples are the national helplines managed by Childline, Lifeline and the DSD.

3.1 Purpose of the service and associated theory of change

Childline is the oldest of the three helplines and was established in KwaZulu-Natal in 1986 as a response to children's assertions that they had no-one to whom they could report their abuse. By the end of the decade further offices of Childline had been opened in Gauteng and the Eastern and Western Cape, with the service extended to the remaining provinces in the 1990s. The first national helpline responding to violence against women, the 'Stop Women Abuse' helpline was inaugurated in July 1999 to coincide with the broadcast of a series of Soul City focused on domestic violence. Originally initiated as a partnership between the National Network on Violence Against Women, Soul City and the Departments of Justice and Social Development, the helpline's management was soon handed over to Lifeline. In 2005 the line was renamed the 'Stop Gender-based Violence' helpline. The newest of the three lines is the GBV Command Centre which was formally launched on 25 March 2014.

The helplines' theory of change is really a theory of use informed by three features of telephonic communication which distinguish it from in-person communication, namely: immediacy, convenience and anonymity.

Telephones do away with distance, with the result that people need not physically travel somewhere for help. They are thus of particular benefit to those living at great distances from services, as well as indispensable to obtaining immediate assistance in times of crisis or emergency. Further, while it is better for people to be physically present during counselling sessions, this is not a requirement for obtaining information. A telephone call is thus more convenient than going in person to an office. Finally, the anonymity conferred by telephonic contact offers its own unique therapeutic benefits. First, the facelessness of telephonic contact is less exposing than in-person counselling and so less threatening to those whose experiences have left them consumed by shame. Second, they are a safe way to test others' reactions to difficult emotional material, allowing callers to reveal as much as they feel comfortable with at any one time, again without exposing themselves. Thirdly, because callers can hang up, or stay silent when the phone is answered, telephonic services facilitate the process of converting raw experience into language, allowing people to become ready to speak. The telephone, therefore, is a less risky medium of communication than in-person communication.

Childline also encourages children to see the helpline as their own resource, and even as form of a play, given how central this is to children's learning. Thus, when children call the line to tell counsellors about their school-day, or other events, this is welcomed as providing children with an opportunity to be listened to, articulate their thoughts, and plan their own futures. Encouraging children to see the line as theirs may also increase the likelihood of it being turned to for support should something serious happen in individual children's lives.

The Command Centre is the most likely of the three lines to emphasise the immediacy of telephonic communication, describing its line as 'the frontline for GBV calls'[117] which, along with the NERT, forms part of an emergency package of services.[118] The emphasis on urgency is further underscored by the Command Centre's reliance on digital technologies which geolocate and link callers to the nearest police station and other emergency services. Digital technologies also enable particular ways of capturing and storing data. Because all engagements are captured and transmitted electronically, paperwork is reduced and statistics made easier to collate. Additionally, the data can potentially be used to understand the incidence of violence in particular areas and the corresponding need of social workers.[119]

3.2 Description of the service

The helplines serve a variety of purposes to callers, providing information and referrals, a reliable listening ear to those who may be lonely and isolated, a route to urgent help, and on-going emotional support and assistance to those who either have no other access to services, or who prefer the anonymity of telephone lines. Some callers are thus fairly regular and there are also callers who counsellors will follow up with.

All three lines operate on a 24/7 basis and are free of cost to the user. While all rely on the telephone to provide their service, the Command Centre also offers people the opportunity to contact them via Unstructured Supplementary Service Data (USSD) *'please call me'* messages and short message services (sms). Deaf callers can contact the Command Centre through Skype or, in the case of Lifeline, via WhatsApp.

3.3 Availability and demand for the service

Drawing on records provided by all three helplines this section presents figures detailing their use. Key to understanding this is the distinction between calls and cases. While helplines manage a high volume of calls the immediacy, convenience and anonymity offered by the telephone results in a high number of hoax calls and calls about matters unrelated the helplines' focus – in addition to the calls that are hung up or where the caller remains silent. These calls only become actual cases once an individual caller makes sufficient contact with the counsellor to explain their problem and receive assistance. Cases are thus a more meaningful measure of a helpline's service than calls. Due to the fact that the three services do not record calls in the same way only limited comparison of their services can be offered.

The table below reports the number of calls made to Lifeline, the GBV Command Centre and Childline Gauteng between 2016 and 2019. (In the case of the GBV Command Centre the number of sms and USSD messages has been added to the number of phone calls to create one overall total.) While Childline Gauteng receives the most calls by far it must be remembered that they respond to a far wider range of issues than do Lifeline and the GBV Command Centre. (This number also includes calls from the Western Cape, as Gauteng takes over the after-hours and weekend service to the province.)

Table 10: Total number of calls received by Lifeline, the GBV Command Centre and Childline Gauteng, by year

Year	Lifeline[120]	GBV Command Centre[121]	Childline Gauteng[122]
2016	46 202	97 321	305 223
2017	378 038	182 354	370 241
2018	114 265	102 286	401 347
2019	81 431	96 620	337 522

[117] DSD, 21 June 2017.
[118] ibid
[119] DoJCD 2019: 117
[120] All data in this section provided by N Papale of Lifeline
[121] Data taken from the response to National Assembly question 30, February 2020
[122] All data in this section provided by L Cawood, Childline Gauteng.

Table 11 provides an annual breakdown of calls received by Lifeline and Childline, versus those answered. According to Lifeline's manager the eight-fold increase in calls between 2016 and 2017 is explained by the organisation's concerted effort to raise the helpline's profile. These efforts were initiated during the latter half of 2016 and continued until the funding to do so fell away at the end of 2017. What the table also illustrates is the effect of understaffing on both Lifeline and Childline's services, with at least 26.3% of calls, rising to 41.3%, going unanswered by Lifeline, and between 22.2% to 29.0% unanswered by Childline. (The insufficient number of counsellors on duty is discussed further in the next section of the report.)

Table 11: Lifeline and Childline - calls received and answered by year

Year	Total calls received		Calls answered		Calls unanswered (%)		Childline (actual)
	Lifeline	Childline	Lifeline	Childline	Lifeline	Childline	
2016	46 202	305 223	31 720	237 171	14 482 (31.3%)	68 052 (22.2%)	237 171
2017	378 038	370 241	221 611	285 150	156 427 (41.3%)	85 091 (22.9%)	285 150
2018	114 265	401 347	81 297	284 849	32 968 (28.8%)	116 498 (29.0%)	284 849
2019	81 431	337 522	60 013	243 104	21 418 (26.3%)	94 418 (27.9%)	243 104

Lifeline collects its data within limited parameters that do not lend themselves to further analysis and so the next section of the analysis concentrates on Childline Gauteng and the GBV Command Centre's cases.

Data for Childline Gauteng is detailed below. (With the exception of the abuse calls, we have not provided a detailed breakdown of all call categories.) The apparent drop in numbers between 2015/16 and 2016/17 is explained by their shift to capturing cases only. Like Lifeline, Childline attributed the decrease in cases to the ending of sponsorship for their billboards and other advertising in the province.

Table 12: Number of cases dealt with by Childline by type and by year

	2015/16	2016/17	2017/18	2018/19	2019/20
TOTAL CALLS AND CASES	**49 710**	**21 155**	**19 877**	**14 527**	**11 248**
ABUSE	**13 613**	**2 751**	**5 167**	**2 697**	**2 698**
Abduction	*287*	*171*	*54*	*64*	*46*
Emotional abuse	*5077*	*727*	*1997*	*805*	*922*
Exposure to Criminal Violence	*1248*	*16*	*24*	*22*	*19*
Exposure to Domestic Violence	*1443*	*140*	*114*	*123*	*133*
Exposure to Pornography	*17*	*9*	*20*	*8*	*18*
Harassment	*493*	*72*	*57*	*66*	*77*
Inappropriate Sex Talk	*116*	*38*	*39*	*19*	*28*
Physical Abuse	*4390*	*1215*	*2416*	*1134*	*1064*
Rape	*374*	*199*	*261*	*258*	*213*
Sexual Assault	*169*	*164*	*185*	*198*	*186*
Alternative care	1745	142	53	41	44
Behavioural problems	1855	417	312	364	439
Commercial exploitation of child	218	72	61	40	42
Disability	98	48	51	45	34
Discrimination	184	26	37	18	17
Family relationship problems	4396	728	674	786	809
HIV/AIDS	152	55	57	70	62
Homelessness	1169	102	67	52	44
Legal issues	1962	330	410	340	355
Neglect	1470	958	889	1043	1135

Peer relationships (incl bullying)	224	47	53	51	35
Physical health	635	93	88	97	62
Poverty and grants	2741	163	145	207	207
Psychological health	949	169	198	224	201
Refugee child	13	12	17	15	12
School problems	731	603	725	821	706
Childline services and information	13357	6427	3862	3701	2389
Sexual health and behaviour	375	102	89	92	77
Substance abuse	2665	4084	3619	316	389
Undefined / other	1156	3826	3303	3507	1491

The GBV Command Centre also distinguishes between calls and cases. In 2017 it reported receiving a total of 182 354 calls. However, only 1 047 (0.6%) were GBV cases, with this number comprising 32 cases of abandoned children, 12 cases of indecent assault and 1 003 cases of physical violence.[123]

A more detailed picture emerges for 2018/19 when the Command Centre received 102 286 calls, with 6.8% being converted to cases. The number of GBV cases, calculated as a percentage of all calls, was 2.2%. When calculated in relation to cases only, GBV made up 32.7% of all cases. Table 13 provides an overview of the various cases dealt with by the Command Centre.

Table 13: Number and type of cases received by GBV Command Centre 2018/19124

Incident type	Total
Abandoned children	23
Abduction/ Kidnapping	11
Assault	84
Bullying	18
Child neglect	312
Child pornography	2
Elderly neglect	58
Emotional abuse	491
Forced initiation	1
Hate speech	17
Human trafficking	7
Incest	14
Indecent assault	8
Molestation	15
Physical violence	776
Rape/Corrective rape	318
Sexual harassment	6
Stalking	7
Verbal abuse or intimidation	89
Total GBV cases	**2 257**
Total non-GBV cases (e.g. marriage difficulties, child custody concerns, substance abuse, Home Affairs queries, depression)	**4 648**
Total all cases	**6 905**

[123] DoJCD 2018: 108
[124] DoJCD 2019: 119.

3.4 Service process flow

Providing telephonic support follows a fairly standard format: a call comes in, is answered, and the exchange then documented for administrative purposes. How calls are dealt with differs somewhat between the three agencies. Lifeline, for example, does not take at face value calls purporting only to seek information. Working with the possibility that such requests can also function as a kind of disguised help-seeking, they will further probe callers' requests – with the result that some information requests become actual counselling cases. Calls made to Childline that reveal abuse, or create the suspicion that abuse may be occurring, legally oblige the organisation to instigate processes of investigation and removal. Childline is not designated to undertake statutory work however, and liaises with other agencies around these processes. On an emergency basis it can also accept children into its Sunlight Safe House. The Command Centre's use of digital technology adds a slightly different modification to the processes followed by the service. When a call is received, the counsellor requests permission to geolocate the caller. If this is granted the counsellor then sends the caller's particulars to the nearest available social worker for attention via a mobile app. The social worker is then expected to provide feedback on the outcome of the case via the same app to the Command Centre.

The Command Centre's geolocation functions are helpful in those urgent cases where the police need to be dispatched. But a caller using a fixed landline can also be geolocated – not via satellite but through the register Telkom maintains of the physical addresses of the phones they have installed. This means that both Lifeline and Childline can ensure that emergency assistance is still provided when a call is disconnected before an address can be obtained verbally. Both helplines provided examples of such situations and the assistance provided by Telkom in tracing the caller's address so that the police could be dispatched. This however, is a more time-consuming process than that enabled by satellite location.

Despite the similarities in their work each service has very different resources at its disposal. The table below summarises the personnel available to the different lines, showing the Command Centre to have a total staff complement of 69, with 61 of these dedicated to the counselling service. Lifeline has 24 staff and Childline 20. However, because 14 of Lifeline's 19 staff work a maximum of seven days per month, far fewer person-hours are available for the staffing of their helpline. This accounts for its under-staffing and the unanswered calls highlighted earlier.

Table 14: Personnel available at different telephone helplines

Agency	Staffing
Lifeline	▪ Supervisors ▪ 19 counsellors (5 permanent, 14 temporary working 7 days/month)
Childline	▪ Supervisors ▪ 17 counsellors (2 permanent, 15 on stipends)
GBV Command centre: Counselling component	▪ 1 manager ▪ 8 Supervisors ▪ 48 social workers ▪ 4 quality assurers
Technological support (provided by Vodacom)	▪ 4 shift supervisors ▪ 1 technical support ▪ 1 training co-ordinator ▪ 2 IT specialists

Lifeline and Childline operate with three shifts, and the Command Centre two. Lifeline allocates the bulk of its counsellors to the 10am – 6pm shift (between 5 and 6 counsellors) and utilises between one and three counsellors for the other two shifts. Both Childline Gauteng and the Command Centre are able to place 10 counsellors on a shift. All three services ensure that at least one supervisor is on duty every shift. Childline Gauteng and Lifeline utilise counsellors to provide their respective services (although their supervisory staff are a combination of social workers, social auxiliary workers and psychologists). Where Lifeline's counsellors have received the standard package of Lifeline training, Childline utilises social work interns who are paid a stipend by the relevant Sector Education and Training Authority.

The Command Centre's care and support staff complement is entirely composed of social workers. The Command Centre also has eight members of staff whose purpose is to ensure that the various digital systems function as they should. These are all sourced through Vodacom, which initially made the services available at no cost in 2014 for the first five months of the Command Centre's existence. Since then these, and other costs, have been paid in full to Vodacom.

3.5 Cost of service – expenditure analysis

Two sets of financial data for the GBV Command Centre are reviewed and compared below. The first from 2017/18 shows the Command Centre operating at an annual expenditure of R23 million (as at June 2017[125]). Operating expenditure amounted to approximately R9 million per year, where the rental costs accounted for 52% and technical workflow management costs accounted for 22% of total operating expenditure. (Note, the annual cost of the Voice and Data line is R416 000.)

In 2019/20 only global figures for staff costs and goods and services are available, which total R21 million.[126] It is worth noting that even though the total cost of the Command Centre was reduced by about R2 million over the two year period, the number of social work staff (those actually providing the service) was reduced by 12, while the number of technical staff increased by eight. It is not clear what necessitated this shift in operations. We also see a reduction in total calls over the same period of up to 80 000.

Table 15: Expenditure of GBV Command Centre

2017/18	Number	Unit cost	Total cost Annual
Recurring cost			**R23 450 576**
Staff			
Call Centre Manager	1		R657 558
Social Work Supervisors	6	R341 322	R2 389 254
Social Work Agents	48	R226 686	R10 880 928
Quality Assurers	2	R281 418	R562 836
Facility rental			R4 680 000
GPS Facility			R984 000
Mobile Facility			R864 000
Technical Workflow Management			R2 016 000
Voice and Data costs			R416 000
Total cost of service			**R23 450 576**
Total GBV cases			**1 047**
Total calls			**182 354**
Service expenditure per case			R22 398
Service expenditure per telephone call			R129

2019/20	Number	Unit cost	Total cost Annual
Recurring cost			**R21 001 000**
Staff			R15 843 000
Call Centre Manager	1	No breakdown	
Social Work Supervisors	7		
Social Workers	36		
Social Auxiliary Workers	2		
Technical Manager	1		
Technical Shift Supervisors	4		
Information Technical	2		
Quality Assurance Manager	1		
Quality Assurers	2		
Goods and services			R5 158 000
		No breakdown	
Total cost of service			**R21 001 000**
Total cases			**6 905**
Total calls			**102 286**
Service expenditure per case			R3 041
Service expenditure per telephone call			R205

In 2017/18 the Command Centre received a total of 182 354 calls, of which 1 047 were reported as GBV cases. (No information is available regarding any other cases the Command Centre may have dealt with during this period.) This means that in 2017/18 the expenditure per beneficiary (all calls) equalled R129 and expenditure per GBV case equalled R22 398. In 2018/19 the Command Centre received 102 286 calls, of which 6 905 became cases. Of this total 2 257 were GBV-related cases and 4 972 for other concerns. If we apply the costs provided for 2019/20 to these figures, then expenditure per call increased to R205 and expenditure on all cases decreased to R3 041 per case. However, if we take only the GBV cases into account on the basis that these represent the purpose of the Command Centre, then expenditure per GBV case was R9 305.

Table 16: Expenditure of Childline Gauteng's helpline

[125] DSD, 21 June 2017.

[126] National Assembly question 30, February 2020

	Number	Unit cost	Total cost Annual
Recurring cost			**R2,500,000**
Staff			
Supervisors	3		R1,600,000
Counsellors	17		
Operating expenditure			
Facility rental			R 32,541
Communication			R 216,437
Other			R 651,022
Once off cost			**R -**
% of once off cost (20%)			**R -**
Total cost of service			**R2,500,000**
Total cases			**11,248**
Service expenditure per case			R 222

No break down

Table 17 shows Childline's total expenditure with its expenditure per case. This shows Childline to employ less than half the staff complement of the Command Centre – but to respond to double the number of cases, with expenditure per case being 14 times less than that of the Command Centre.

Table 17: GBV command centre and Childline comparison

	GBV Command Centre	Childline
Total cost	R21,001,000	R2,500,000
Total staff cost	R15,843,000	R1,600,000
Number of staff	56	20
Average cost per staff	*R282,911*	*R80,000*
Total cases	6,905	11,248
Average cost total calls	*R3,041*	*R222*

Lifeline's expenditure is similarly low per beneficiary. For all calls the cost is R18 per call.

Table 18: Cost of Lifeline Stop Gender Violence helpline

	Number	Unit cost	Total cost Annual
Recurring cost			**R1,458,641**
Staff -Gauteng			
Chief social worker	1	R17,488	R209,851
Aux Social Worker	2	R13,050	R313,190
Counsellors	14	R2,300	R27,600
Staff - National			
Counsellors	5	R13,969	R908,000
Operating expenditure			
Transport			
Other			
Once off cost			**R0**
% of once off cost (20%)			**R0**
Total cost of service			**R1,458,641**
Number of calls			**81,431**
Service expenditure per call			R18

3.6 Concluding commentary

Telephonic helplines are a core service conferring the important benefits of immediacy, convenience and anonymity. But as the analysis of calls suggests, at best only 7% of callers appear to be seeking help. Of course, callers who remain silent, or hang up when the telephone is answered may well be testing the service or gathering the courage to speak. It is also possible that at least some hoax calls and calls about matters outside of the helplines' purview represent disguised forms of help-seeking, meaning that the percentage of callers assisted in some way may be higher. Even so, ensuring that the costs of a helpline do not ultimately outweigh its benefits means paying careful attention to the type of staff employed to work on helplines. As expenditure on the Command Centre illustrates, the use of social workers makes for a very expensive service relative to the number of callers helped.

We recommend that a cost-benefit analysis be done of the three national helplines so as to compare their relative cost effectiveness. The key comparative elements of each service should be the average cost per staff member as well as the cost per call to each centre. The study should consider the reach of these services versus their costs and what level of staff is necessary for the helplines. We further recommend a review of the value and necessity of the digital component of the Command Centre, as it is unclear whether the benefits of these tools justify their cost. Analogue, or landlines, may well provide equal, if not better, value when other factors are taken into account. If it is found that the digital component of the Command Centre be kept, it should be put out to tender. The relative benefits of a decentralised versus a centralised service should be evaluated and, depending on the outcome, it may be advisable to restructure the service into province-based or even regional helplines.

4 SERVICE MODALITY: THE NATIONAL EMERGENCY RESPONSE TEAM

Care and support services rely on a range of modalities, or methods, techniques and procedures thought to be helpful, supportive and change-inducing. These may include counselling (which could be individual, couple or family counselling); play therapy; group support; clinical diagnosis and medical intervention; accompaniment; the provision of information; and practical assistance (such as finding a job, or an alternative place of accommodation). On the whole these modalities did not function as services' organising principle – with the exception of the NERT. While its form is shaped by a particular understanding of short-term emergency psycho-social support, this design is also inspired by a theory about the place of government in people's lives.

4.1 Purpose of the service and associated theory of change

The NERT is a product of the 2010 Soccer World Cup and the need to provide a rapid response to any disasters or traumatic events that may have occurred at the time. Its role and purpose have evolved considerably since then to include interventions at Marikana following the deaths of 32 miners at the hands of the police in 2013, support to families affected by the collapse of TB Joshua's church in Nigeria, as well as assistance to those affected by the closure of Lily Mine. It became more closely focused on GBV in 2015 following the #RUReferenceList protests at Rhodes University in 2015 and was formally launched on 29 November 2016 by the Deputy-Minister of Social Development as a structure closely allied to the work of the GBV Command Centre.[127] The murder of Karabo Mokoena some months later in 2017 further consolidated the NERT's role in responding to GBV.

The NERT's approach to GBV adopts the methods and approach typically deployed during emergencies, disasters and traumatic events. This is short-term frontline psychosocial support, provided as soon after the event as possible, on the assumption that immediate intervention minimises the later development of pathological symptoms and other difficulties. This is a standard principle of trauma theory that also informs the health facility-based services discussed later in the report. The difference between the NERT and these

[127] Bogopane-Zulu, 29 November 2016.

services lies in the conceptualisation of GBV incidents as traumatic events akin to disasters or humanitarian emergencies. As such, intervention is required at the site of the traumatic event rather than a facility situated elsewhere. This is one aspect of the logic informing the design of the NERT's intervention. Its second aspect emanates from a particular understanding the role of government. On this approach the NERT should be the tangible, material expression of government at the coalface of emergency; it should ensure government 'is brought very close to the people'[128] and made visible in people's time of need. This understanding likely influences the way cases are chosen for intervention, as we discuss later.

4.2 Description of the service

The work of the NERT is largely undertaken by the National Institute for Community Development and Management (NICDAM) on behalf of the DSD. The team consists of four full-time staff including a former teacher and nurse, as well as social workers. When necessary, the team can be supplemented with other professionals.

Four categories of beneficiary are assisted through a combination of psycho-social support, debriefing, and facilitated discussion.

- Category A beneficiaries, or direct victims – receive short term psycho-social support in GBV cases described as 'sensitive' or 'complex' (especially those that are the focus of media attention);
- Category B beneficiaries, or indirect victims – include schools and communities who typically participate in facilitated, supportive discussion of difficult events (such as the murder of a fellow pupil or community member);
- Category C beneficiaries – include direct victims of violent crime, disasters and accidents, as well as front-line workers. Short term psycho-social support is provided to victims and debriefing to front-line workers;
- Category D beneficiaries – are those who participate in community dialogues in areas where there is a high prevalence of reported cases.[129] This includes universities and colleges.

As the NERT cannot respond to all traumatic events, given their sheer number, its focus is cases prominent in the media, as well as cases referred to it by state officials.

4.3 Availability and demand for the service

The NERT made three intervention registers available for the period March 2017 to March 2020. These were not complete, the records for July to September 2018 being missing. What was available is presented in Table 19 below, organised by time period and intervention type. The table also captures both the total number of interventions in each category, as well as the total number of people reached by each intervention. While psychosocial support comprised the greatest percentage of interventions (37.0%), it also reached the smallest percentage of beneficiaries (0.8%). University dialogues, by contrast, amounted to 20.9% of all interventions but had the greatest reach, with university and college students comprising 68.0% of all beneficiaries.

Psycho-social support was provided to 46 cases over the three-year period, with the majority (33 or 71.8%) of these being GBV matters. Assistance for non-GBV-related violence or other difficulties – such as unexpected deaths, or murders committed in the course of other crimes – was made available to just over one in four of the cases in this category (13 or 28.2%).

Beneficiaries of group/community support or dialogues are not recipients of psychosocial assistance. However, this category does include occasions when the NERT is asked to attend an event in case someone should request counselling. But how many such individual requests are received is unknown, as the figures provided by the registers reflect the total number of people in attendance at the event, rather than those who sought counselling. To provide an example: in 2018 the NERT attended the GBV Summit to provide support to the

[128] Video interview with Siza Magangoe available on NICDAM's Facebook page https://web.facebook.com/187482721270389/videos/1350757821609534

[129] Based on interviews; information from South African Government News Agency, 6 July 2018; and Deputy Minister Bogopane-Zulu's speech of November 2016.

audience. However, the total number of those attending the Summit (1 200) was provided, rather than the number of individual participants who requested help.

Table 19: NERT intervention types, by time period, number and beneficiaries

Intervention type	March '17 – June '18		Oct. '18 – Sept '19		Oct. 19 – March '20		Totals	
	Number	Beneficiaries	Number	Beneficiaries	Number	Beneficiaries	Number	Beneficiaries
Individual / family psychosocial support	17	143	25	60	4	16	46 (37.0%)	219 (0.8%)
Group / community support, dialogue	9	1 738	2	1 350			11 (8.9%)	3 088 (24.9%)
University dialogues	16	6 800	10	12 300			26 (20.9%)	19 100 (68.0%)
Meetings, events, exhibitions	4	12	11	3 205	16	1 923	31 (25%)	5 140 (18.3%)
Training	2	100	1	160	7	240	10 (8.0%)	500 (1.8%)
TOTALS	**48**	**8 793**	**49**	**17 075**	**27**	**2 179**	**124 (100%)**	**28 047**

4.4 Service process flow

The NERT's GBV service entails the following: NICDAM staff monitors the media (both traditional and social) and alerts the DSD when a matter is identified, or a government official identifies a matter and refers it to the NERT. If the case can be transferred to the relevant province for immediate attention, the intervention ends there. But if the province is not able to respond immediately (especially at nights and over week-ends), or the national DSD is required to spend some days complying with the bureaucratic procedures necessary to intervening at provincial level, then NICDAM will respond to the case.

While a small number of beneficiaries of psychosocial support are attended to at NICDAM's offices, it is much more common for the NERT to travel to people's homes where the focus will typically be on the family, rather than the victim alone, and even friends and neighbours in some instances.

The great majority of cases required only a single contact with the victim and/or their families, judging from the NERT intervention registers. Of the 46 cases recorded, 36 (78.2%) involved one contact. The most contacts recorded for any case was four, with two cases – one being the murder of Karabo Mokoena – receiving this amount of assistance. In Karabo Mokoena's case these contacts took the following form: psychosocial support to her family; then to those who attended her funeral; followed, a month later, by the NERT attending a walk against GBV and offering support to any participant who requested it; and finally, offering psychosocial support to those who attended the inaugural lecture in her name.

4.5 Cost of service – expenditure analysis

The total cost for the NERT service in 2019/20 was R633 985. To match activities to this expenditure period the relevant data were extracted from Table 20 and recalculated, with these figures presented below. As this table shows care and support services were no longer the NERT's main output by 2019/20; meetings, exhibitions, events and training had taken precedence.

Table 20: NERT interventions for the period April 2019 to March 2020

Intervention type	April 2019 – March 2020	
	Number	Beneficiaries
Individual/family psychosocial support	14	30
University dialogues	1	3 300
Meetings, events and exhibitions	19	4 998
Training	7	240
TOTALS	**41**	**8 568**

In keeping with this distribution of activities, university dialogues, meetings, events and exhibitions constituted the bulk of the output for this expenditure, with incident intervention fees allocated 4% of total expenditure. If we separate expenditure on care and support services (highlighted in red) and compare that to the number of interventions and beneficiaries, we find that care and support interventions cost R1 929 per intervention and R900 per beneficiary.

Table 21: NERT expenditure

2019/20	Total expenditu Annual	% of total
Recurring cost	**R633 985**	
Project Management	R75 000	12%
Project Communication	R5 931	1%
Project stationary and printing	R9 813	2%
Project Financial Management	R50 000	8%
Project Transport	R31 496	5%
Coordinator Fees	R60 000	9%
Administrative Support	R25 000	4%
Office Rental and Furniture	R12 333	2%
Incident Intervention Fees	**R27 000**	**4%**
National Social Workers GBV Training (6 provinces	R284 917	45%
University Dialogues	R40 995	6%
Meetings	R11 500	2%
Total overall cost of NERT intervention	**R633 985**	
Number of beneficiaries overall	**8 568**	
Number of interventions overall	**41**	
Number of care and support interventions	**14**	
Number of care and support beneficiaries	**30**	
Expenditure per individual care and support case	R1 929	
Expenditure per individual beneficiary	R900	

4.6 Concluding commentary

There are different components to the NERT intervention, ranging from individual psychosocial support, to dialogues and training. Our recommendations are restricted to the psychosocial support component alone; we do not offer an opinion on the other elements of the intervention.

It is widely accepted that supportive interventions in the immediate aftermath of a traumatic event can limit the subsequent development of pathological symptoms and other difficulties. However, a NERT-style intervention is not the most appropriate form for such a service. This has much to do with that aspect of its theory of change which conceptualises GBV as a form of disaster or emergency – a consequence of its origins in the 2010 World Cup.

Disasters or humanitarian emergencies are singular events directly affecting many people simultaneously because concentrated in space and time. Incidents of GBV, by contrast, are everyday, distributed across space and time, and affect individuals and their immediate circle. The problem with a NERT-style design is therefore one of scale: while one team could assist most of those affected by the shootings at Marikana because it was a once-off, localised event, it cannot reach all victims of the many daily incidents of rape in South Africa (let alone those involving domestic violence). Restricting the NERT's response to cases attracting public attention does not solve the problem of scale either. Indeed, it only creates a new, additional problem, that of inequity. For that reason and because an emergency-style response is not cost-effective in terms of its reach, we recommend prioritising first responder services at health facilities over NERT-style interventions. As the section dealing with health services will show, these see many victims of rape and IPV – but currently offer little more than the medical minimum in response.

5 SETTING AS ORGANISING PRINCIPLE

The VEP is government's flagship programme addressing the needs of victims of violence and crime generally and provides the overarching framework for care and support services. First launched in 1998, the VEP has been further fleshed out through the *Service Charter for Victims of Crime in South Africa* developed by the Department of Justice[130] and the *Victim Empowerment Guidelines*[131] compiled by the DSD in 2009, as well as the *Norms and Minimum Standards for Service Delivery in Victim Empowerment*[132] issued in 2013 ("the 2013 Norms and Standards"). Women and children, among other groups, are a priority for the various services on offer.

VEP services are intended to be multi-disciplinary and to straddle the departments of Social Development, Justice (including the NPA), Health, and Education, as well as the SAPS. This reliance on partnerships and interdepartmental and intersectoral collaboration produces a web of interdependencies and referral pathways. Each service can thus be imagined as a nodal point within these layered and multi-directional networked processes of intervention and assistance.[133] This makes much of the VEP highly dependent on myriad implementation outcomes, with Table 22 below detailing these multi-directional pathways.

Table 22: Description of referral pathways for community-based counselling services

Service type	Description of referral pathways
Health facilities	Often the entry point for victims of violence, these may include hospital casualty and the out-patients department, along with community health centres and TCCs.
Police	Victim Friendly Rooms, or a SAPS Investigating Officer at the local station, serve as the primary point of service and referral.
DSD service points and NGO services	Both sets of services may be referred to by other agencies, as well as acting as a source of referral. They are important to those who have not utilised the legal system, or who are exploring their options in this regard.
Schools	Schools are some of the most frequent places for children to report abuse, or where teachers observe behaviour or harm. Counselling services are often initiated through schools reporting this either to a social worker or the police.
Courts	These offer both court preparation and support and may refer their users to shelters and counselling services.
Prisons	While their incarceration prevents offenders – largely men – from seeking assistance outside of the environment of the prison, they will come into contact with first responder services based at health facilities.

[130] DoJCD, n.d.
[131] DSD, 2009
[132] DSD, 2013
[133] DSD 2009:

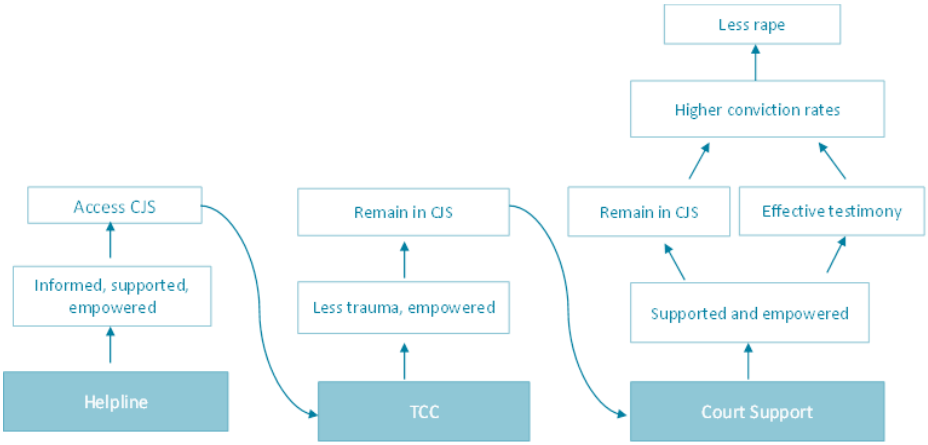
NGO services are distributed across most of these service points as Table 23, taken from a study of 27 NGOs based in the TCCs in 2015,[134] illustrates. Taken together, these 27 organisations accounted for at least 183 different service points to rape survivors (although, because some of these were satellite offices, the service would not have been available every day). The health facility coupled to the counselling office was the most typical service combination in this study and the court-office combination the least frequent.

Table 23: Number of organizational services, by setting

Site of service	No. of organisations providing such service (n=27)	Total no. of sites
Court	6	15
Police station	8	31
Shelter	10	11
Non-TCC health facility	10	22
TCC	27	39
Offices and satellites	27	65

When care and support services are distributed in this way they can be described as modular, that is, comprised of different parts which combine to make a whole. Figure 3 illustrates how each component of one particular organisation's services to rape survivors is envisaged as fitting together to produce such an interlocking and comprehensive framework of support.

Figure 3: Interlinked forms of support to rape complainants



Modular services not only create multiple pathways to counselling but also enable organisations to provide a service that is intermediary in style, that is, one which, alongside and in support of the victim, negotiates and navigates formal procedures such as reporting a rape; undergoing a forensic examination; applying for a protection order; or testifying in court. The aim of intermediating processes in this way is the elimination of secondary victimisation:

> *The victimisation that occurs not as a direct result of the criminal act, but through the response of institutions, the community at large and individuals close to the victim, whether by blaming the victim, ignoring his/her role in the criminal justice process and/or through insensitive treatment. Secondary victimisation describes the way in which personnel of the criminal justice system, or associated systems such as the health or welfare services or the community at large, may victimise victims a second time by blaming them, being insensitive to their needs and ignoring the victim's role in the criminal justice process. Secondary victimisation may be particularly likely in the case of victims who have little knowledge or experience of the criminal justice and associated systems and therefore do*

[134] Vetten, 2015

> *not expect and are ill-equipped to handle processes such as undergoing a forensic medical examination, or giving evidence and responding to cross examination in court*.[135]

One dimension of care and support services thus attends to the direct effects of an incident of sexual victimisation or IPV, while another is focused on the secondary victimisation often consequent upon such violence. The remainder of this section describes how the study sample, within the context of different settings, sought to address these two aspects of victimisation. We start with the community-based counselling services, which typically function as the hub in a modular service design.

5.1 The community-based counselling service

The origins of GBV-specific care and support services do not lie within the VEP – although the programme certainly helped increase their number. Their source is the NGO sector and they may be dated to at least 1976 when Rape Crisis Cape Town was established, followed by the setting up of People Opposing Women Abuse (POWA) in 1979. These services have since grown well beyond providing telephonic assistance from volunteers' homes[136] and are now based within a variety of settings that not only offer multiple points of entry into care and support services, but also reach those who may not wish to engage with the criminal justice system (CJS).

5.1.1 Purpose of the service and associated theory of change

The problem the VEP has set for itself is the country's high levels of crime, with the criminal justice system and victim services identified as key to reducing these numbers. A more responsive criminal justice, it is suggested, will mitigate fear and insecurity and prevent further violence, with assistance to victims serving a dual purpose. First, their establishment may offset perceptions that only wrongdoers benefit from the country's system of human rights;[137] and second, their interventions may contribute to ending cycles of violence, understood as the:

> debilitating succession of violence from which the victim finds it increasingly difficult to escape. It can lead to repeated victimisation and repeated offending and sometimes eventually spiral into fatality. It also refers to a longer-term cycle that involves more than one generation in a family in violence, where children who are exposed to violence grow up to perpetuate violence.[138]

According to the 2009 Guidelines[139] the goal of victim empowerment is to restore the victim "to a state as close as possible to that existing prior to the offence and ideally to a state where the person has been able to learn and grow", or to put it somewhat differently, to support the transition from victim to survivor.[140] This outcome is to be realised through ensuring access to victim support services (or "empathic, person-centred assistance rendered by an organization or individual following an incident of victimisation"[141]) and encouraging victims' reliance upon their inner resources and support networks, as well as their agency.[142] Victim empowerment is thus the outcome of a process guided by a particular ethos which eschews dependence upon "the expertise and assistance of a professional or someone else" and seeks instead to facilitate people's innate skills and competencies so that they are enabled to help themselves or cope better with an incident of victimisation.[143]

The 2013 Norms and Standards add another dimension to the VEP's working by setting out the programme's four levels of service delivery:

- Prevention – comprising two elements, information and awareness, and training and capacity building

[135] DSD 2011: 8.
[136] Vetten, 2019.
[137] DSD 2009: 1
[138] DSD 2209: 27
[139] The Victim Empowerment Support Services Bill was under consideration at the time of writing and is therefore not dealt with here
[140] DSD 2009: 3
[141] ibid
[142] ibid
[143] DSD 2013: 8

- Early intervention – which includes engagement/reception, assessment and referral, and access to legal representation
- Support with statutory processes – referring to assessment, referral and support (specifically in relation to legal processes and procedures), and court preparation
- The continuum of care – which is addressed to the staffing of services; the interventions and processes required to support victims (including the health care they should have access to); the management of victim support facilities; and the rights of service users, including complaints measures, as well as the use of surveys and other methods to gauge victims' satisfaction with services.

The VEP is a complex programme of many moving parts, processes and procedures and theorising its workings is undeniably more challenging than theorising a service with a single focus, such as court preparation. For the purposes of this discussion we focus only on those limitations of the VEP that directly affect services, noting that this does not amount to a comprehensive, all-encompassing review of the VEP.

The first limitation of the VEP is its theorisation of violence only in relation to prior victimisation; it does not consider the role of other factors in violence. Granted, the VEP does contemplate victim empowerment as applying to those who have "suffered harm, trauma and/or material loss through violence, crime, natural disaster, human accident and/or through socio-economic conditions."[144] But these questions of material loss and the role of socio-economic conditions in violence are scarcely developed. Both the rights to restitution, as well as compensation, are offered only in relation to criminal procedures – yet again tying the VEP to the criminal justice system and further delinking victimisation and its effects from the realm of socio-economic rights and their entitlements.

To its credit, the VEP avoids pathologisation and offers an optimistic vision of personal growth and self-reliance. Yet this is only part of the story. The literature review suggests a bleaker and more painful reality, one marked by the profound depletion of victims' inner resources – to an extent that makes expert and professional assistance vital. This assistance is not available. Indeed, it may be speculated that the emphasis on self-reliance and independence undermines the potential for a more complex response. For example, the assumption that no particular skill is required to implement the VEP may be part of the explanation for the limited budget it receives in comparison to other welfare services. It may also be contributing to the deskilling and professionalisation we have observed. The deskilling may be a consequence of the assumption that reliance upon victims' inner resources is sufficient and no specialised skills are necessary to dealing with victims, while the professionalisation may be a consequence of the realisation that support to victims does require some skill.

Further compounding the problems identified above is the fact that the 2013 Norms and Standards contain no actual standards. For example, Norm 18 deals with therapeutic programmes and is conceptualised as follows.[145]

- The norm is that all victims should be offered therapeutic programmes and services
- The standard is set as: Therapeutic programmes and services are in place
- The outcome is defined as: Psycho-social and emotional wellbeing of all victims are restored and supported

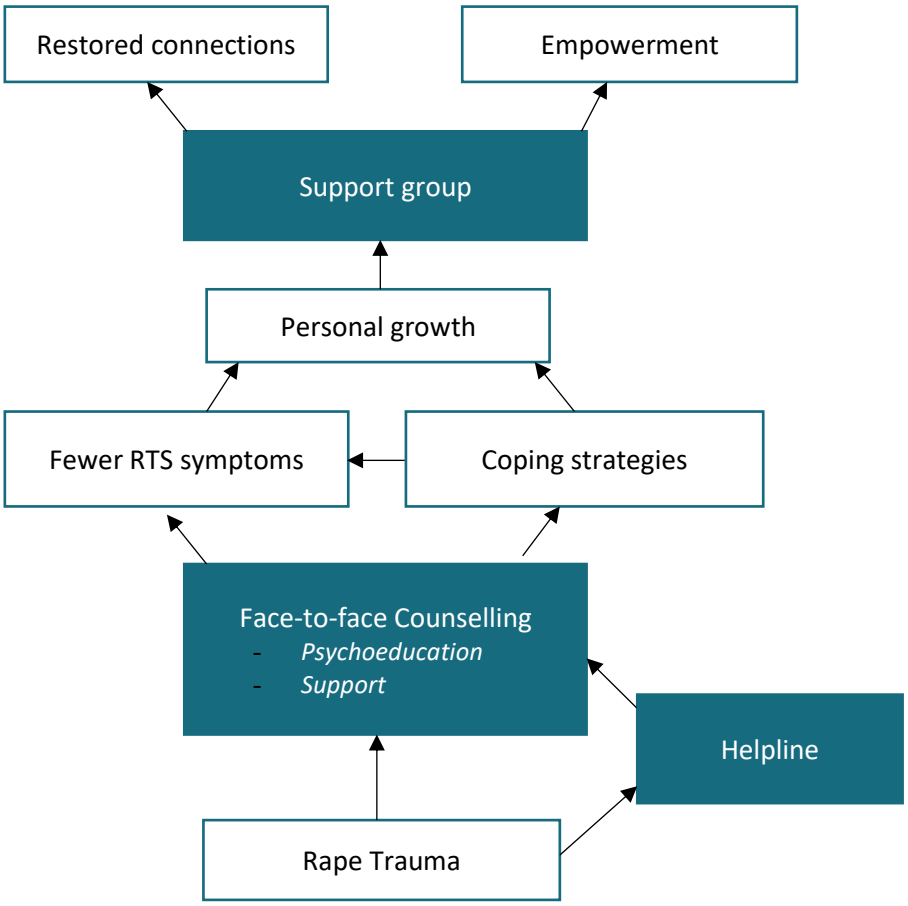
The proposed standard offers little more than a description of a hoped-for state of affairs; it provides no measure that would allow for the comparative evaluation of programmes and offers no guidance around the level or quality of programmes or services. As the content of programmes or services is not specified either, almost anything could potentially be fitted under their headings. Not unexpectedly then, these community-

[144] DSD 2009: 3.
[145] DSD 2013: 23

based counselling services were the most disparate in the study, with some exhibiting a particularly 'make-do' quality – offering what they could within the constraints of the resources made available to them.

The elements of a more viable theory of change could be discerned in individual organisations' programmes. Figure 4, for example, takes rape trauma as its central problem and proposes a sequenced set of service methods to overcome this.

Figure 4: Theory of change for modality of service



In this service speaking is the mechanism of change. Counselling is a way of "breaking the silence" both for the victim, who has been shamed into silence, as well as for society, where awareness grows of "a silent thing happening to women."[146] Relief and change occur when the rawness of experience is converted into language and speech.

A number of organisations also understood the effectiveness of their services to depend upon the relationship between helper and beneficiary. Their theorisation of this relationship was informed by a particular understanding of what made services acceptable to those who needed them:

> People may be more likely to seek help from services whose staff are similar in some way i.e. they are from the same community, or have experiences in common, such as violence, or being a refugee. Commonalities can bridge social distance to make the service provider appear more trustworthy, as well as more likely to relate to people's circumstances.

For this reason they did not rely solely on social workers to provide their services but also drew staff from their beneficiaries' peers – other refugees, survivors of domestic violence, or individuals who identified as LGBTQ+. The involvement of community members in providing care and support services also enriched organisations'

[146] Focus group discussion, Western Cape

notion of empowerment. Helping other victims, they observed, could be personally transformative for a survivor of GBV – with the caveat that survivors needed to have gained some distance from their experience so as to neither impose their experiences on others nor be retraumatised.

An understanding of the especially transformative power of community support was most evident in support groups where the relationship between participants was that of peers, rather than professionals. When all participants shared an experience in common, this resulted in a sense of communal solidarity that reduced both isolation and a sense of being alone in the problem: "Clients say that the value is in being acknowledged – which they don't often get anywhere else."[147] Stigma and shame also lost their potency – a point strongly made by the focus group with adult caregivers of children who had been abused; all had blamed themselves at some point for their child's abuse (as had some in their circle) and felt they had failed as a parent.

Were all these different dimensions to victim empowerment to be woven together, then a far richer, more complex theory of change would emerge in support of the VEP. This would also make clear the importance of involving members of beneficiaries' communities, as a matter of principle, in the services provided to them.

5.1.2 Description of the service

The GBV care and support services in the study sample were a mix of the specialised, general and dedicated. Dedicated, specialised services were evident in those organisations which either focused solely on the problem of rape and/or domestic violence and/or child abuse, or a beneficiary population. Where the service focused its attention on a specific population of beneficiaries, GBV care and support services were one element of a broader programme of assistance. A second example of services focused on beneficiary populations was that organised around a particular geographic community. This category of organisations' concern was the various issues faced by their community, with attention to GBV comprising one part of a broader palette of community development services.

Organisations offered multiple kinds of services, including telephonic helplines, shelters or court support services, and utilised various modalities of support such as individual counselling, support groups and couples counselling in the provision of these services. Their assistance ran the gamut from information and practical support (such as assistance with housing; work and employability; legal processes and case follow-up; grants; and basic needs in the form of food and clothing), to counselling that was either once-off or ongoing. In keeping with the prescripts of the VEP, outreach and awareness-raising, in the form of community workshops, dialogues and campaigns around GBV (which often included information on policing and legal processes), also comprised an important part of their work.

The most ill-defined category of service was the White Doors. In the North West the referred only to emergency, short-term shelters[148] while in the Eastern Cape 'White Door' was an umbrella term for all and any GBV services. It could thus be applied to victim-friendly rooms; emergency shelters; reception, assessment and referral (RAR) centres; or community-based counselling services.

5.1.3 Availability and demand for service

Two organisations provided data around the use of their services. Organisation 1, based in the Western Cape, provided the following figures showing each beneficiary to receive approximately three sessions of counselling on average.

Table 24: Organisation 1 - utilisation of service 2017-2019

Year	2018	2019
Number of clients	666	482
Number of counselling sessions	1 929	1 429
Number of support group sessions	6	9

[147] Interview, Eastern Cape

[148] See 'The White Door centre will offer shelter to abused women in the North West', in Health24. (26 November 2014).

Number of telephonic support calls	1 676	1 261
Number of supportive email responses	74	61

Organisation 2, a legal service based in an informal settlement in Gauteng, also provided psychosocial support services, with the table below setting out demand for these. While demand for both their legal and psychosocial support services increased over the three-year period reported on, use of the legal service increased more rapidly. The number of counselling sessions attended by beneficiaries also increased. In 2017 beneficiaries attended, on average, 2.7 counselling sessions each; in 2018 this increased to 4.2 sessions and in 2019, 5.7 sessions.

Table 25: Organisation 2 – utilisation of service 2017-2019

Assistance provided	2017[149]	2018[150]	2019[151]
Total number beneficiaries	196	223	253
Criminal case support	52	100	127
Protection order assistance	127	126	88
Legal advice			61
Total number beneficiaries psychosocial support	126	128	138
Total number therapy sessions	341	541	790
Group therapy sessions	30	33	24*[152]

The demand for services is mediated by survivors' assessment of the benefits of counselling. Its intangible value may not be evident in a context marked by poverty, or dependence upon abusive partners. What is wanted are "things that are touchable/food on the table." Acceptability is also influenced by whether or not beneficiaries are "ready for the whole thing. They want to move on with lives, and don't want to think about what happened." For adolescents in particular, counselling was often undesirable because it was seen as making them "different." And sometimes the victim wanted to continue counselling but was being pressurised by either her family or her partner to stop attending sessions.

The question of counselling's acceptability in deprived contexts is an important one and highlights the need to expand the VEP's focus beyond the criminal justice system to also encompass the domain of the socio-economic. However, the exponential increase in the number of counselling sessions attended at organisation 2 suggests that women in poor communities do find value in such support. In the next section on shelters women also single out the counselling services as having had the greatest impact upon them. Ultimately, however, this question ought not to be treated in an either/or manner; both care and support services and schemes intended to strengthen women's livelihoods are helpful. Indeed, there may be a mutually reinforcing relationship between the two. The Siyakha Youth Assets Study, for example, tested a variety of interventions aimed at increasing the employability of young South Africans classified as Not in Employment, Education or Training (NEET). The study found that spending more time on the 'human capabilities' element of the training – referring to life or soft skills such as self-esteem, communication and leadership skills (the first two often a focus of counselling) – resulted in an 8 per cent increase in the probability of employment.[153]

Finally, the accessibility of many services is dependent upon their distance and costs, with the burden of travel costs either shifted to the police, or to organisations. How successful these options were depended on the availability of police officials and vehicles, as well as individual stations' positions on the use police vehicles to transport civilians. In the case of organisations their ability to absorb beneficiaries' travel costs was dependent upon whether they had a transport budget and/or a vehicle. Ownership of a vehicle also assumed a driver or several staff members willing and licensed to drive, as well as the substantial costs of registration, insurance and running expenses.

[149] All figures taken from LvA 2017: 6-8
[150] All figures taken from LvA 2018: 3
[151] All figures from LvA blog post '2019 Year in Review' https://www.lva.org.za/2019/12/30/17675/
[152] This figure refers to the number of beneficiaries, rather than the number of sessions as the latter figure was not provided
[153] Graham et al., 2018.

Some beneficiaries were simply unable to access public transport due to injury, trauma, disability or age.

5.1.4 Service process flow

The steps in the process followed by NGOs were not that dissimilar and involved reception and intake; screening and prioritisation; counselling (both single, once-off sessions and on-going sessions); and additional practical support – such as help with obtaining a grant. The most truncated version of this process was offered by the RAR centres, outlined below.

RAR centres and their service

As their name suggests, RAR centres – also termed White Doors – received victims, assessed their circumstances and made referrals to shelters or other services offered by DSD, SAPS or the DoH. Victims may spend no more than three to six hours at any RAR centre but if they cannot be referred elsewhere then some RARs may provide on-going counselling, undertaken by the caregiver who may also provide mediation sessions between couples. Many RARs do not receive funding for social workers and the service is provided by volunteer community members who are trained as caregivers. It is an extremely limited service in the absence of other referral points.

Reception and intake

Some organisations had instituted processes of case finding, identifying prospective beneficiaries through screening, or through support workers active in the community. These cases were referred to the office for further assistance. In other instances, contact with the organisation was self-initiated by the beneficiary and an appointment booked telephonically, or sometimes beneficiaries were assisted following an unscheduled walk-in. From a time management perspective, the former allowed for greater control over the day but the latter cannot be disallowed; crises occur in women's lives and they cannot be refused assistance. They may also not be in a position to book appointments beforehand.

Whoever is responsible for reception (which can be a receptionist, a counsellor or SAW) is responsible for intake which is intended to determine if the beneficiary is indeed in need of the specific service or someone referred incorrectly, or seeking a referral.

Counselling – once-off and on-going

The counsellor has the task of determining the immediate needs of the beneficiary and assessing their safety, as well as any emotional and behavioural risk, including suicidal ideation. The support systems surrounding the person may also be discussed, and agreement reached on how they can activate and use these. Many beneficiaries face multiple, inter-linked challenges and the need for legal, medical, or psychiatric referral will be ascertained, and the necessary processes set in motion. Where concerns arise around the beneficiary's safety there may need to be referral to a shelter, and support in reporting to the police or approaching the courts. Some organisations took a team-based approach to cases, with one member of staff providing practical assistance (such as obtaining a grant), while another staff member focused only on the beneficiary's emotional difficulties. In other organisations one person is responsible for all aspects of the beneficiary's needs. Beneficiaries might also be referred to a support group or to other service modalities such as digital storytelling or art therapy (where such skills existed in the organisation).

Referral networks and implementation outcomes

The premium placed on intersectoral partnership and collaboration by the VEP makes attention to implementation outcomes particularly necessary. Many assumptions underpin the likelihood of their effective functioning, with one of these being that a sufficient number of psychologists and psychiatrists work in the public sector and that they are evenly distributed across the country. This is not so. Even when beneficiaries' difficulties lay at the severe end of the spectrum they were still allocated appointments some months away and frequently at a DoH hospital in the nearest major city, which could be 100 km away or more.

The unavailability of facilities also affected beneficiaries with substance abuse disorders, and shelter services especially: "all shelters deal with addiction, because as a coping mechanism substance abuse is almost a norm," observed one shelter worker. While substance abuse as a problem is not evident in all provinces

equally,[154] there are too few resources to address it in those parts of the country where it is a significant concern. Women who are still actively using substances cannot be admitted to shelters but need to attend a rehabilitation service first. Indeed, detoxification processes can only be undertaken under medical supervision. Shelter staff have not been trained to work with addiction.

Referrals: DSD and the Department of Health

These various activities were undertaken by lay counsellor/volunteers, SAW, social workers or registered counsellors. Where organization were expected to refer to DSD officials both they and the DSD observed DSD officials to prioritise referrals between DSD officials or those from other government departments, such as Health. Virtually all of the department's human and material resources were observed to focus on meeting the policy imperatives around foster care. Indeed, as DSD officials observed of the department's services:

> *The services are accessible but foster care is a priority and everything will wait before the social worker can see them – priority is the children.*
> (Interview DSD, Eastern Cape)

> *I would say we need this [*dedicated personnel*] for GBV – there are so many beneficiaries falling in the cracks – if the social workers are busy with foster care backlog – then they don't have time to deal with the client who is a GBV survivor.*
> (Interview DSD, Eastern Cape)

DSD officials interviewed for the study also observed that their ability to provide GBV-related care and support is further limited by the fact that they are generalists; they may work within the speciality of the VEP but also have a weighty and varied caseload to attend to within an assigned area. These dual mandates and the legal duty to prioritise child protection and foster placement reduce their ability to respond with focus to GBV cases. Counselling sessions may even be cancelled at the last minute to attend to child-related emergencies. This may contribute to why organisations observed there to be limited uptake of DSD counselling services:

> *I can talk to the social worker and set it up, but they don't want to go because they complain that they take long to attend to them. They come back and say that they didn't get help.*
> (Interview, Eastern Cape).

Obtaining services from psychologists or psychiatrists in the DoH were described as "virtually impossible." Recognising this, the DSD had provided one organisation with funding to obtain psychiatric assessments and support from a nearby registered psychiatric nurse, outside of the DoH. This however, was a highly unusual arrangement.

5.1.5 Cost of service – expenditure analysis

With funding amounting to just under R300 000 this White Door is able to provide a very limited counselling service and a range of awareness campaigns.

Table 26: White Doors Expenditure: Organisation 1 (yearly cost)

[154] Vetten, 2018; Vetten and Lopes, 2018.

	Number	Unit cost	Total cost
Recurring cost			**R 280,000**
Staff			
Management	1		
Social Worker	0		
Social Auxiliary Worker			
Registered Counsellors			R 165,000
Lay counsellors	0		
Paid volunteers	2		
Unpaid volunteers			
Operating expenditure			
Awareness campaigns			R 115,000
Community awareness workshop			
Capacity building programmes			
Accommodation for clients			
Groceries, care packs, toiletries			
Security			
Once off cost			**R 20,000**
Outreach programmes			
Community sensitisation and awareness setup			
Infrastructure			R 20,000
% of once off cost (20%)			**R 4,000**
Total cost of service			**R 284,000**
Number of beneficiaries			**606**
Service cost per capita			R 469

This White Door's funding request lacks a lot of detail. However, based on the information in the document, one can see it runs both a more costly service per beneficiary than the next organisation, as well as offering less. As a RAR it also offers less than the comprehensive counselling service offered by the second organisation (Table 27). It is also not possible to separate out the number of those assumed to benefit from the awareness campaigns from those receiving the RAR service.

The second analysis focuses on an organisation's expenditure on their counselling programme, which represents a percentage of their total programme costs. As such, the organisation will add that percentage of its operational costs to the totals in their financial statements. In 2018 that would have been 19% of the total operating costs, which was R792 976, bringing the 2018 total to R2 242 186. In 2019 that would have been 21% of total operating costs, which was R1 258 715, bringing the 2019 total to R2 561 506.

Table 27: Counselling Service Expenditure: Organisation 2 (yearly cost)

	2018	2019
Organisation 1 operating expenditure		
Catering and refreshment	R14,012	R9,830
Telecommunications	R42,865	R17,186
Equipment and supplies	R1,455	R0
Other direct project costs	R24,404	R28,368
Photocopying and printing	R1,067	R1,381
Salaries and wages	R706,934	R772,337
Supervision	R3,241	R8,854
Transport costs	R3,875	R8,042
Volunteer contracts	R395,543	R239,037
Volunteer training	R0	R0
Volunteer stipends	R106,397	R364,175
Road to Recovery		
% of operating expenditure	19%	21%
Cost of Road to Recovery	R792,976	R1,258,715
Total expenditure	**R2,242,186**	**R2,561,506**
Number of interventions/sessions	**3685**	**2760**
Service expenditure per beneficiary (total)	R608	R928
Service expenditure per beneficiary (RTR)	R215	R456

There are two social workers and a counselling psychologist employed full time (salaries and wages) plus three full time project administrators who are lay counsellors (volunteer contracts). This is a team of two at each of the three offices. There are 35 trained lay counsellors in the project across the three offices who receive volunteer stipends.

5.1.6 Concluding commentary

Community-based care and support is a core service, especially for those who do not engage with legal systems. These services are however, weakened by the way the VEP theorises crime, violence and victimisation, concentrates its efforts around the criminal justice system, and provides inadequate guidance around the standardisation of services. As a result, services are distributed along a continuum of effectiveness, with some services likely to be accomplishing meaningful change in many of their beneficiaries' lives, and others accomplishing insignificant outcomes. Care and support services, as currently provided, thus demonstrate multiple inequalities affecting those who provide the service, as well as those who receive the service. Indeed, it is possible that the weaknesses in the conceptualization of the VEP are contributing to the conflicting, parallel processes of deskilling and professionalization of NGO services observed by this study. We suggest:

- A comprehensive review of the VEP. This is not with the aim of replacing it in its entirety but with an eye towards substantially revising its theory of change – including by expanding its focus beyond the criminal justice system to attend to the socio-economic conditions that facilitate violence and limit victims' chances of escape.
- The review should also recognize the more complex emotional and psychological consequences of violence and explicitly incorporate access to mental health and other related services within the VEP.
- Comprehensive practice guidelines and norms and standards must be developed to support the implementation of the VEP across a range of dimensions.

5.2 Safe houses, shelters and one-stop centres

In *S v Baloyi,* the Constitutional Court ruled that domestic violence violated a number of core rights, including those to freedom and security of the person; bodily and psychological integrity; as well as the defensive rights of everyone not to be subjected to torture, nor to be treated or punished in a cruel, inhuman or degrading way. Shelters, through the refuge they offer, are key to upholding these rights. But these are not the only rights they promote. Most shelter residents live at the sharp edge of poverty: approximately two-thirds are unemployed[155], and the proportion of those with no access to any income ranges between 26% to 51%.[156] As a social welfare service, shelters are also a socio-economic right,[157] while the programmes they offer could link women to other social benefits.

This section sets out the spectrum of sheltering available in the country, from the short-term/emergency and longer-stay, to the one-stop centre, and describes the current state of their care and support services.

5.2.1 Purpose of the service and associated theory of change

The first shelter established in South Africa with the specific aim of assisting women experiencing domestic violence was opened by POWA in 1984. Some 35 years later, by early 2020, at least 91 shelters of various types could be counted,[158] including the one-stop centres that DSD first began establishing in 1999[159] and the Gauteng Department of Community Safety (GDoCS) in 2004. What has not increased during this period are transitional forms of housing for women exiting shelters. While St. Anne's pioneered what it termed second-stage housing in the early 1990s, the second such prototype was only introduced in 2009 by POWA.

Two theories of change apply to shelters, one in relation to their purpose and the other to the design of their facilities. The first can be summarised as follows:

> Shelters break the cycle of violence through the provision of a range of services, including temporary safe accommodation, basic necessities, job skills training, childcare and psychological support. These interventions enable women to leave their abusive partners – which contributes to reducing women's future use of health facilities, as well as court and policing services. By limiting children's exposure to violence, shelters also help reduce the likelihood of children growing up to either perpetrate or experience violence as adults. Shelters thus benefit the state, society and individuals.[160]

Specific and comprehensive, the theory attends to the circumstances of both mother and child and appears to have been borne out in practice. Reviews of shelters' case records have shown that between 53% and up to 79% of residents did not return to their abusive partners upon exiting the shelter.[161]

Some shelters have expanded this theory still further by conceiving of the ending of an abusive relationship as a process, rather than something permanently accomplished all at once through a single action. Recognising that leaving is shaped by women's economic context (as those who lack the means to live independently may be forced to return to their abusive partners),[162] some shelters permit women to leave and return more than once. A very few have also been able to establish second-stage shelters on the assumption that these support women's ability to live free of their abusive partner by providing safe, alternative accommodation, as well as access to ongoing psychosocial support.

Changes in DSD policy, specifically the 2001 decision to expand shelters' focus to all victims of crime and violence, require these theories to be revisited. At present, approximately half of women in shelters are

[155] This percentage ranged from 64% (Vetten, 2018) to 68% (Vetten and Lopes, 2018)
[156] Vetten, 2018.
[157] National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2014] ZAFSHC 127 (28 August 2014)
[158] This number was calculated from a list being circulated by the DSD, with the researchers adding one more shelter not contained on the list – a DSD facility in the Eastern Cape.
[159] DSD, 2011
[160] Stone, Watson and Thorpe 2013: ii
[161] Vetten, 2018; Vetten and Lopes, 2018.
[162] Lopes et al, 2018.

seeking refuge from IPV, with the balance requiring assistance with family violence, pregnancy crises, homelessness, non-partner rape, and threats of community violence.[163] Some shelters are also designated to assist victims of trafficking.[164] The understanding of shelters' purpose outlined previously thus has limited applicability to women accommodated following rape by a non-partner, for example – a scenario that accounted for one in eight women's stays in five shelters in the Eastern Cape.[165]

Shelters and their design

The great majority of NGO shelters are single-use facilities whose purpose is to accommodate women who have experienced different forms of violence. By contrast, the one-stop centres and multi-purpose service complexes offered by government departments provide shelter in addition to a range of other on-site services, which shapes the design of these facilities in particular ways. The logic of one-stop centres is this:

> Secondary victimisation can be prevented by creating one central point where victims of crime and violence are offered a continuum of services by practitioners from a range of different disciplinary backgrounds.[166]

Where the VEP theorised secondary victimisation as the outcome of prejudicial attitudes, this conception understands it to result from the ways in which services are distributed geographically. The solution to the time and travel costs imposed by the spread-out nature of services is their centralisation. This is a narrower formulation of secondary victimisation than that offered previously – but perhaps it is assumed that staff well-informed about GBV will automatically gravitate towards working in these centres.

A multi-purpose service complex is far more general in scope than a one-stop centre and intended to include old age homes; child and youth care centres; early childhood development centres; secure care centres; sheltered and protective workshops for people with disabilities; homes for people with disabilities; places of safety; shelters for victims of crime; partial care facilities; shelters for abused women; drop-in centres; and substance abuse treatment centres. Their design too is informed by theory, set out in the DSD's 2009 *Shelter for Abused Women Design Guide and Space and Cost Norms*. The principle here is that form follows function, or that design can be used to shape behaviour in particular ways by:

- Creating a secure environment for staff, children, educators and support staff;
- Emphasising rehabilitation rather than punishment;
- Creating a "subtle containment or confinement complex" that has less of an institutional feel and is more domestic or homelike in nature.[167]

A theory of design couched in the language of security, rehabilitation, containment and confinement both associates these centres with the world of correction, detention and supervision and suggests that control is one of their underlying goals. This objective may be appropriate to secure care facilities – but is deeply discomfiting when applied to women who have experienced abuse. Not only is this emphasis on control reminiscent of their relationships, but it also implies a conception of abused women as unmanageable and in need of confinement. It is also not unique to the multi-purpose service complexes, being implicit in the ways some shelters are managed, the limitations placed on women's contact with the outside world, including the use of curfews.[168] While understanding that these restrictions are aimed at their safety, women have observed that their effect is to make them feel as if in a prison.[169] These unexamined assumptions about abused women are not indicative of a supportive or empowering approach to their circumstances.

5.2.2 Description and parameters of the service

The DSD's operational definition of a shelter provides its parameters of service:

[163] Vetten, 2018.
[164] Vetten and Lopes, 2018.
[165] Ibid.
[166] DSD 2011: 20
[167] DSD 2009: 5
[168] See the CGE's investigation of the state of shelters and its discussion of curfews in place at Ikhaya Lethemba (CGE, 2019)
[169] Lopes et al., 2018

> a residential facility that accommodates all victims of crime and violence as well as their care-dependents up to the age of 18 years (unless infrastructure provides for the admission of youth older than 18 years in a situation where the livelihood and safety is at risk) providing short term intervention in a crisis situation for one day up to approximately six months (6 months) as the need dictate. This intervention includes meeting basic needs (protection, food, accommodation, and clothing) as well as support, counselling and skills development including victim's rights and capacity building. The shelter for victims of crime and violence does not provide statutory services to children hence shelters cannot accommodate children without their parents.[170]

Violence does indeed account for the bulk (87%) of stays at a shelter, according to the only study[171] investigating the circumstances driving women to seek shelter. In this study IPV accounted for over half of admissions, with rape and family violence accounting for a further 14% and 13% of admissions respectively. Another 3% of women arrived at the shelter after having been trafficked or arrested by the police for their engagement in sex work. Another 6% were homeless – although not as a result of long-term destitution.

While the women's presenting problems may have been different, there was considerable overlap in the role shelters played in addressing their circumstances. These included:

- Providing emergency accommodation – this applied to women who had been evicted by their abusive partners (often with their children) or who had been released from police cells with nowhere to go, as well as women made homeless by the destruction of their dwellings homes. Also evident in this category were women suffering a high degree of psychological distress through being abandoned by their partners, or losing their employment, or by having become part of the revolving door that circulated individuals between mental health facilities and other institutions. Even though shelters do not usually admit women with substance abuse problems, or who have psychiatric disorders requiring specialized care, they were nonetheless functioning as a kind of short-stay community mental health facility.[172]

- Securing the safety of women and their children – this function is key, study of case files suggesting that in almost one in five women had been threatened with death by their abusive partners before arriving at the shelter. These were not idle threats, given the history and forms of violence detailed by this group of women (a small number of whom had also moved provinces to escape their partners). Safety was also a primary concern of women who had been raped by non-partners.[173]
- Providing a space of retreat and reflection – this role seemed to be what women most valued about their stay,[174] with the group work and counselling perceived as giving women a new way to understand themselves, the relationship and their circumstances.[175] This opportunity to recraft their lives led to women securing employment after their shelter stay, completing their school education or otherwise furthering their educations.
- Enabling strategic withdrawal – referring to the way women used their departure from the home to renegotiate the terms of the relationship (such as securing a commitment from their partner to enter drug or alcohol rehabilitation, or counselling). Staying at the shelter also enabled women to obtain protection orders evicting their abusive partner from the household – so allowing safe return to their homes.[176]

Shelters also benefit government departments such as the SAPS and Home Affairs who may rely on them for temporary accommodation either of women or children due to testify in court, or who are shortly to be deported. This usage is often a function of distance and so more evident in rural provinces.[177] There is also evidence of DSD using shelters as places of safety for children – including in the absence of their legal guardian and in violation of the law.[178]

[170] DSD, n.db.
[171] Vetten and Lopes, 2018
[172] ibid
[173] Lopes et al., 2018; Vetten and Lopes, 2018
[174] Baholo et al., 2015; Lopes et al., 2018.
[175] Lopes et al., 2018
[176] Vetten and Lopes, 2018
[177] ibid
[178] ibid

Second-stage shelters or transitional housing

Second-stage shelters are a form of transitional housing available only to women who have exited a first-stage shelter, are employed and able to pay rental fees ranging from R1 200 to R3 000 per month (inclusive of levies, utilities and maintenance). Stays typically last around 12 months with few rules in place so as to facilitate women's transition to independent living; they shop, cook and take care of their children as they would in the absence of shelter staff.

The requirements for second-stage shelters include a secure building with additional safety measures such as burglar proofing and access to police services; and a location close to health services, legal services, schools, and commercial areas that also has access to public transport. The facility should be integrated within the community near opportunities for women to engage in local activities (where safe) and have access to other communities and recreational opportunities. Second stage shelter services include psycho-social services and specialist life skills programmes, which may include savings schemes. Where possible, children have continued access to the longer-stay shelter's ECD facilities or are referred to children's agencies for on-going support.

One stop centres

One-stop centres are intended to be 24-hour services typically located at a hospital, clinic or house in the community. In addition to the psychosocial, victim support and trauma counselling services offered by their shelter component, one-stop centres provide victims of domestic violence or sexual offences with legal and police assistance, health and medico-legal services.[179] In the case of Ikhaya Lethemba (a one-stop centre established by the GDoCS) members of the FCS Units, as well as a doctor and forensic nurses are based on-site. Other centres are located in close proximity to the police or a health facility. One-stop centres may also undertake assessments, provide reports to the Children's Court, or to the criminal courts, and document the impact of trauma on child and adult victims of rape, domestic violence or human trafficking for sentencing purposes.[180]

Children

Study participants noted that keeping mother and children together at shelters supported the well-being and outcomes of both:

> *Women would come* [to the shelter] *and leave their children back in the community and did not fully commit to the programmes* [at the shelter] *because they were worried about their children who is back home with the perpetrator*.
> (FGD_children's services_WC)

Nonetheless, both government and NGO shelters placed restrictions on the admission of children, and older boys in particular. For example, two of the shelters participating in the focus group admitted only boys 10 years and younger, while the third shelter only accepted children under six years.[181]

Yet in at least one respect neither this prioritisation nor the argument advanced above are evident in the logic of the VEP's funding approach: shelters cannot access funds for children's programmes because the VEP is targeted at adults. This is one faultline in the programme.

Children's ambiguous status within women's shelters is reflected in policy. At a minimum, children must have access to early childhood development (ECD), as well as preventive and early intervention programmes. However, the 2013 Norms and Standards on Victim Empowerment require only "appropriate and relevant education" to be provided.[182] The provisions of the Children's Act, 38 of 2005, along with the 2010 General

[179] DSD, 2011.
[180] See also Kwanobuhle's service delivery procedure manual (Eastern Cape Department of Social Development, 2011).
[181] This was due to the shelter being located some distance away from schooling facilities, making it difficult for women to collect their children after school, as well as time-consuming and disruptive of participation in shelter programmes. School registration fees were also high. Children could also not be kept out of school for the period of their mother's stay (Lopes et al., 2018).
[182] DSD, n.dc – document issued at the start of the COVID-19 Lockdown.

Regulations Regarding Children are also applicable to children in adult shelters, meaning that they should therefore receive the same scope and standard of programming available to children in other residential facilities. Shelters, however, are funded through the VEP which focuses itself on services to adults – the VEP Guidelines' prioritisation of women *and* children notwithstanding (our emphasis). Funding for children's services must be directed to a different division of welfare services within DSD which, because it focuses on children, does not readily fund adult facilities.

What was being made available by the three shelters attending the focus group included:

- An ECD/crèche service to children under six years (which is also crucial to enabling women to attend training, search for work and/or hold down a job), along with either individual or group play therapy;
- Individual counselling to older children (where they were admitted), as well as their enrolment into local schools.
- A life skills course for adolescents.

Positive parenting sessions were provided to mothers, with two shelters able to offer music therapy to children.

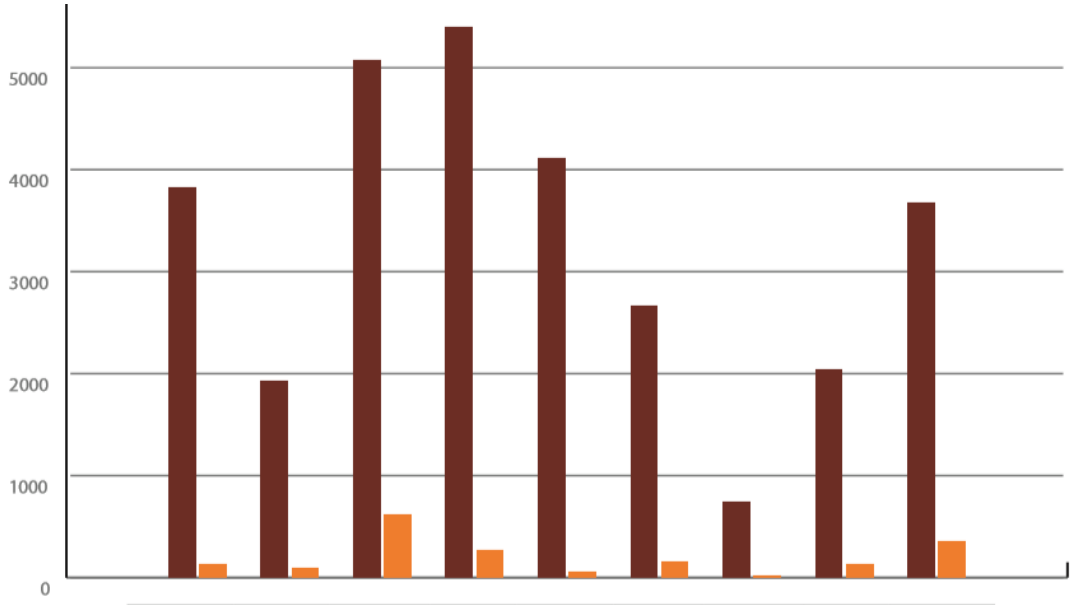
5.2.3 Availability and demand for the service

In early 2020 the DSD issued a list of 90 shelters nationally, which also included each shelter's bed capacity. While this ranged from two beds to 120, 66 facilities (or about three-quarters) contained less than 20 beds.[183] Is this sufficient to the need?

One way of answering the question is by measuring it against the extent of domestic violence. If the SADHS 12-month figures are applied to the Eastern Cape for example, then the number of women experiencing IPV in the province in 2016 would have been **48 283**, with violence occurring "often" for **8 804** women. Given that some of these women would be able to find sheltering with family or friends, or have the resources to rent alternative accommodation, the numbers calculated on the basis of the SADHS are likely too high to equate with actual need. Measures of poverty may be more relevant to estimating need. This was the approach followed by the 2016 *Review of the White Paper for Social Welfare*[184] which took as its proxy for need 1% of poor women aged 18 to 59 years who were either married or cohabiting, and compared this against the current capacity of domestic violence shelters (as reflected on DSD's infrastructure database). On this basis, while **3 828 women** in the Eastern Cape required shelter, only 138 beds, representing 3.6% of the projected need, were available.

Figure 5: Comparison of need and capacity – shelters for abused women[185]

[183] Ikhaya Lethemba, at 120 beds, was exceptional. (DSD, n.dc)
[184] Department of Social Development, 2016.
[185] Department of Social Development 2016: 176



	EC	FS	GT	KZ	LM	MP	NC	NW	WC
1% poor partnered women 18-59	3828	1928	5077	5403	4115	2665	748	2046	3678
Capacity	138	92	627	267	60	162	25	134	361

Availability is not just a question of the number of shelters; it is also a function of distance and hours of operation. In terms of these the SAPS had inadvertently become a source of emergency shelter, one study reporting that 10% of stations contacted in the Western Cape, 14% of those contacted in Mpumalanga and 4% in KwaZulu-Natal could offer one night's accommodation in the station's trauma room.[186] Given that the provision of shelter is neither a policing function nor mandate, the creation of these overnight facilities appeared to have resulted from need, victims' lack of transport money, the shortage of SAPS vehicles to transport victims and the police's obligation to comply with their duties in terms of the Domestic Violence Act:

> *For example, there is a lack of safe places for domestic violence victims. Now we need to keep the person after hours until the next day to find a place or we must drive many kilometres away from the police areas to take the victims if there is nowhere to accommodate her*. (SSI_SAPS_NW)

The national SAPS disapproved of this practice and at the time of the study interview were instructing stations to cease offering shelter. While the decision is correct in terms of the SAPS mandate it does not solve the problems of availability identified above.

Women's length of stay provides yet another measure of availability, being an indicator of the kind of shelter required. In the Eastern and Northern Cape eight days was the median average stay, with three-quarters of women (75%) having left within 29 days of their arrival.[187] In Mpumalanga more than half (59%) of women stayed for less than a month, while 47% stayed less than a month in KwaZulu-Natal. Stays in one of the Gauteng shelters averaged one month, with the remaining four shelters housing women between two and five months, while the Western Cape shelters averaged stays of three to four months. Length of stay has implications for decisions around the kinds of shelters needed – short stay versus long stay – with concomitant implications for costs. However, factors external to women were also affecting their length of stay:

- Some shelters are designated short-term crisis centres which can only accommodate women for short periods, regardless of need. Policy also places a six-month cap on stays, although this is open to negotiation and dependent upon individual women's circumstances;[188]

[186] Stone and Lopes, 2018.
[187] Vetten and Lopes, 2018
[188] Lopes and Mpani, 2017b

- Shelters are prescribed targets by the provincial offices of the DSD around the number of women they are expected to accommodate in a 12-month period. Under the pressure to admit women they may, in turn, be encouraging women to move on as rapidly as possible – even when they might benefit from a longer stay.[189]

While length of stay can reflect women's inability to find employment and/or an alternative accommodation, it is also an indicator of both the quality and impact of shelter programmes, with longer stays seeming to positively affect women's coping abilities after exiting the shelter.[190] This seems right, as it takes time to bring about the kind of valued life transformations described earlier. However, neither this time nor investment is required by women who require a few days in which to arrange alternative accommodation with family members before moving on.

Finally, inefficient payment practices by the Eastern Cape DSD have also prevented shelters from accepting women on the basis that they did not have the funds to purchase food.[191]

Acceptability of shelters

Estimates of need must also be nuanced by considering how acceptable shelters are as an option. In the Eastern Cape, for instance, staying in a shelter was perceived as stigmatising and, in rural areas, frowned upon as culturally inappropriate, it being preferred that women resolve the violence through family structures.[192] The conditions at some shelters are so poor that they discourage women from staying,[193] while personality clashes between individual residents and housemothers may also result in women shortening their stays.[194]

Access to shelters

Review of shelter records showed shelters, to varying degrees, to be accessible to a diversity of women, including older women, refugees and undocumented migrants, women with disabilities, including mild forms of cognitive impairment,[195] as well as women abused by their lesbian partners.[196] However, they were not all equally accessible in the same way. Certainly, all did not have access to the funds needed to make their facilities physically accessible to women with mobility impairments, while a 2019 investigation by the Commission for Gender Equality (CGE) also recorded one shelter stating that it would not accept transgender individuals.[197]

Section 9(3) of the Constitution is clear that the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including gender, sex, and sexual orientation. Lesbian and gay relationships are also formally recognised through the Civil Union Act (17 of 2006) and the DVA's protections extend to both heterosexual and same-sex relationships. There can be no justification for refusing lesbian, bisexual or trans women admission to a shelter for victims of crime and violence. The demand thus far has however, been low. The Saartjie Baartman Centre for Women and Children has specifically created space for trans women and is linked to both Gender Dynamix and the Triangle Project for referral purposes. Between 2017 and 2019 the Centre provided accommodation to just two trans women, one on three separate occasions. This does not mean that trans women experience no violence or have no need of shelter. Low use could indicate the kind of understandable mistrust highly stigmatised groups feel towards those outside their group. But it is also possible that access to shelters for victims of crime and violence does not adequately respond to the particular nature of the homelessness faced by some trans women.

Trans women are not an homogenous category, with homeless transgender female sex workers located at the nexus of a series of compounding disadvantages and exclusions. Sex work exposes trans women to the rape,

[189] Lopes and Mpani, 2017a
[190] ibid
[191] Vetten and Lopes, 2018
[192] Vetten and Lopes, 2018
[193] Lopes and Mpani, 2017b
[194] Lopes et al., 2018
[195] ibid
[196] ibid
[197] CGE, 2019

beatings and harassment regularly meted out to street-based sex workers by their clients, pimps and police.[198] This may be in addition to the violence targeted at homeless people generally, as well as the violence directed at trans people specifically. Their homelessness is often long-standing, beginning in early adolescence in some instances[199], and marked by the kind of familial estrangement characteristic of many homeless people's lives – further compounded by the stigmatisation and social rejection experienced by trans individuals that also limits their employment opportunities.[200] Trans women are also subject to the kinds of routine harassment visited upon homeless persons generally, the destruction of their makeshift shelters and being robbed by others.[201] If accommodated in homeless shelters trans women may be placed in men's facilities, there to be pressurised into providing sexual favours.[202] Shelters for victims of crime and violence also do not accommodate women who have experienced long-term homelessness, whether cisgender or transgender. Those they do assist constitute a very small percentage of residents whose homelessness is also temporary. In any case, the undeniably real, acute problem of this group of trans women's homelessness will not be solved by a stay in a shelter, which provides only temporary accommodation at best. The appropriate intervention, identified by SistaazHood, who advocate on behalf of this group of women, is housing.

Children in shelters

On average, each woman is accompanied by two children to the shelter,[203] with the number of children admitted by the three shelters captured below. All three organisations confirmed that most of these children showed symptoms of trauma, either as a witness of domestic violence or as a direct victim of the abuse. There was however, no data on the exact number of children accessing therapeutic interventions.

Table 28: Number of children attending shelter services in WC

	Shelter 1	Shelter 2	Shelter 3
Number of children admitted in last 12 months	65	63	54
Number of children admitted in last month	No data	18	14

5.2.4 Service process flow

This section distinguished between safe houses and shelters and describes the kinds of services offered by shelters, which are not greatly affected by whether or not the service is based in a one-stop centre; what is set out here is general practice.

Women's access to shelters is significantly enabled by the SAPS, which accounts for between 29% to 41% of referrals, followed by NGOs, which made between 21% and 26% of referrals. Between 3%[204] to 16%[205] of shelter residents are self-referred, with the lowest percentage of referrals made by DSD officials (9% and less), courts (6% and less) and health facilities (4% at most).[206]

Safe houses

A safe house provides emergency accommodation on a 24/7 basis for a period of one night and up to one week. Its main purpose is to provide immediate safety, contain and address the immediate crisis and identify alternative accommodation. Where the service has access to a social worker then the individual woman's circumstances will be assessed and decisions taken accordingly. While safe houses do not undertake in-depth therapeutic work or offer programmes around job skills some may involve their residents in handicrafts – but

[198] Cloete, 2017; Vickerman, 2018; GenderDynamix, 2013
[199] Cloete, 2017
[200] Cloete, 2017; Vickerman, 2018; GenderDynamix, 2013
[201] Harrisburg, November 6 2019.
[202] ibid
[203] Some of these children may be adult or living with another family member while others are in foster care, or living with their fathers or a community member (Vetten, 2018)
[204] Vetten and Lopes, 2018
[205] Vetten, 2018.
[206] Vetten, 2018; Vetten and Lopes, 2018.

this represents more of an attempt to take women's minds off their difficulties than an income-generating scheme.

Ideally, safe houses act as a conduit of referral to shelters (which is how the Eastern Cape's White Door facilities are envisaged as working). But in some instances, this emergency role can be played by shelters able to reserve a bed for crisis situations.[207]

Shelters

Women may arrive at a shelter, whether government or NGO, via any of the referral sources outlined above, as well as safe houses (where these exist). On admission they are expected to compile both a care plan, as well as an individual development plan. This will outline the various forms of assistance that women may require in accordance with their personal circumstances, including:[208]

- Individual and group counselling, assistance with parenting skills, family reunification services and couple counselling, as well as mediation (this was infrequently provided)
- Help with applying for a protection order, maintenance, divorce and custody, as well as reporting the violence, following up on the criminal case and preparing for trial
- Health care, including support with taking any medication or other treatment
- Obtaining identification documents and birth certificates, applying for grants, and opening bank accounts
- Placement of women's children in foster care, or securing them adoptive parents; and liaising with local schools to accept children and obtain new school uniforms
- Helping women develop their curriculum vitae; conducting training/skills programmes; providing access to newspapers, the internet and telephones to enable women to seek and apply for work; and facilitating women's attendance at interviews, including by directly engaging with prospective employers[209]; and
- Enabling exit from the shelter by liaising with family members around providing women with alternative accommodation, providing advice about rentals, helping women find work with live-in accommodation, and assisting with the actual move. [210]

The extent to which NGO shelters are able to accomplish any of these activities is dependent upon funding, especially for staffing. Table 29 below sets out the staffing of six shelters - five in the Eastern Cape and one in the Northern Cape.[211] (Numbers marked by an asterisk indicate that these staff do not work in the shelter programme only).

Table 29: Staffing of six shelters

Staff type	Shelter 1	Shelter 2	Shelter 3	Shelter 4	Shelter 5	Shelter 6
Shelter/programme manager	1*		1*	1	1	1*
Social worker	1	1*	1*	1	0	1*
Social auxiliary worker	1*	0	0	0	0	0
Housemothers	2	2	2	4	0	2
Counsellor	1*	0	0	0	0	0
Crèche teacher	1*	0	0	0	0	0
Cleaners/gardeners	2	4*	0	1	0	1
Security staff	0	0	0	0	0	1
True volunteers		2		5	4	
Stipend volunteers (excl. management)		6*	6*	0	1	2*

By contrast, government-run facilities had considerable staff complements:

[207] Vetten, 2018
[208] Vetten, 2018.
[209] Vetten and Lopes, 2018.
[210] ibid
[211] Taken from Vetten and Lopes, 2018

- The Kwanobuhle shelter had a staff complement of 15 plus five SAW students and also has access to eight professionals contracted to provide nursing, psychological and energy therapy services;
- At Ikhaya Lethemba 38 staff were responsible for their residential services' programme.

Children

Twenty per cent of my time as social worker is spent on children at the shelter through observation or assistance with corrective behaviour and supervising or supporting the teachers. The other 80 percent of my time is spent with moms. Ideally [we need] *one social worker for every 22 children.*
(Focus group discussion, children's services Western Cape)

Children accompanying their mothers to shelters receive few psycho-social services. Social workers were not routinely trained in play therapy and shelters could not afford additional staff to provide this and other therapeutic interventions.[212] While children's therapeutic interventions should be provided weekly these were typically only taking place once every two to four weeks.

The number and type of staff providing children's services was similar across all three organisations and included:

- One to three ECD practitioners or childcare facilitators with Education and Training level 4 or 5, responsible for running the ECD centre/crèche at the shelter for children under five years;
- One social worker with a Bachelor's degree responsible for case management, psycho-social services, counseling and support to children and their families;
- One SAW responsible for psycho-social services, counselling and support;
- One to three house mothers/carers responsible for day to day running of the shelter;
- Volunteers for additional support when available.

The ECD practitioners were the only staff dedicated to children. Play therapy and individual counselling were provided by either a social worker, an external service provider or university students. The remaining staff including the social workers, SAWs and house mothers, did not provide dedicated services to children but spent a good proportion of their time supporting children's needs.

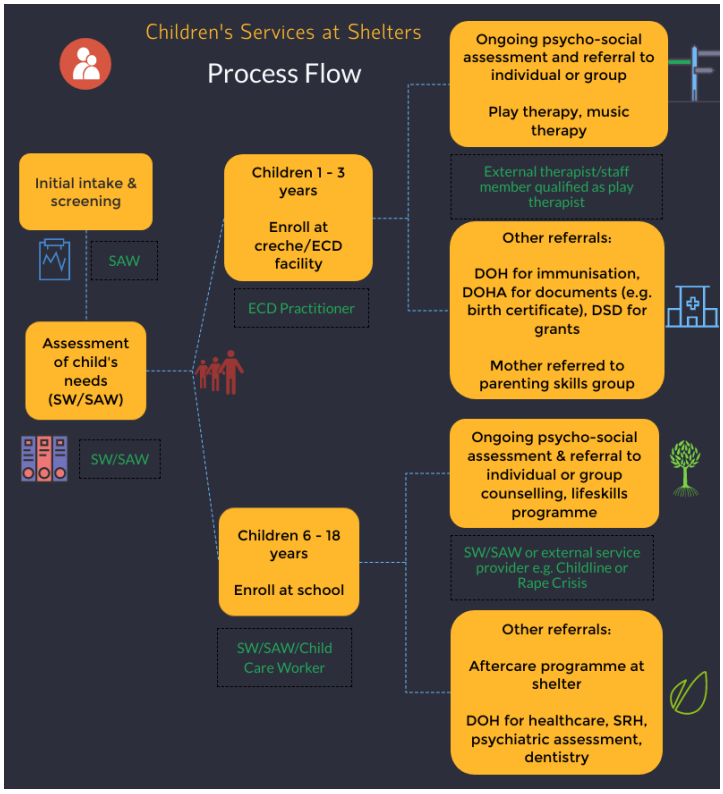
Each shelter had an extensive referral network for specialised counselling if required; health care (including dentists); as well as for specialised interventions such as physiotherapy and psychiatry. In the Western Cape shelters many children presented with Foetal Alcohol Syndrome or other learning disabilities. Access to clinical psychologists and psychiatrists, as well as speech and occupational therapy, was a significant challenge.

Positive parenting groups were run after hours over a three-week period (2-4 hours every evening). Once again, their frequency was dependent on resources available at the shelter.

The diagram below captures the service process flow of children's services in shelters and is based on the activities identified during the focus group discussion.

Figure 6: Process flow of services for children's services in shelters

[212] Vetten, 2018.



5.2.5 Service expenditure analysis

Expenditure of short-term shelter

The analysis presented below includes expenditure on the short-term shelter at one of the visited sites, plus the other services offered by the organisation. A total budget of R705 039 is required (extracted from the centre's latest business plan) to provide the following:

- Integrated support service for victims – including counselling, court preparation and trauma debriefing;
- Community awareness campaigns and advocacy on various aspects of domestic violence;
- Temporary accommodation, therapeutic services and shelter programmes for victims of crime.

Table 30: Safe house expenditure: Organisation 1 (yearly cost)

	Number	Unit cost	Total cost
Recurring cost			**R 703,998**
Staff			
Management	1	R48,000	R48,000
Social Worker	1	R135,186	R135,186
Social Auxiliary Worker			-
House mother	2	R66,000	R66,000
Lay counsellors			
Paid volunteers	4		R104,112
Unpaid volunteers			
Operating expenditure			
Transport			R41,760
Shelter services			R50,000
Therapeutic services			R10,000
Rental & services			R82,800
Training of staff			R45,000
Debriefing			R10,000
Other			R111,140
Once off cost			**-**
% of once off cost (20%)			**-**
Total expenditure			**R703,998**
Number of beneficiaries			**3000**
Service expenditure per beneficiary			R235

In the 2019 financial year, this NGO received funding from DSD to the amount of R527 524, or 84% of its total expenditure for that financial year.

The subsidy paid by DSD to this particular NGO for their social worker (R135,186) is only 52% of the that paid to the lowest grade social worker in the government sector (R252,597). The subsidy is not even equivalent to the salary paid by government to the lowest grade social auxiliary worker - R148,215 (grade 1 SAW in 2019).

The following table shows the cost of running a White Door facility undertaking a range of activities in addition to its safe house.

Table 31: White Door Expenditure: Organisation 1 (yearly cost)

	Number	Unit cost	Total cost
Recurring cost			**R546,800**
Staff			
Management	1	R5,000	R5,000
Social Worker	1	R13,300	R13,300
Social Auxiliary Worker			R0
Registered Counsellors			R0
Lay counsellors	1	R4,500	R4,500
Paid volunteers	8	R3,500	R28,000
Unpaid volunteers			
Operating expenditure			
Awareness campaigns			R14,400
Community awareness workshop			R35,000
Capacity building programmes			R54,600
Accommodation for clients			R278,000
Groceries, care packs, toiletries			R54,000
Security			R60,000
Once off cost			**R11,020**
Outreach programmes			R11,020
Community sensitisation and awareness setup			
Community based care (vehicle)			
% of once off cost (20%)			**R2,204**
Total expenditure			**R549,004**
Number of beneficiaries			**3900**
Service expenditure per beneficiary			R 141

The expenditure of this service per beneficiary is R141 per year.

One organisation provided costs for their children's service, an ECD facility. It currently serves 63 children per year with a budget of R71 916. Expenditure per beneficiary is therefore R1 142. This includes childcare, therapy and parenting assistance but excludes any school fees that may or may not be received for this service.

Table 32: Children's services expenditure: Organisation 1

	Number	Unit cost	Total cost
Recurring cost			**R71,916**
Staff			
ECD practitioner			
Night housemother			R40,117
Relief housemother			
Support staff			
Operating expenditure			
Childcare/Therapy/Parenting			R5,146
Food and groceries			R18,534
Subscriptions			R1,712
Other			R6,407
Once off cost			
% of once off cost (20%)			**R0**
Total expenditure			**R71,916**
Number of beneficiaries			**63**
Service expenditure per beneficiary			R1,142

No break down

The final table provides the entire budget for a government-run one stop centre and not just that for the shelter. Its staff complement overall is considerable, amounting to 43 permanent members of staff, plus a

further eight contracted to provide specialised services. This was a proposed budget so it is not clear if this was the final amount allocated.

Table 33: Government-run one stop centre expenditure

	Number	Unit cost	Total cost Annual
Recurring cost			**R 31,597,000**
Staff			
Management			R 25,000,000
Social Worker			
Social Auxiliary Worker			
House mother			
Lay counsellors			
Operating expenditure			
Rental of building			R 1,740,000
Water and electricity			R 252,000
Security			R 504,000
Food			R 1,900,000
Outsources services			R 650,000
Nursing services			R 450,000
Transport			R 136,000
Capacity building			R 480,000
Awareness programmes			R 50,000
Satellite one stop facility			R 435,000
Other			R 1,056,000
Once off cost			**R -**
% of once off cost (20%)			**R -**
Total cost of service			**R 32,653,000**
Number of in-patient beneficiaries			**45**
Number of out-patient beneficiaries			**83**
Service cost per beneficiary			R 255,102

5.2.6 Concluding commentary

Violence committed within intimate and familial relationships presents a set of challenges more complex than those resulting from a single incident of stranger rape. These include problems of housing, income and employment; of children's schooling and their mothers' education; of health; of safety, protection and law; and of crisis, trauma and psychological difficulty. Yet shelters are delinked from the broader package of social benefits such as housing, health and education that are necessary components of care and support services. This lack of integration exemplifies one of the blind spots in the way the VEP conceptualises victimisation and victims' needs.

The DSD is currently developing a new framework for shelter policy, which is also listed as an output by the National Strategic Plan on Gender-based Violence and Femicide 2020 – 2030.[213] This should:

- Adapt the current theory of change. While much of it is solid and has been borne out in practice, it needs to acknowledge the wider range of women accommodated by shelters and provide clear

[213] Interim Steering Committee, 2020.

guidance around the admission of transgender women.

- Provide a clear description of the different services, along with their parameters. We recommend use of the term safe house to refer to emergency short-term assistance and to distinguish it from longer-stay shelters. 'Safe house' also captures the primary purpose of such accommodation. It is evident from the police's use of the VFR facilities as temporary, overnight accommodation that there is a need for such a service. However, the number of women requiring safe houses may not be high, potentially making this an expensive service. We suggest investigating different ways in which such temporary accommodation could be offered – including by coupling designated bed and breakfast services to shelters. Norms and standards for the various interventions provided by safe houses and shelters must be developed.
- Provide a clear description of shelter services for children.
- Set out a comprehensive framework for an intersectoral approach to the sheltering, housing and employment of women who have experienced crime and violence.
- Provide direction on a shelter enrichment grant allowing for the repair and renovation of shelters, including ensuring they are accessible to women with physical disabilities. This would be along the lines of the conditional grant approved for ECD centres to undertake similar upgrades.

5.3 Health facility-based services

The health sector's response to GBV is almost entirely focused on the examination and treatment of rape complainants, with questions of treatment dominated by the provision of PEP to prevent infection with HIV. IPV, by contrast, remains shrouded in policy silence despite signposts pointing to different ways of doing things. In 2012, through their *General Ethical Guidelines for Reproductive Health,* the Health Professions Council of South Africa (HPCSA) issued a set of practical guidelines around screening patients for domestic violence;[214] while a growing body of small-scale studies provide promising illustrations of how the public health sector's response to IPV can be improved.[215] These various proposals and experiments in doing things differently have not been taken up and IPV continues not to be routinely recognised when patients present in health settings, even in the context of injury.[216] Mental health services remain severely limited – and not only in relation to GBV.

In this section we focus on the two care and support services that are currently available within the public health sector: post-rape care offered by the TCCs and the GBV service provided by the Kgomotso Care Centres (KCC) – perhaps the only public health sector initiative to pay explicit attention to IPV.

5.3.1 Purpose of the service and associated theory of change

In 2000 the NPA's Sexual Offences and Community Affairs Unit opened the first TCC at GF Jooste Hospital in the Western Cape. By the start of 2020 the number of functioning TCCs nationally had grown to 51. The aim of the TCCs is threefold: the reduction of secondary victimisation; an increase in conviction rates; and a reduction in the length of time taken to finalise cases.[217] The model consists in two sets of services: a care centre located at a public health facility; and (ideally) a sexual offences court dedicated to the prosecution of rape cases. Post-rape care is not unique to health facilities housing TCCs, however. When the SOA was introduced in 2007 it mandated the provision of PEP to rape victims, with the subsequent *National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Act* prescribing how PEP was to be administered and designating 265 facilities to do so.

In a separate development, the North West Province's DoH established the KCCs in 2013. Two years later in July 2015 further support was offered to these by Medecins sans Frontieres (MSF), specifically four community

[214] Health Professions Council of South Africa, 2016.
[215] Joyner and Mash, 2011; Aschman, Meer and Artz, 2012; Artz, Meer and Aschman, 2018; Hatcher et al., 2019
[216] Joyner et al., 2007; Vetten et al., 2009; Joyner and Mash, 2012; Gordon, 2016.
[217] NPA, n.d.

health centres (CHC): Boitekong, Bapong, Letlhabile and Tlhabane.[218] They thus differ from the TCCs in terms of their location, as well as their emphasis, being far more oriented towards the health, rather than criminal justice system, response to GBV. But they share with the TCCs the idea that one-stop centres promote continuity of care and reduce secondary victimisation.[219]

The KCCs and NGO TCC service share a similar theory of change. The NACOSA Guidelines and Standards for the Provision of Support to Rape Survivors[220] offers the following rationale for NGO intervention at the TCCs:

> Good supportive care is crucial during the acute stage of trauma to prevent further harm to the victim. Supportive interventions soon after rape can also help counteract victims' experience of others as dangerous and harmful, as well as make them aware that further help is available, including support around dealing with criminal justice system processes. The value of good help at this stage is made all the more important by the fact that for many survivors this will be the only time they receive mental health assistance.[221]

The KCC theory of change offers a more abbreviated version of this:

> An early counselling intervention (that is, within the first four weeks of the incident having taken place) prevents the development of more serious mental health disorders.

Containing and preventing longer-term psychological distress is therefore the outcome desired by both the KCCs and NGO TCC services.

At the same time, post-rape care is also treated as a means towards an end by the country's AIDS strategy. First, by ensuring that rape survivors obtain PEP and are supported to complete the 28-day drug regimen, post-rape care is thought to contribute to preventing new HIV infections and second, where rape survivors test positive and are referred to treatment, this assists in meeting the 90-90-90 targets.[222] This is the basis for the Global Fund to Fight AIDS, TB and Malaria's ('the Global Fund') support to NGO TCC services. These services are therefore also shaped by what is theorised to encourage adherence to PEP: :

> Supportive networks are key to reducing people's defaulting on anti-retroviral treatment; establishing similar networks is therefore likely to encourage rape survivors to complete PEP.

There is some evidence to support this approach. Over a two-year period, eight of the organisations based in TCCs and managed by the Aids Foundation of South Africa saw adherence rates increase from 8% to 22%, while the 10 TCC-based organisations managed by NACOSA reported an increase from 13% to 31%. These improvements were attributed to the introduction of telephonic follow-up and home visits. It is not possible to say whether both modes of intervention were equally successful, or if one was more effective than the other.[223]

5.3.2 Description of service

A range of services is provided to complainants presenting at the TCC:

- Reception and the provision of information outlining the services and procedures
- History-taking and a medico-legal examination
- Prophylaxis and treatment for pregnancy and sexually-transmitted infections, including HIV
- Bath/shower, refreshments and a change of clothing
- Transportation home (or to a place of safety), referrals and follow-up support.

[218] MSF, 2018.
[219] MSF 2018: 6-7.
[220] NACOSA, 2015
[221] ibid.
[222] These targets refer to ensuring that 90 per cent of people living with HIV know their status, 90 per cent of people with HIV are on treatment, and 90 per cent of people on anti-retroviral treatment have a viral load that is undetectable.
[223] Creative Consulting & Development Works, 2018.

At some TCCs it is also possible for the victim to open a case on-site, give the police a statement and/or receive longer-term psycho-social counselling and other services – including support with adhering to PEP.[224] More recently, although very little information is available in this regard, the TCCs have been offering services to victims of IPV.

The KCCs, by contrast, focus on rape and IPV equally, as well as child abuse and assaults committed by those other than an intimate partner. Victims may either present at the clinic after a rape or assault or be referred to the clinic – possibly as a result of having been screened for violence by a health promoter. They will first be treated for any injuries and then assisted by a registered counsellor, who may then see a victim for up to eight sessions. Adherence to PEP is asked about during counselling sessions but not actively supported to the same extent as the TCC-based services. Referrals are made to police and justice services where necessary, as well as to hospitals and more advanced mental health care. In addition to this direct care, health promoters undertake community sensitisation and awareness at key community centres and present a programme at schools.[225]

5.3.3 Availability and demand for the service

In 2017 MSF sought to describe the functioning of the 265 services then designated to provide PEP.[226] Of the 167 (or 63%) facilities contacted, 7% were entirely unable to deal with rape cases and referred patients elsewhere. Thirty per cent of facilities did not have access to social work services and less than half (46%) had a separate area or room whose use was dedicated to rape patients. Eighty-six per cent (86%) of facilities were located in hospitals,[227] limiting their accessibility to rape victims in smaller, rural localities. By the 2018/19 financial year the number of designated facilities had risen to 281[228] (including the TCCs). It is unknown to what extent the limitations identified by MSF had been addressed by then.

The number of health facilities offering post-rape care and support services is small relative to the total number of designated facilities and fluctuates according to the availability of funds. In 2015 the Global Fund grant was supporting 39 NGO services based at the 51 TCCs then functional, as well as two of the facilities designated to offer PEP. [229] In 2016 the decision was taken[230] to focus funds and efforts on the 27 districts which account for 82% of all people living with HIV, as well as the majority of new infections.[231] Nonetheless, the Global Fund continued to finance all organisations' work in the TCCs until the start of the 2019 round of funding. In terms of this grant it was not only geographical location that determined funding to a TCC; the district also had to be running at least one of the following: a programme for sex workers; or a programme for adolescent girls and young women; or a programme for people living with HIV. Only if two of these conditions were met, could a post-rape care service then be funded. Those that did lose funding were not necessarily supported by the DSD, with the result that some services fell away or were scaled back.

USAID also began funding post-rape care in 2019. Like the Global Fund they have concentrated their grants within the same 27 districts but coupled funding to a different conditionality: the existence of a USAID-funded programme for orphans and vulnerable children. In addition to funding TCC and designated facilities, USAID also supports the provision of post-rape care services at CHCs. Technically, the latter is not designated to provide such services. However, discussion between USAID, the Department of Health and NACOSA (the organisation managing the grant) led to their introduction under the following conditions: space was available, a forensic nurse was in place, and neither a TCC nor designated facility existed in the area.

[224] Vetten, 2015
[225] ibid
[226] MSF, 2017.
[227] ibid
[228] DoJCD 2019: 196
[229] Vetten, 2015
[230] See the National Strategic Plan for HIV/AIDS and Tuberculosis, 2017-2022 (South African National Aids Council, n.d)
[231] These include: City of Johannesburg, Ekurhuleni, City of Tshwane, Sedibeng, eThekwini, Umgungundlovu, Uthungulu, Zululand, Ugu, uThukela, Harry Gwala, Ehlanzeni, Nkangala, Gert Sibande, OR Tambo, Amathole, Alfred Nzo, Chris Hani, Buffalo City, Thabo Mofutsanyane, Lejweleputswa, Bojanala, Ngaka Modiri Molema, Dr Kenneth Kaunda, Capricorn, Mopane, and City of Cape Town.

At the time of the study the Global Fund and USAID were supporting NGOs to offer post-rape care at 56 health facilities. Twenty-eight sites are supported by the Global Fund, of which 19 are TCCs and nine designated facilities, while USAID funds 28 sites, nine of which are TCCs, 10 designated facilities and nine non-designated hospitals or clinics. This means that at least 47 (or 16.7%) of the 281 designated facilities are offering some form of post-rape care in addition to health services. It is unknown what the vast majority of designated facilities are providing over and above PEP and the forensic examination. Table 36 summarises this distribution of services.

Table 34: Distribution of NGO services across type of designated facility

281 facilities designated to provide PEP and conduct clinical-forensic examinations			
51 TCCs		230 designated centres	
28 NGO services	23 services unknown	19 NGO services	211 services unknown

Like court support to people with ID, TCCs demonstrate one specialisation's central tensions, that between accessibility and economies of scale. Table 35 was compiled from data provided by one organisation managing two TCCs. TCC 1, a far busier site than TCC 2, offered a 24/7 service provided by six first responders, two social workers and a social auxiliary worker, while TCC 2 provided an office hours service staffed by one social worker and two first responders. In 2017/18 TCC1 – based in a district whose population numbered 935 835 people – provided assistance to between 75 and 78 beneficiaries per month. By contrast, TCC 2, based in a district with a population of just 149 908 people, assisted, on average, 33 beneficiaries per month, decreasing to 22 in 2018/19 when funding to the service ceased.

Table 35: Number of beneficiaries seen at two TCCs, by year

	2016/17	2017/18	2018/19	2019/20
TCC 1	937	904	911	923
TCC 2		377	265	

In localities with small populations (such as rural and peri-urban areas) it may be difficult to argue for the establishment of facilities or services dedicated exclusively to a problem or need that would not seem widespread. One solution to this is to concentrate and centralise specialised skills in a way that increases the volume of cases. However, this raises a different challenge. For victims in rural localities long distances between the police station, the nearest office of the Family Violence Child Protection and Sexual Offences (FCS) unit and the TCC can result in the process of reporting a rape being spread out over more than 24 hours. The KCCs whose services are located at CHCs, or local-level community clinics, represent one attempt to address this tension and victims' transport costs:

The PHC facilities are in the community – this was done in response to the challenge of how to bring care closer to victims.
(Interview, North West)

MSF provided data on the use of the KCCs in 2018 and 2019, as well as the first four months of 2020. Between 2018 and 2019, there was a decline in patient numbers at three clinics but a rapid increase in numbers at one clinic – Thlabane. This resulted in an overall increase to their numbers between 2018 and 2019.

Table 36: Number of patients seen at each clinic, by year

Clinic	2018	2019	2020 (Jan – April)
Boitekong	408	381	116
Letlhabile	429	327	90
Bapong	369	265	68
Thlabane	60	343	74
Totals	**1 266**	**1 316**	**348**

Table 37 provides greater insight into who used the KCC service. On average, adults made up about two-thirds of beneficiaries, although the proportion of children being seen at the KCCs was increasing every year. Non-

sexual violence, most of it IPV, comprised more than half of cases seen. (Note that sexual violence within intimate relationships is included within the sexual violence category.) Overall, intimate partners comprised just over one-third of perpetrators, with other members of the household comprising between some one in seven, to almost one in five perpetrators. (These were all cases of child abuse.) Finally, strangers, neighbours, friends and acquaintances accounted for just under half of perpetrators.

Table 37: Beneficiaries of service by age, status, violence type and year

	2018	2019	2020
Child (under 18)	392 (30.9%)	446 (33.9%)	126 (36.3%)
Adult (over 18)	873 (69.0%)	866 (66.0%)	221 (63.6%)
Sexual violence	540 (42.8%)	636 (49.1%)	153 (46.4%)
Non-sexual violence	723 (57.2%)	659 (50.9%)	177 (53.6%)
Perpetrator is Intimate partner	466 (36.8%)	469 (37.1%)	122 (36.9%)
Perpetrator other member of household	207 (16.4%)	185 (14.6%)	62 (18.8%)
Other	590 (46.7%)	641 (50.6%)	146 (44.2%)

Beneficiaries' use of the different services offered by the KCCs is summarized below, showing mental health and social work services to be the most frequently used. The medical services are provided by a forensic nurse, who is also equipped to conduct the forensic examination in cases of rape and IPV. The lower utilization of this service suggests that more patients are presenting some time after the incident of violence, rather than in its immediate aftermath. (All percentages are calculated as a proportion of the totals provided in Table 38.)

Table 38: Use of different services, by year

	Medical		Mental Health		Social Work		Totals
	1st Consultation	FU Visit	1st Consultation	FU Visit	1st Consultation	FU Visit	
2018	551 (43.5%)	363	1094 (86.4%)	811	1034 (81.6%)	677	1 266
2019	715 (67.2%)	308	1143 (86.9%	820	1064 (80.9%)	614	1 316
2020	141 (40.5%)	39	278 (79.8%)	184	273 (78.4%)	178	348

5.3.4 Service process flow

The type of care and support service offered most frequently by NGOs based in the TCCs was PFA, which is characteristic of those who work in emergency or frontline settings such as police stations and hospitals. As the group that victims will first encounter in the immediate aftermath of violence, or other traumatic event, they are termed first responders and their purpose is to provide immediate emotional containment and practical assistance during the acute stage of trauma. TCC first responders are also encouraged to act as victims' advocates, ensuring that survivors are always well-treated during the reporting and forensic examination processes, including by not being left unattended for lengthy periods of time.

Most of the steps outlined below will be followed at both a TCC and KCC:

- Providing psychological first aid
- Explaining the various procedures needing to be followed when a rape is reported and/or a forensic examination is conducted
- Being present, at the survivor's request, during statement-taking, as well as during the forensic examination
- Providing information about PEP and referring victims already HIV-positive at the time of rape for further support and treatment
- Maintaining client records and other information
- Issuing comfort packs
- Liaising effectively with all role players to ensure that survivors are attended to promptly and compassionately and taking action when procedures are not followed. Where possible, first responders

should seek to limit the number of people a survivor is exposed to and ensure they are not required to retell their experience unnecessarily
- Providing referrals to further help – including to longer-term counselling offered by the NGO or another body if the organization is unable to offer this
- Supporting adhering to PEP either via telephonic and/or in-person follow ups, accomplished either through victims' return visits to the hospital, or home visits by NGO counsellors. Home visits are dependent upon the availability of funds for transport.

Additional funding has enabled some organisations to provide include support groups for survivors.[232] At less busy sites (such as TCC2) first responders may alternate their time at the TCC with other offices and community work.

Far fewer rape victims seek assistance at CHC level than from the TCCs, which affects the staffing component of the service. At these smaller sites three first responders and one linkage officer will be made available while funding to a TCC will cover more, and professional, staff such as social workers. The CHC service is thus a more limited, HIV-focused service.

At the KCCs women may either present at the clinic after an incident of violence or be referred to the clinic – possibly as a result of having been screened for violence by a health promoter. They will first be examined and treated for any injuries and then referred to a registered counsellor, who may see a victim for up to eight sessions. Referrals are made to police and justice services where necessary, as well as to hospitals and more advanced mental health care. In addition to this direct care health promoters undertake community sensitisation and awareness at key community centres and present a programme at schools. [233] The staffing of each KCC includes a social auxiliary worker and social worker, a registered counsellor, and doctor/sexual assault nurse.[234]

Table 39 below compares the allocation of care and support tasks by the TCC-based NGO services and the KCCs. While the kinds of tasks undertaken by the two services are identical for the most part, they differ in respect of the professional qualifications of those who undertake them. The KCCs make no use of staff without formal qualifications, while their employment of a registered counsellor enables them to provide a more psychologically-oriented service than the TCCs. Finally, where the TCC-based services are required to focus on HIV, the KCCs focus on healthcare after violence more broadly, including the forensic examination.

Table 39: Comparison of care and support tasks by service type

Care and support tasks	TCC (NGO service only)	KCC
Reception	Victim assistance officer (NPA)	Social auxiliary worker
Containment	Social auxiliary worker/lay counsellor	Registered counsellor
Clinical examination	Doctor/forensic nurse	Forensic nurse
Ongoing counselling and support	Social worker or lay counsellor	Registered counsellor and social worker
PEP adherence support	Social auxiliary worker/linkage officer	Not actively pursued

5.3.5 Service expenditure analysis

The KCCs are a project of the North West DoH and combine staff employed both by the department and MSF. Salaries are thus in accordance with government pay scales. The KCCs employ two managers who each oversee two sites. The expenditure is projected for the 2020 financial year based on current data available and trends. Beneficiaries are also projected using an average of the last two years and latest figures from January to April 2020.

[232] Creative Consulting & Development Works, 2018.
[233] MSF, 2018.
[234] MSF 2018: 10.

Based on these projections, this service expenditure is R5 501 per beneficiary. The main cost driver to this service is the salaries which are paid at DPSA rates. This is the cost for the full service, including cleaning and nursing staff, so not readily compared with the NGO TCC service, which covers counselling services only.

Table 40: KCC expenditure

	Number	Total cost
Staff		R 6,149,034
Nursing activity manager	2	
Counselor educator	4	
Social worker	4	
Registrar	4	
Cleaner	4	
Nurse	4	
Operating expenditure		
Fuel		R166,858
Food		R58,047
Stationary & consumables		R41,414
National travel		R60,288
Other		R174,960
Total cost of service		**R6,650,600**
Projected beneficiaries 2020		**1209**
Service expenditure per beneficiary		R 5,501

The table below was calculated in accordance with the expenditure provided for a NGO-managed care and support service.

Table 41: TCC Expenditure – NGO service (monthly cost)

	Number	Unit cost	Total cost
Recurring cost			**R 132,934**
Staff			
Management	1	R 14,000	R 14,000
Social Worker	1	R 19,056	R 19,056
Social Auxiliary Worker	8	R 9,307	R 74,453
Registered Counsellors			
Operating expenditure			
Medical and drug supplies			R -
Travel for programme			R 8,925
Debriefing	5	R 1,000	R 5,000
Community sensitisation and awareness			R -
Admin cost			R 11,500
Once off cost			**R 14,000**
Medical equipment			
Community sensitisation and awareness setup			
Community based care (vehicle)			
Furniture & equipment			R 14,000
% of once off cost (20%)			**R 2,800**
Total cost of service			**R 135,734**
Number of beneficiaries			**300**
Service cost per capita			R 452

The organisation's monthly expenditure amounted to R132 934 servicing 300 beneficiaries (estimated number).

5.3.6 Concluding commentary

The health sector response to GBV has lagged behind that of other sectors and is skewed towards the medical management and forensic examination of rape complainants. Yet even this intervention requires development, as the vast majority of facilities designated to provide such services offer little more than the bare medical minimum, with care and support services being enabled by entities outside the health sector. This is evident in MSF's support to the KCCs and the Global Fund and USAID's funding to the TCCs. However, the consequence of relying upon external funding is unstable care and support services subject to the changing winds of donor preferences and interests. Donors also impose their own conditions upon services and while it is their prerogative to fund what they choose, this can introduce conflicting rationales into services. Thus, because post-rape care offered at the TCCs is narrowly and instrumentally conceived in terms of its ability to address HIV and AIDS, rather than as a service that all rape survivors should have access to, its availability is accordingly restricted.

Specialised post-rape care is also affected by economies of scale. In the context of the under-staffing of health facilities it is difficult to motivate for specialised staff dedicated exclusively to these services if they are not constantly occupied. From that perspective specialised services are more feasible and cost-effective when located in facilities treating a large number of rape survivors. But this approach then limits what can be offered by facilities serving smaller, less-populated parts of the country.

To address these gaps in services we recommend the following:

- The DSD should recognise that first responder services offered at health facilities form part of the VEP, integrate these within the programme and fund them accordingly. The costs of these services could also be shared with the DoH.
- Context-sensitive norms and standards are necessary to ensure that all rape complainants receive a minimum standard of care, regardless of whether they report at a TCC or a small rural hospital. The

TCCs provide a sufficient variety of contexts to enable such comparison, while the services offered at designated centres as well as the KCCS would allow for further development of these standards. The goal ultimately is to provide an acceptable standard of post-rape care and support that is available at any designated facility and not only the TCCs.

- The KCC service offered by the North West DoH appears to be the only health service in the country to focus equally on domestic violence and rape. A comprehensive policy response to domestic violence needs to be developed that will also guide the sensitive and responsible identification and referral of survivors of IPV.

5.4 First responder services at police stations

Attempts to improve the police response to complainants of rape and IPV have been underway for over two decades. The 1998 DVA also placed a host of duties on the police aimed at ensuring a more engaged and assertive response to complainants of domestic violence, with these set out in greater detail in *National Instruction 7/1999: Domestic Violence*. Following the enactment in 2007 of the SOA *National Instruction 3/2008: Sexual offences* was issued. *National Instruction 2/2012: Victim Empowerment,* which guides the establishment and management of victim friendly rooms (VFRs) at SAPS stations, provides the focus of this section.

5.4.1 Purpose of the service and associated theory of change

SAPS, through its local police stations are a first point of contact for many victims of GBV. The SAPS National Instruction 2/2012 on Victim Empowerment provides for the establishment of VFRs at all police stations and describes these as follows: A dedicated room at a police station to provide a space for victims of intimate violence (gender-based violence, child abuse, sexual offences and domestic violence) to make their statements in private and in a non-threatening environment.[235] However, section 9 of the Instruction refers to VFRs as a space in every police station for the purpose of interviewing 'victims of crime in privacy' thus suggesting that these rooms are for *all* victims of crime and not just GBV survivors.

The National Instructions provides detailed guidance on how VFRs and victim empowerment services should be equipped and managed at police stations. These instructions will be referred to in the relevant sections of the report below.

Theory of change

The implicit theory of change underpinning the SAPS National Instruction is that 1) the provision of an appropriate environment, together with 2) a network of volunteers who are properly trained and supervised by professionals, and 3) adequate coordination by a trained police victim empowerment coordinator will provide an opportunity for victims of GBV to make their statements in a conducive environment and have improved access to relevant support services.

Theory 1:

Volunteers from the VFRs in the Western Cape view first responder services primarily as a **support service to SAPS members** with the focus being on 'making the SAPS function more successful'. This is closely aligned to the theory of change put forth by the SAPS National Instruction. As one respondent noted:

> *The volunteers help calm the victim down before SAPS takes a statement. They get them in the right headspace and suddenly they remember a lot more. SAPS are unable to get so much information.*
> (Interview, SAPS Western Cape*)*

This supportive function is explained further:

[235] National Instruction 2 of 2012 – Victim Empowerment, section 2(o)

The volunteers are crucial for SAPS because they [the victims] *are more mentally prepared for the discussion they're about to have whereas the SAPS have all sorts of things on their mind and aren't always in the right frame of mind to deal with the immediate need*.
*(*Interview, SAPS Western Cape)

In summary, the volunteers are contributing towards taking the pressure off SAPS officials and improving the survivor's ability to give an accurate statement which is key to the effective investigation of GBV complaints.

In terms of theory 1, the VFR solves problems of policing. However, the findings from the focus group discussions and interviews reveal that there are competing rationales underpinning the implementation of VFR services at police stations. This was producing very different understandings of what a VFR is in practice and, in some instances, made the VFRs a site of conflict.

Theory 2:

In theory 2 the VFR is a solution to a different problem: the unavailability of care and support services.

> In many parts of South Africa there are no services but for the local police stations, which are also often the only 24/7 services in the area. The VFR at a police station can thus act as a gateway to a more expanded package of psycho-social services for GBV survivors, inclusive of family intervention, often in partnership with DSD.

An underlying assumption here is that for many survivors, reporting a crime to the SAPS may be the only time they will seek out and receive psycho-social support services.

5.4.2 Description and parameters of the service

As previously stated, the National Instruction identifies both GBV survivors and *all* victims of crime as key recipients of the 'safe space' provided by VFRs, thus making it a generic victim empowerment service. The National Instruction, section 12(2) specifies that it is the role of the Divisional Commissioner: Supply Chain Management to ensure that all police stations are constructed with a VFR; and all existing police stations are provided with a VFR. This takes the form of either a room within the police station or a park home located in close proximity to the station.

Respondents in the Western Cape, North West and Gauteng confirmed that, although the service targets all victims, most people using the VFR services are GBV survivors (both rape and domestic violence). There were however, stations that seldom saw cases of GBV and whose volunteers were mostly assisting crime victims generally. In contrast, SAPS in Eastern Cape indicated that the VFRs were used solely for GBV survivors. On occasion, volunteers in both the Western Cape and Gauteng sometimes accompanied SAPS to the crime scene to provide initial emotional containment to the victim.

Section 11 of the National Instruction specifies how the victim empowerment programme should be run at police stations. Whilst it stipulates that a victim empowerment station coordinator be appointed for coordinating and managing matters related to victim empowerment at station level, the oversight of the VFR is the role of the Station Commander. One respondent noted the following:

"Sadly the SAPS VEP Coordinator is only an appointment, it's not a post within the SAPS. The appointed SAPS VEP Coordinator has, in most cases, other portfolios such as DVA Coordinator, Social Crime Prevention Coordinator, Safer Schools Coordinator, Reservist Coordinator etc. Which translates to inadequate coordination"
(SAPS official)

It was suggested that SAPS consider this function as a post and a career path for those police officials that considered this their vocation.

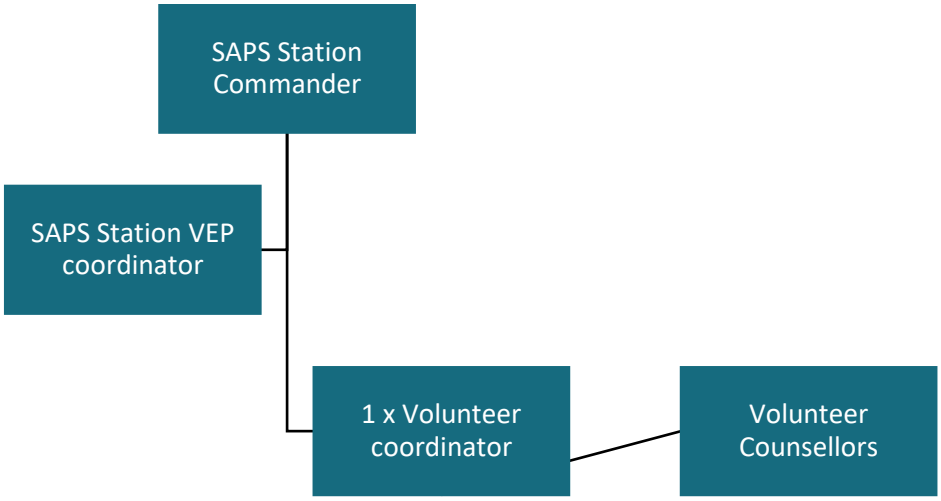
Section 15 deals with volunteers who are defined as "a person who voluntarily performs or offers to perform a service". It is stipulated that "an effective community-based victim support programme needs a strong

network of volunteers". In practice first responder services at VFRs are either volunteer-driven or NGO-driven structures. These are discussed below.

Volunteer-driven structure

In the Western Cape SAPS has taken the decision that VFRs should be reserved for debriefing and capturing statements and that counselling should occur off-site. There is no memorandum of understanding in place between SAPS and DSD for service delivery and the SAPS National Instruction is followed closely with VFR services being provided by volunteers who do not receive stipends. Each station has one SAPS victim empowerment coordinator and one volunteer coordinator who work together to ensure volunteer counsellors are available when called upon for support (see figure 7 below).

Figure 7: Structure of volunteer first responder service at police stations in Western Cape



Whilst the staff and volunteers from five different precincts represented in the focus group were able to confirm this structure in their police stations, the extent to which it is being replicated across all stations in the province was unclear.

The origins of much of the dispute around the VFRs hinge on how volunteering is understood and the form it takes. Section 18 of the South African Police Service Act 68 of 1995 deals with the purpose of the community policing forums (CPF) which includes collaborating with the police in order to respond to the needs of the community in relation to policing; and improving the rendering of policing services. Thus, in a number of the stations the CPF is closely involved in the selection and management of volunteers. In middle and upper-income neighbourhoods where CPFs are able to mobilise financial resources towards the VFR and associated services, and where volunteers are professionals in a position to offer their skills for free, this arrangement appears effective. But a structure reliant on volunteers does not particularly benefit lower-income areas with far less access to resources. Respondents stated that in many instances people volunteered in the hope of finding employment and drifted away when they realised this would not be forthcoming. This resulted in a high turnover of volunteers, as well as no volunteers, or a few volunteers occasionally. Volunteers were also seldom trained because there is no funding for this activity. As a consequence, police stations located in under-resourced township areas, with the highest police-to-population ratios, had the fewest volunteers and weakest services (if they existed).[236] The likelihood of the VFR being taken over to serve police, rather than victims' purposes, is good under these circumstances. (By this we mean the VFR's closure or its use by the police as a recreation site.)

[236] These findings echoed the CGE's 2016 assessment of government department's implementation of the Victim's Charter. According to the CGE there were discrepancies in funding and resource allocation across rural VFRs compared to city-based VFRs. City based stations were generally better resourced to provide victim-friendly services, whereas rural-based stations were poorly resourced (CGE, 2016).

The focus group discussions suggested that the problem was typically addressed in one of two ways: some sharing of resources between upper and lower-income stations in the form of joint training of volunteers and payment of their travel costs; or, more frequently, the involvement of a NGO.

> *The VFR only works if there is an NGO. It was a battle – they* [SAPS] *wanted to take it over for other things….there is one with a shower, waiting room.. it was well equipped but full of files, the server and chair. They don't understand what this thing is and whoever is responsible for GBV should be defending it…the VFR is used as a police rest room.*
> *(*Focus group discussion, North West)

NGO-managed VFR services

Section 14 of the National Instruction states that the station commander may enter into a partnership agreement with NGOs at local level to ensure effective victim support services. This includes training and supervision of volunteers. The research findings revealed variations of this arrangement across provinces but in general the structure includes an NGO which manages the victim support services at the police station with DSD funding for either volunteer stipends or social worker/SAW salaries.

Unlike the police who are oriented to the law, matters of investigation, and how to strengthen these, NGOs are primarily oriented to questions of care and support. They thus notice absences and limitations in services – especially when they attempt to refer. The shortage of TCCs and short-term shelters, and the limited availability of social workers after 16h00 for counselling and child protection services were most frequently mentioned as barriers to successful referrals. What is not unusual then, is for VFRs to attempt compensating for these absences by transforming themselves into a hub for care and support services.

In the Eastern Cape the DSD had termed some VFRs 'White Doors' and designated these as RAR centres. In still another permutation the VFR had moved beyond the provision of first responder services to offer counselling by a social worker. At least two sites in Gauteng had also found ways to incorporate the clinical-forensic examination into the policing service and appeared to be on the way to constructing a one-stop centre of sorts that incorporated counselling, health and policing services.

This was resulting in different kinds of tensions, one over the use of the room itself. In this instance the police complained that when the only available VFR was being used by social workers to provide psycho-social services, this prevented the police from using the room in accordance with their National Instructions. Additionally, section 12 (5)(xiv) of the National Instruction states that the station commander should "ensure that the VFR is not used as an overnight facility or shelter". It is considered a high-risk scenario for SAPS in both Eastern Cape and North West:

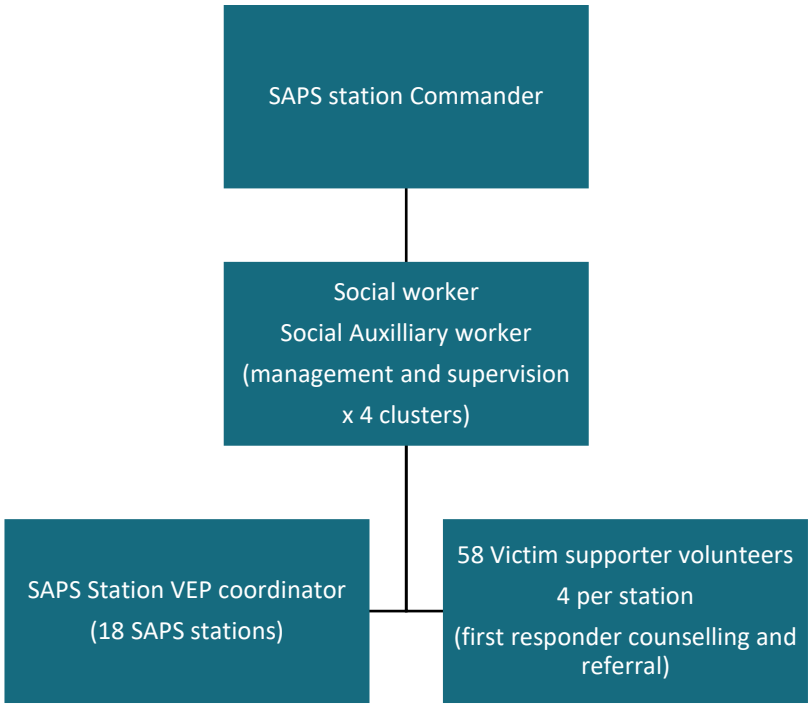
> *They* [VFRs] *previously had beds and now they have been removed following the National Instruction…they* [victims] *must not sleep at the police station. We have to make a referral. The reason being that in some police stations there is not enough personnel….and if something happens to the victim then it 'comes back' to SAPS.*
> (Interview SAPS, Eastern Cape)

Another set of challenges arose over the management of the volunteers. While sometimes managed by the CPF the National Instruction makes it SAPS' responsibility to oversee the volunteers. But if a NGO has been brought in to run the VFR then management of the volunteers is the NGO's responsibility in its capacity as the employer. The question of management and 'ownership' of the VFR had become deeply contested at some sites. Adding yet another dimension of complexity to this was the fact that volunteers connected to NGOs were receiving stipends via DSD funding – although these amounts were not standardised – while those attached to the station were not.

While the Western Cape SAPS may have taken the decision to restrict VFRs' use to debriefing and capturing statements no such decision had been taken in Gauteng at the time of the field work. Instead a memorandum of understanding exists between SAPS, DSD and the GDoCS. NGOs link to police stations and manage the VFR services while DSD provides the funding for volunteer stipends and the social worker and social auxiliary workers. GDoCS provides monitoring and oversight and funds programme-related costs.

VFR Organisation 1, with funding from DSD, has been providing VFR services at 18 police stations in the Johannesburg region since 2011. This service is generic and offered to *all* victims of violence and the structure of the service is presented in the figure below.

Figure 8: Structure of VFR Organisation 1's VEP programme



Number and type of staff required to provide services and level of skill/qualification

The National Instruction requires all volunteers to submit a CV and demonstrate they have no criminal record, possess the ability to communicate with traumatised victims, and are willing to attend training. It is vague on the actual qualifications of volunteers but notes that "a relevant social sciences qualification is not a prerequisite but may assist in providing basic counselling".

In the Western Cape the recruitment of volunteers is led by the victim empowerment coordinator and the National Instruction is followed closely. Volunteers are recruited from interested members of the community although it was noted they often apply because they are looking for employment rather than being motivated by a genuine interest in providing a voluntary service. The recruits are then trained as lay counsellors (see details on training below). As stated previously, the number of volunteer first responders per VFR ranges from two to 21.

In North West, VFR Organisation 3 initially recruited volunteers with matric level qualification but gradually shifted towards requiring more professional qualification and they now only recruit intern social workers. There are currently five intern social workers located at each VFR.

Ideal number of staff

Respondents proposed the ideal number of counsellors for a continuous first responder service to be between **four to five** volunteers per VFR to allow for distribution of acceptable workload and rotation of shifts. There should not be less than four volunteers per VFR.

In Gauteng GDoCS had a volunteer policy with directives about working hours: five volunteers per VFR working no more than five hours per week on a rotational basis.

A key theme emerging is that **supply should be matched to demand** of the community. The rationale here is twofold:

Firstly, some police stations deal with a high number of GBV cases and these should receive more counsellors.

Secondly, there are peak times which are considered higher risk for GBV including weekends and the festive season when alcohol abuse is high. During these times it is proposed to have four to five volunteers on call but in smaller stations where there is no rising crime, one to two volunteers on standby is reportedly sufficient.

Hours of operation

Respondents were unanimous that first responder services should be available on a continuous 24-hour basis, seven days per week.

> *Why we encourage the volunteer FR service being 24 hours compared to working 8am-4pm is that people get raped 24 hours a day.*
> (Interview, government official Gauteng)

The data reveals that hours of operation vary across provinces and is dependent on funding, availability of volunteers and geographic location.

In the Western Cape the five urban police stations provide first responder services 24 hours a day, seven days per week. Volunteers are on standby when the need arises and work on a rotational basis. At some police stations, first responders are not called at night because of safety and transport issues. Instead, the coordinator sends out the CPF and neighbourhood watch trauma counsellors.

In the Eastern Cape, VFR Organisation 2 provides first responder services at SAPS stations from 7am – 3pm, seven days a week. They are on standby at night and on Saturday and Sunday.

> *Sitting at the station on night shift is not desirable – this might involve sitting all night with no beneficiaries while away from your family.*
> (Interview, VFR Organisation 2, Eastern Cape)

In North West, VFR Organisation 3's intern social workers are placed at VFRs for eight hours a day. Their role is to receive beneficiaries, contain them and keep in contact with the police to ensure that the momentum is sustained. Without this intervention the victim could wait a very long time (eight hours in one case) before being attended to by the police.

Referral systems

By identifying current needs and concerns, first responders also note what other assistance is needed and provide direct links and referrals to these services. According to Section 110 (1) of the Children's Amendment Act of 2007 and the SOA first responders working with children have a legal responsibility to report sexual and other forms of abuse and ill-treatment of children. Family members need to be informed of this legal obligation.

Section 13 of the National Instruction outlines the procedure for referrals by SAPS officials. The NACOSA Guidelines state that every station-based service should maintain a comprehensive and up-to-date referral list that includes contact details for local shelters and medium to long-term counselling services. In addition, the list should contain information about specialised services for people with disabilities, LGBTQ+ survivors, refugees and migrants and any other grouping which require specialist assistance.

First responders across all provinces confirm that referrals include the courts for protection orders, DSD social workers for child protection related cases, and NGOs for counselling, shelters, TCCs and hospitals. However, the referral process is not without its challenges.

Coordination mechanisms

There are multiple forums in place to coordinate the response to GBV in provinces. The most frequently mentioned is the provincial and regional VEP Forum. Others mentioned include: Trafficking in Persons forum, LGBTQ+ forum, Child Justice Forum and Older Persons Forum. At the district and local level the CPF convenes local VEP forums and representatives from these structures attend the provincial forum. The TCC runs a forum

focused on sexual offences related cases. This is convened by NPA and is reportedly effective in North West and Gauteng.

The VEP forum is convened by DSD, meets on a regular basis (monthly or quarterly) and is multi-sectoral in nature, including key government departments (NPA, DSD, SAPS, DoH) and NGOs. The VEP forum in North West appears to be more active and functional than the one in Eastern Cape. The main challenge cited is the irregular attendance of certain departments, particularly the DoH.

Whilst the various forums contribute to improved planning, and standardisation of VEP interventions, most respondents were of the opinion that service delivery remains fragmented with poor cooperation between departments.

When the Office of the Premier takes the lead, then the forum is more effective, presumably due to its stronger convening power. Whilst the Office of the Premier has recently become more involved in the Eastern Cape, it has been leading coordination in Gauteng for some time due to the Premier-led Ntirhisano Programme aimed at promoting cross-departmental coordination in the province.

Monitoring and evaluation systems in place

SAPS Eastern Cape report that the CPFs (where active) are monitoring VFR utilisation. Based on this they help to source donations for equipping the rooms and making them more 'victim friendly'.

5.4.3 Availability and demand for the service

In Gauteng, GDoCS monitors VFRs and has up to date information on their functionality in the province. A team of coordinators visits stations and submit reports on a weekly basis. This includes assessment of a dedicated space, open 24 hours, and its management, including visibility, signage, accessibility to people with disabilities, and the extent of referrals and follow ups. This is captured in VEP reports compiled monthly and submitted to the Office of the Premier on a quarterly basis.

SAPS data on domestic violence and sexual offences is collected at station level and by FCS Units respectively. Statistics are sent to the provincial office crime register and then sent to SAPS National Head Office. DSD local service offices collect monthly and quarterly data on the number of victims and type of victimisation. Reports are sent to district and then provincial level where they are collated and sent to National DSD. According to DSD North West, data is being used for planning, largely to comparing baseline and target figures. A key challenge, however, is that data is only being collected at activity/output level and not outcome/impact level making it difficult to monitor change for the beneficiaries:

> *"We have funded 23 NPOs to deal with DV but they are forgetting to measure the impact of it – we don't know if it is making a difference".*
> (Interview, government official North West)

A further challenge is poor 'matching' of data across departments, highlighting a flaw in the process flow and referral system as the following quote reflects:

> *With the stats – I would like it if we go to a meeting and if DSD is reporting, my report should not be different to their report – when we differ, then it means there is something they are not doing correctly – this is a problem with the referral system.*
> (Interview, SAPS North West)

Availability of VFRs at police stations

According to the SAPS Annual Report for 2018/19 there were 1 070 VFRs as at 31 March 2019, with 984 of these located in the 1 146 police stations country-wide.[237]

Table 43: Number of VFRs by province and facility

[237] SAPS 2019: 142.

Province	Police stations	Satellite police stations	Contact points	Airports	Railway and coaches	FCS Units	Total
Eastern Cape	157	0	0	0	0	2	159
Free State	82	10	0	0	0	0	92
Gauteng	135	2	0	0	0	5	142
KwaZulu-Natal	154	1	0	1	0	10	166
Limpopo	86	4	0	0	0	5	95
Mpumalanga	82	1	0	0	0	1	84
Northern Cape	70	1	0	0	0	2	73
North West	68	0	0	0	0	8	76
Western Cape	150	21	1	1	4	6	183
Total	984	40	1	2	4	39	1 070

However, respondents in the North West point out that not all VFRs are functional:

> *The police have VFR – some have and some don't and they are not always used.. some were dirty and full of documents and not used. The room is there in most police stations but often not used.*
> (Focus group discussion, North West)

This finding is supported by studies conducted by the Commission for Gender Equality in 2016 which found that the mere existence of the VFRs was no guarantee of effective institutional capacity for the police station to respond to GBV in the area. In many cases, centres were under-staffed and lacked basic furnishings and equipment.[238]

Availability of first responder counselling services at police stations

SAPS in Eastern Cape and North West were unable to provide data on the range, coverage and reach of first responder services at police stations in the province.

The GDoCS is monitoring VFR services and reported that 52 out of the 142 police stations have a network of volunteers; the remaining 90 police stations have NGOs managing VFR services which include volunteers, social workers and SAW. The latter are being funded by DSD.

Data from the five stations represented at the Western Cape focus group confirmed that the number of volunteers per station ranged from two to 21. The table below provides a snapshot of this and compares it to the police-to-population ratios for each station.

Table 42: Number of volunteer counsellors per police station (FGD_VFR_WC)

Area	Number of volunteers	Police-to-population ratios[239]
Durbanville	21 (12 are in training)	1 per 640
Elsies River	12 (includes coordinator)	1 per 371
Brakenfell	8	1 per 531
Nyanga	3	1 per 628
Harare	2	1 per 745

Demand for service

Information on the number of beneficiaries accessing first responder services is not readily available although individual NGOs providing such services may be collecting this monitoring data. For example VFR Organisation 1 reports that, on average, the Trauma Centres assist and support up to 1 000 victims per month with the total

[238] CGE, 2016 6b.

[239] See the media statement issued on 10 October 2018 by the Western Cape Provincial Government (https://www.gov.za/speeches/western-cape-government-police-under-resourcing-16-oct-2018-0000)

number of beneficiaries reached being 4 837 victims assisted in 2017; 17 931 victims assisted in 2018; and 12 822 victims assisted in 2019.[240] Whilst the data does not give the number of victims of GBV assisted, these figures give some insight into the high demand for such services at police stations.

VFR Organisation 3 in North West reports seeing about 480 beneficiaries at the five police VFRs annually of which about seven out of 10 have experienced domestic violence and rape. This would be a total of 340 per year (or approximately 28 GBV beneficiaries per month).

Demand creation

The National Instruction (section 15) includes involvement in education and awareness campaigns as a function of volunteers. Respondents confirm efforts are being made to create awareness and promote VFR services. In North West and Western Cape the CPF supports SAPS and multiple platforms are used including: door to door campaigns, pamphlets, social media, Facebook, radio, community newspapers. In Gauteng the GDoCS conducts awareness raising on GBV through door to door campaigns and conducting a survey to assess community needs including those related to GBV. A kiosk at satellite police stations in hot spot areas is used to bring SAPS services close to the community including information on VFR services.

5.4.4 Service process flow

Counselling sessions

First responders provide one-on-one counselling with the focus on providing emotional support and practical assistance followed by referral to an appropriate service for further counselling and intervention – this could include a TCC, FCS unit, a shelter, a DSD or NGO social worker (see process flow below).

The session usually lasts between 45 minutes to two hours but is also dependent on the availability of referral services in the community. For example, if no shelter is available, volunteers 'sit' with the victim for long periods of time. This issue was raised in all provinces.

Number of sessions

First responder services are generally limited to one to two sessions with the second being a follow-up session.

The issue of where the service begins and ends is an important theme. In the Western Cape, volunteers shared the importance of 'knowing their boundaries':

> *"An important part of the volunteer training is to know the boundary between debriefing (which is our focus) and counselling, which is beyond the scope of SAPS volunteers".*
> (FGD_VFR_WC)

The National Instruction, section 15(4), states that the expertise of volunteers may be used to provide related services for victims but that *counselling should not be given by volunteers without appropriate skills.*

The diagram below provides an overview of the process flow of a volunteer-driven service, from the point the victim enters a police station, to referral.

Figure 9: Process flow for counselling services at volunteer-driven VFR

[240] There is no detail in the report indicating the reasons for the significant increase in the number of victims assisted from 2017 to 2018.

Management and coordination of the service

First responders need adequate training and supervision to offer a quality service to survivors. The National Instruction stipulates the need for volunteer training and provides a list of generic topics to be covered (there are no topics on GBV) but stops short on specifying duration, accreditation and the like.

Section 15 (6)(7) specifies that supervision and training is the responsibility of the station commander who can request assistance from DSD or a NGO contracted by DSD. Both training and supervision of volunteers should be undertaken by professionals including psychologists or social workers who have expertise in trauma management and counselling.

The NACOSA Guidelines and Standards for first responder services to rape survivors proposes that all such staff attend a minimum of 60 hours of in-depth training; their competence be assessed to ensure they demonstrate the requisite levels of skill and knowledge before working with survivors. Organisations should seek either to accredit their training, or to utilise accredited training materials. [241]

5.4.5 Government departments' commentary

The two different understandings of the purpose of VFRs are also evident within the SAPS; there are those who understand them in terms of the National Instruction and those who see them as offering psycho-social services more broadly. For VFRs to work in the way intended by the National Instructions assumes a great deal. Respondents from SAPS, DSD and GDoCS highlighted these assumptions:

- The station commander is committed to victim empowerment as a concept and practice – if not, the service is treated as an afterthought and the VFR is used for purposes it was not intended, and appropriate staff are not appointed to its management. Station commanders not particularly taken with

[241] NACOSA, 2015.

victim empowerment are likely to appoint unsuitable members to this position which is seen as dumping ground for troublesome members
- The victim empowerment coordinator is committed to victim empowerment as a concept and practice – while competent coordinators certainly exist, they are often also effective police officers generally and so brought back into the mainstream of policing, rather than being allowed to retain oversight of victim empowerment functions
- Station members are committed to victim empowerment as a concept and practice – ordinary members do not always appear to be aware of the existence of the VFR and even when they are, do not routinely refer complainants to the service. Members also subvert the purpose of the room by utilizing it for other activities
- The CPF is active and able to secure resources for victim empowerment – at a minimum this enables ongoing training and supervision and the payment of volunteers' travel costs
- Skilled volunteers, who also have access to their own vehicle, are available to give of their time – where this assumption is not valid the VFR tends to exist in name only; in practice it becomes an empty room
- There are a range of services in the locality, including a shelter, to which people can be referred.

A further complicator identified by study participants was the frequent changes in leadership and administration at provincial level. This often resulted in new ideas being introduced and implemented with limited evidence-based planning, and the old ideas being abandoned for no obvious reason.

5.4.6 Cost of service

Only one set of costs for a VFR was made available for analysis, summarised below.

Table 43: NGO-run VFR cost of service

	Number	Unit cost	Total cost
Recurring cost			**R 3,204,922**
Staff			
Management	1	R 67,416	R 67,416
Social Worker	4	R 142,359	R 569,436
Social Auxiliary Worker	6	R 115,191	R 691,146
House mother			
Lay counsellors			
Paid volunteers	58	R 25,832	R 1,498,256
Unpaid volunteers			
Operating expenditure			
Transport			
Training of staff			
Debriefing			
Other			R 378,668
Once off cost			**R -**
Outreach programmes			
Community sensitisation and awareness setup			
Community based care (vehicle)			
% of once off cost (20%)			**R -**
Total cost of service			**R 3,204,922**
Number of beneficiaries			**R 12,822**
Service cost per capita			R 250

5.4.7 Concluding commentary

The aim of the VFRs is, on paper, a simple one. However, their effectiveness is dependent on a great many implicit assumptions that do not hold up within the context of South Africa's current socio-economic conditions. As a consequence, they have come both to reflect existing underlying inequities, as well as to inadvertently foster the emergence of new ones. Their theory of change requires considerable revision and adaptation to address this, which must include the further development of policy as VFRs have expanded in scope and purpose and not in ways that reflect the SAPS National Instruction.

We recommend two variations to the service:

- Variation one: this applies to areas that are relatively affluent (possibly quintiles 1 and 2) and whose CPF and volunteer profile is largely professional. VFRs are managed in accordance with the SAPS National Instruction and the services remain as they are; they reflect important altruistic values and volunteers can give back in ways that do not come at either their expense or that of the service. Nonetheless, they should be part of all discussions around service standards for the VFRs, as well as any training around these.
- Variation two: is characteristic of VFRs based in quintiles 3 to 5 areas and is a service with paid first responders attached to a NGOs responsible for their training, debriefing and supervision of first responders.

Finally, the VFR is a narrow and limited service in support of the goals of policing. Up to a point this may be acceptable. VFRs have, however, expanded in scope and purpose in ways that do not reflect the National Instruction. This is suggestive of need that is not currently being recognised. We further recommend:

- The explicit incorporation of first responder services based at police stations into the VEP. Their inclusion should result in a clear description of the service, its purpose, scope of practice and associated norms and standards.

- Investigation into and identification of contexts where it may be appropriate to develop a service attached to a station that offers more than first responder assistance

5.5 Support with navigating the courts

Services assisting those who approach the courts are born of a certain irony: that the systems and procedures intended to promote justice can themselves be obstacles to justice. This is for two reasons. First, fear of, as well as lack of familiarity with, court proceedings affects complainants' participation in court proceedings by discouraging reporting,[242] encouraging the withdrawal of matters[243], or the giving of testimony in ways that undermine complainants' credibility. Second, actual legal processes are themselves damaging to complainants in a range of ways. Simply the fact of having to once again relive the experience of rape or assault is sufficient to evoke psychological distress and upheaval[244], while some rape complainants have asserted that it is they, rather than the accused, who are placed on trial.[245]

Two types of court services have arisen in response to these difficulties: court preparation and court support, with both further adapted to the needs of children and people with ID. A further variation on court support has also emerged within the civil, rather than criminal, sections of the courts with the aim of supporting individuals who are applying for protection orders in terms of the DVA. These services all have a strong intermediating function, that is they act as an interface of sorts between the complainant (or applicant) and court processes and procedures and they do so in two ways. One is as a kind of translator who converts arcane language and bewildering rules into everyday understanding, while the other is a way of being with witnesses that is supportive, kindly and sometimes literally containing. That is, they literally use their presence to absorb and carry complainants' fear and anxiety.

The 2020 Regulations on Sexual Offences Courts[246] set out the distinction between court preparation and court support. The Regulations make clear that 'court preparation' only refers to the programme developed by the NPA "aimed at familiarising complainants and witnesses in sexual offence cases with the court environment, with a view to preparing them to testify in court and providing assistance and support to them, in line with the standard operating procedures for court preparation officers."[247] Court support, by contrast, is provided by:

> a person employed by a non-profit organisation, registered in terms of the Non-profit Organisations Act, 1997 (Act No. 71 of 1997), accountable to the Provincial and Local Departments of Social Development and rendering a voluntary service to complainants and witnesses in sexual offence cases as contemplated in regulation 19;[248]

Court supporters are permitted to carry out five tasks at court:

- Accompany complainants and witnesses to and from any of the facilities referred to in regulation 4, the court room and the restrooms to be used by them
- Accompany complainants referred to in regulation 7(1)(b), to the designated area
- Provide support to complainants and witnesses during the proceedings in court, if a complainant or witness so wishes;
- Refer complainants and witnesses to the correct institutions for professional services; and
- Assist complainants and witnesses to obtain witness fees.[249]

Court supporters may only conduct court preparation programme if they have received written permission to do so by the NPA.[250]

[242] Jewkes, Penn-Kekana and Rose-Junius, 2005.
[243] Vetten et al., 2008.
[244] Herman, 2002
[245] Wheatcroft, Wagstaff and Moran, 2009.
[246] Government Gazette, 7 February 2020
[247] Regulations, section 15
[248] "Definitions", Regulations
[249] Section 19(1)
[250] Section 19(2)

In this section we first describe Ke Bona Lesedi (KBL), the court preparation programme first developed by the National Prosecuting Service (NPS) of the NPA in 2001, and then NGO court support services.

5.5.1 Court preparation: Purpose of the service and associated theory of change

KBL was initially established in 2001 under the auspices of the Serurubele Project and the NPA's 'Employing the Unemployed Project.'[251] The programme is described as a form of therapeutic jurisprudence for the way it ensures that judicial and administrative processes are responsive to witnesses' needs.[252] The notion of therapeutic jurisprudence derives from the assumption that law should serve, rather than undermine, the mental health of those it affects. Substantive rules, and the ways in which they are applied should therefore be analyzed to determine their impact on therapeutic values.[253] This is not to suggest that the chief purpose of law is to provide therapeutic benefits but to argue that mental health ought to be a factor in weighing up legal policy options, with choices informed by empirical research around particular legal practices and their (anti)therapeutic effects.

KBL is also justified by its operational utility. Because prosecutors feel pressured to meet performance targets that require them to finalise a set number of court cases every month, they either hurry through case consultations (often only meeting with the complainant for the first time on the day of the trial), or ask the court interpreter to undertake these on their behalf.[254] By allocating the preparation of witnesses to court preparation officers (CPO), prosecutors are able to spend more time in court finalising matters.[255]

Court preparation's theory of change can be summarised as follows:

> Understanding how the court works and the witness' role in its procedures lessens stress and increases confidence, resulting in responses that are more accurate and complete. Maximising witness' ability to respond effectively in court increases the likelihood of their being perceived as credible and their testimony capable of sustaining a conviction. Court preparation also effects change beyond individual matters. If prosecutors are given more time to concentrate on the legal issues and concerns affecting their matters, this may manifest in a higher conviction rate generally which will ultimately contribute to enhancing the credibility of the criminal justice system.[256]

The NPS qualifies these broad claims by noting that no straightforward cause and effect relationship can be assumed between court preparation and case outcomes; too many other variables are at play.[257]

5.5.2 Description and parameters of the service

Norms and Standards for Court Preparation Services were issued in 2010, with court preparation further institutionalised in February 2020 through the Sexual Offences Court Regulations.[258] The Regulations detail the facilities and spatial layout of court preparation services, along with their other requirements, and define both court preparation and court support.

CPOs' main responsibilities are court preparation, as well as some outreach and community education activities intended to increase understanding of their service. The norms and standards for KBL define court preparation as a specific and bounded intervention undertaken in collaboration with the prosecution when a matter comes to trial.[259] Court preparation makes no claim to providing counselling or therapy[260] and comprises two elements:

[251] NPS, 2015: 15
[252] Tewson 2016:10
[253] Wexler and Winick 1992: 230
[254] Tewson 2016: 10
[255] ibid
[256] NPA 2015: 17-18
[257] NPA 2015: 18
[258] Government Gazette, 7 February 2020
[259] NPA, 2010

- The readying of witnesses to testify;
- Assisting complainants with preparing a victim impact statement (VIS).

In terms of the first, CPOs are expected to:

- Book witnesses for preparation sessions and compile comprehensive records regarding all their interactions with witnesses
- Explain court processes and procedures, provide an orientation to the physical layout of the court, as well as the various role players and their functions
- Apply a competency test in the case of a child to assess their capacity to distinguish truth from lies
- Make referrals for psychosocial assistance
- Assist witnesses with transport to and from court, including applying for witness fees.

The VIS is obtained for purposes of sentencing and is different from victim impact reports. The former is a voluntary written statement, facilitated by the court preparation officer or the victim assistance officer, by a complainant; a person who is by law authorised to make a statement on behalf of a complainant; a relative of the complainant authorised by the complainant; or any other person authorised by the complainant, regarding the emotional, physical, psychological, economical or any other effect of the sexual offence on him or her[261]. A victim impact report is a professional's assessment of the impact of the sexual offences on the victim or family.[262]

While the VIS is deposed to in the form of an affidavit, its drafting is not particularly legalistic. Victims complete the forms by hand in their own words and describe the impact of the crime upon their life, from its physical and emotional effects, to its economic consequences. In relation to the latter an application in terms of section 300 of the Criminal Procedure Act can be included within the VIS to claim the costs of medical treatment or damages, as well as loss of income. Victims are also invited to include drawings or poems in their VIS – or even replace the statement with these.[263] Children are particularly encouraged to express themselves in this way. However, it should be noted that not all victims wish to submit a VIS – indeed, in Mpumalanga it was noted that only a minority chose this option.[264]

KBL has developed a comprehensive set of guidelines to systematise and standardise these various tasks.

5.5.3 Availability and demand for the service

The 2020 Regulations make court preparation an imperative for every sexual offences court, of which 106 were listed on the Department of Justice's website in August 2020. [265] Court preparation is not however, exclusive to these courts but may be offered to any other witness in need of such assistance, including those appearing in the High Courts, with CPOs expected to conduct at least 75 court preparation sessions monthly, as well as compile at least 15 VIS.[266] The table below provides a summary of CPOs' work over a five-year period. In terms of the NPA's counting rules CPOs do not report on the number of witnesses seen but on the number of sessions of court preparation provided. The numbers recorded below reflect the fact that CPOs assist many witnesses more than once, including before the trial, on the day they give evidence, on the day of sentencing (should they be required to be present), as well as on any occasion witnesses come to court and the matter is postponed.

Table 44: Summary of CPO work over a five-year period

[260] NPA 2010: 19
[261] Government Gazette, 7 February 2020: 47
[262] ibid.
[263] KBL n.d. Master Training Manual: 'How to Present a Victim Impact Statement in Court'
[264] NPS 2019: 29.
[265] See "List of Regional Courts upgraded into Sexual Offences Courts [106 Countrywide]" available at https://www.justice.gov.za/vg/sxo-SOC-list.html
[266] NPS 2019: 7

Financial year	Total number of court prep sessions - sexual offences (%)	Total number of court prep sessions - other matters	Total witnesses	No of adult witnesses (%)	Average no of CPOs available monthly
2014/2015	48 108 (48.1%)	51 907	100 015	82 571 (82.6%)	118
2015/2016	51 744 (48.5%)	54 944	106 688	88 976 (83.4%)	122
2016/2017	55 503 (44.9%)	68 173	123 676	104 122 (84.2%)	130
2017/2018	55 785 (46.7%)	63 674	119 459	98 336 (82.3%)	127
2018/2019	53 302 (47.4%)	59 213	112 515	92 533 (82.2%)	123

In terms of the KBL norms and standards 160 CPO and five court managers' posts ought to have been filled. However, only 121 CPOs and four court preparation mangers were employed at the end of the first quarter of the 2019/20 financial year, leaving vacant one court preparation manager and 38 CPO positions (largely due to budgetary constraints).[267] It is therefore possible that some sexual offences courts may not currently have access to CPOs. When CPOs are available, they are concentrated within larger courts, with smaller courts (typically in smaller towns, or rural areas) having very limited access to CPO. On request effort is made to send CPOs to periodical courts, or other small courts but this does not solve the problem of their availability.[268]

The table below summarises the number of CPOs available by province.

Table 45: Number of CPOs per province

Province	Number of CPOs
North West	8
Western Cape	19
Northern Cape	4
Free State	11
Eastern Cape	13
KwaZulu-Natal	21
Limpopo	13
North Gauteng Division (incl. Mpumalanga)	17
South Gauteng Division	15

5.5.4 Service process flow

Witnesses may either arrive at the CPO office as walk-ins due to testify that day or will have been referred and booked for a session of court preparation. Referral may be via any one of the following routes:

- The control prosecutor who, in the course of placing matters on the court roll for trial, identifies witnesses in need of court preparation.
- The victim assistance officer or the case manager from the local TCC. Case managers are typically prosecutors and based at the court in whose jurisdiction the TCC falls. They will thus be aware whose matters are coming up for trial. The victim assistance officer based at the TCC will also refer, especially if the complainant has expressed a fear of court processes.
- The investigating officer responsible for the police investigation.
- State advocates based at the High Court.
- NGOs are also a source of referral. Typically, their staff will have been providing counselling and/or other forms of emotional support to the complainant and are therefore aware of the upcoming trial date. Alternatively, the prosecutor will have assessed that the complainant is not yet in an emotional state to testify and will have delayed matters to enable the complainant to obtain counselling. The matter will

[267] NPS, 2019
[268] NPS, 2019

proceed once the complainant is better able to cope with testifying. The CPO will be contacted at this point.

In practice, CPOs participating in the focus group discussions said their days seldom followed an orderly sequence of pre-booked appointments. They will start the day by checking the court preparation and VIS register for bookings. If none have been arranged the CPO will go to the prosecutors' offices to ask if any of their witnesses are in need of preparation and they will also go to the courts to ask those waiting outside court rooms if they require preparation. The court security guards are especially important in directing walk-in witnesses to the CPO offices.

Both court preparation and the compilation of VIS are guided by a particular process, captured by the acronym PEACE. Its steps include:

- Planning and preparation – ideally, this should commence a week or the day before trial and requires the CPO to consider the developmental age of the witness in order to plan the session appropriately, as well as ensure that any disabilities are taken into account. Documentation in the form of booking sheets, register, files, victim impact forms and log forms must be prepared and the office diary updated. The court preparation room must be set up, with age-appropriate tools near at hand.
- Engage and explain – the purpose of this step is to provide witnesses with a clear understanding of trial processes, typically with the witness first being shown an unoccupied court room and familiarized with its layout as well as where they will sit. They then return to the CPO's office and are taken through the procedures to be followed. This includes receiving an explanation of all the role-players in the court room and their functions; an outline of the various procedures followed in court (such as the oath and cross-examination), as well as special measures that can be requested from the prosecutor (such as an in-camera hearing); and examples of the sorts of questions that may be asked, along with tips for dealing with these, especially in relation to questions whose answers they do not know. (Much of this content is made more accessible to children through pictures, puppets, stories and games.) If court preparation takes place in advance of the trial (rather than on the day), witnesses are also provided with advice on how to dress and behave at court, dealing with threats from the accused or anyone else connected to the case, and creating an information pack containing all their case-related materials and documents. Children's competence is also tested to assess their ability to distinguish between what is right and wrong, true and untrue. And finally, children are also provided with a 'comfort' toy to take into the court room. This session is reported on via a manual or electronic log sheet.
- Account – this refers to the prosecutor's consultation with the witness and the witness' testimony in court. The CPO reports their observations to the prosecutor of the witness, especially in relation to the witness' emotional state and readiness to testify, their communication skills and any other needs or concerns noted. In the case of a child the CPO also provides the prosecutor with the pictures testing the child's competency. Once consultation has been completed (if it occurs) the witness will be taken back to the witness waiting room or handed over to the intermediary (in the case of children). In some instances, the CPO will also sit in court while the complainant is testifying.
- Containment and closure – occurs after testifying. The CPO locates the witness to enquire about their experience and explore its emotional effect. Witnesses are also assisted with obtaining their witness fees and, if indicated, referred for further assistance. If the matter has been postponed, the witness will be provided with the next trial date and an explanation for the postponement. Finally, the CPO is expected to update the witness' case file by completing all the required forms.
- Evaluation – requires the CPO to reflect on and assess their performance in relation to each matter, identifying if they require any further training, or other intervention by a senior staff member, as well as whether or not they are in need of additional debriefing. If they have been observed by one of their peers, this assessment of their performance should also be discussed. Overall, CPOs keep copious notes and it is expected that they submit their statistics on a monthly and quarterly basis in support of their performance evaluations.

The infrastructure identified as necessary to supporting KBL (rather than 'preferential') is summarised in the next table.

Table 46: Infrastructure required for KBL CPOs269

Court preparation office	Children's waiting room	Adult waiting room	Refreshments
Phone and pin	Sleeper couch/mattress	Chairs	Fridge
Desks	Blankets/pillows		Kettle
Office chairs	Ventilation fan / heater / air conditioner	Ventilation fan / heater / air conditioner	Cups
Printers	Small table with plastic chairs		Plates/crockery
Photocopier	Curtains/blinds	Curtains/blinds	Dishwashing utensils
Fax machine	Television with accompanying licence	DVDs	Dustbin
Stationery	Toys		
Lockable storage cabinets	First aid kits		
Mini bookshelves			
Signage ('Do not disturb')			

Supervision and management of the service

KBL's training programme was finalised in 2010 and accredited with the Health and Welfare Sector Education and Training Authority in 2015. A five-day course, it consists of 12 modules grouped into three parts. Part 1 describes the model of court preparation and its associated administration; details the court environment and its functioning; provides an overview of crisis, trauma, and abuse; and introduces participants to children's developmental stages towards adulthood. This is then coupled to an overview of communication techniques. Section 2 provides practical guidance around preparing child, adolescent and adult witnesses while the final section of the manual is focused building a portfolio of evidence. A further three training courses have since been added: a five-day programme entitled *Understanding the Sexually Abused Witness*; a course for both CPOs and prosecutors on VIS; and lastly, the course *Understanding Witnesses with Special Needs and Disabilities.* The last focuses on the spectrum of disabilities, as well as some mental health conditions.

By 2019 the NPA had taken steps to consolidate the programme still further by seeking to create two qualification in line with the Department of Labour's regulations for the Quality Council for Trades and Occupations. These will be 'court preparation official' and 'court preparation manager.'[270]

KBL is closely monitored through a variety of logs, reports and form with both self and peer evaluation also in place. CPOs also rotate the position of Cluster Co-ordinator every four months. Debriefing is provided by the NPA's Employee Wellness programme

5.5.5 Government departments' commentary

Government services are affected by limited budgets too, with the insufficient number of CPOs considered to significantly limit KBL's availability to witnesses. At the same time, full use is not always made of CPOs due to court personnel themselves not being aware of the services of the CPOs. CPOs, it is complained, are sometimes put in the position where they have an hour in which to obtain a VIS from the victim and/or their family.[271]

According to one of the officials interviewed for the study, the NPA is responsible for funding the KBL programme but does not have control over courts' allocation of their budget. They therefore cannot determine what portion of a court's budget is spent on food for witnesses, for example.

[269] See NPA Blue Print: Court Preparation 2013/14.
[270] NPS, 2019.
[271] NPS 2019: 27

5.5.6 Cost of service – expenditure analysis

Within the NPS the bulk of the costs lie in compensation of employees. Using the norms relating to the number of staff that must be allocated to courts providing these services one can estimate the cost per KBL.

Table 47: Estimated cost per KBL

	Number per court	Cost per post	Cost per court
Key to KBL service			
Deputy Directors Court Prep	1	R 1 008 519	R 1 008 519
CPO	2	R 271 342	R 542 684
Total key posts			**R1 551 203**

5.5.7 Court support: Purpose of the service and associated theory of change

The various court-related programmes offered by NGOs enhance and complement court preparation services to complainants. KBL's norms and standards, in fact, recognise how court support differs from court preparation, with court support defined as:

> Empathic, person-centred assistance rendered by an organisation or individual following the reporting of a crime by a victim usually associated with the Victim Empowerment Programme and therapeutic services. These services support the victim in relation to the impact of traumatic events, victim and trauma support, trauma counselling, trauma therapy and where necessary in-patient care…[272]

The goals of organisations' court support programmes are oriented towards both social change, as well as the minimisation of individual harm. When focused on social change, court-related interventions formulate their theory of change in the following ways:

> Victims of GBV seldom see justice due to severe deficiencies in the implementation of laws. Their encounters with criminal justice system officials often result in further victimisation manifested by discriminatory police attitudes, victim blaming and the traumatic and adversarial courtroom environment. The failure of the justice system in GBV cases results in a loss of faith in that system and creates an environment where perpetrators of violence are not held accountable for their actions and victims are left vulnerable to further abuse. Holistic legal and psychosocial support to victims of GBV, in combination with strategic engagement with state actors and the communities which the organisation serves, will facilitate structural change.

By contrast, CS Organisation 1 takes as its goal the minimisation of harm and prevention of long-term psychological scarring in abused children. The key mechanisms of change in their work are expertise, information and support in the form of forensic medical examinations, supportive therapy, forensic evaluations, psychological testing and a court preparation programme for children and parents (where cases go to trial).

The court support offered by CS Organisation 2 is motivated by the observation that many survivors do not understand how to access the protection provided by the DVA. The provision of crisis counselling at court, coupled with assistance in completing the protection orders introduces two pathways of change. First, it will ensure that the affidavit is comprehensive and captures the full extent of the abuse which, in turn, will assist the Magistrate to make a well-informed decision around the provision of an interim protection order. Second, the survivor will be brought into CS Organisations 2's continuum of care and linked to follow-up support services such as shelters. These two pathways will contribute to the overall goal of reducing the levels of violence perpetrated in the home.

[272] NPA 2010: 18

5.5.8 Description and parameters of the service

Whilst there are variations in the court support offering, common to all is the following:

- Informing the survivor (and family members of children) about the court procedures
- Supportive presence and accompaniment before, during and after court procedures. This may include providing complainants with stress management techniques (such as breathing exercises) to draw on while testifying. Court supporters may sometimes also be allowed to stand in the witness box alongside highly stressed complainants, to provide a containing and supportive presence
- Providing practical assistance such as filling out forms, reminding beneficiaries of court dates, arranging transport and the like.

Each programme attempts to couple their court support to their counselling services, as this support is understood to have a direct effect on counselling outcomes. Lack of information on case progress from investigating officers, uncertainty and fear related to court processes, exacerbate beneficiaries' distress. The results of DNA tests can take many months and waiting for this information is another source of stress.

> *They get support through counsellors in terms of accessing other services, e.g. court, police station. As an ally they have someone who commits to walk with them through the process of opening a case and follow up. There is a lot of secondary victimization – so counsellors become the advocates for the beneficiaries for getting quality support and care.*
> (Interview Eastern Cape)

The court support services in the sample did not assist the same groups. Three organisations assisted children and their families, while CS Organisations 3's court support targeted both survivors and witnesses of sexual offences aged 14 years and older. CS Organisation 4 assisted both child and adult victims and addressed both domestic violence and sexual offences while CS Organisation 2 assisted adult victims of domestic violence only.

Court support services are either stand-alone programmes situated directly at the court; or they operate independently from the courts, usually off-site. Those who elect court-based services do so for strategic reasons - survivors often choose to make use of court support and not counselling services.

> *We follow the principle of not forcing people to go for counselling….we give them back the choice…but we offer court supporters at court and we never had a case where people did not want court support…it gives emotional containment to function at the court.*
> *(*Focus group discussion, Western Cape)

The presence of CS Organisation 1 at the courts also allows for a degree of integration in the prosecution of matters. The organisation's staff and court personnel liaise directly around matters and refer to each other on an on-going basis. Prosecutors, for example, will refer children to the organisation's social workers to assess their readiness to appear in court and, should the organisation conclude they need further preparation, will then postpone the matter accordingly.

5.5.9 Availability and demand for the service

When court support services are located at courts, this increases their availability for all survivors, which is particularly important when KBL is not available.

Demand for services

Court supporters from two organisations indicated that the number of cases they see in one month is dependent on the court. On average they are providing services to 30-40 new cases per month in each court.

CS Organisation 2 notes a constant demand for their service. Each court support worker sees about 50-70 new clients per month with an average of 7-10 clients per day with every fourth to sixth client presenting as a DV case. The other cases include those requiring protection from harassment, referral to the maintenance courts or child protection related cases. The reason for this is that the initial screening, which is a DOJ&CS-mandated

responsibility is not being adequately fulfilled. The caseload fluctuates depending on time of the year. During holidays (December, January and April) it is quieter when the Prosecutors and Magistrates go on leave.

The table below provides a snapshot of the number of people using the service in the last month and the last 12 months for two of the organisations.

Table 48: Number of people using court support services

Organisation	Number of people using service in last month	Number of people using service over last 12 months
CS Organisation 2 (12 courts)	782	11 418
CS Organisation 3 (5 courts)	61 Survivors 35 Witnesses	657 Survivors (Aug 2018 – Aug 2019: 5 Courts) 419 Witnesses (Aug 2018 – Aug 2019: 5 Courts)

In previous years when CS Organisation 2 was operating in 12 courts with 20 court support workers, the programme was seeing approximately 25,000 applicants per year.

Data for the utilisation of CS Organisation 1's service over the last three years is shown below, distinguishing between the total number of beneficiaries and the total number of sessions. Repeat sessions can reflect a higher degree of need, as well as being an indicator of quality; if services are experienced as unhelpful people will not return to use them. At the same time, returning for follow-up sessions is also contingent upon the affordability of transport costs and, if the care-giver is employed, their being able to take time off work. Return visits are also a function of the number of staff and number of beneficiaries: limited numbers of staff coupled to high numbers of beneficiaries do not give staff the space to book many return visits. Table 49 illustrates this fluctuation in numbers with branches 1 and 2 offering two or more sessions to their beneficiaries, while branch 3 largely offered one session only to its beneficiaries.

Table 49: CS Organisation 1 - utilisation of service 2017-2019

Branch	Number of beneficiaries			Number of sessions		
	2017	2018	2019	2017	2018	2019
Branch 1	128	111	102	274	279	315
Branch 2	148	159	119	509	490	370
Branch 3	180	246	246	310	352	402
Total	**456**	**516**	**467**	**1 093**	**1 121**	**1 087**

5.5.10 Service process flow

There are multiple referral pathways to court support workers including via: Prosecutors; walk-ins at the court; TCCs; SAPS (when a case is opened) and NGOs. They also have access to the court roll through which they identify potential beneficiaries.

Court support work is one part of a broader package of psycho-social services provided by NGOs so an internal referral system exists between to Court Support Workers and NGO social workers/counsellors. For example, at CS Organisation 3, survivors and witnesses of sexual offences are referred from the first responders at TCC; and when a client opens a case they are linked up with the Court Support Workers for consultation and support during the trial. Similarly, social workers at CS Organisation 5 refer children and their parents to the Child Witness Project for court support services.

A client sees a court support worker for an average of 3-4 individual sessions but this depends on the number of postponements in court. The duration of session is usually 45-60 minutes.

In the next section we provide detailed description of three services to illustrate the range and depth of court support programmes.

CS Organisation 1

Each branch of the organisation conducts one group session of court preparation every month, with children typically attending at least three such group sessions (and often more). These are managed by the volunteers and SAW. In one office the volunteers are third-year and Honours level psychology students, while the other two offices are staffed by social work graduates unable to find employment. The organisation has access to another layer of volunteers including dogs; candidate attorneys, retired prosecutors and other legal professionals; as well as a member of the SAPS.

Court preparation sessions include a range of activities such as worksheets, colouring-in, role plays and question and answer sessions. Top ('touch our pet') dogs and their handlers also attend the groups and provide a non-threatening, playful way to introduce children to the court environment. A mock court room is created with each dog, dressed in the appropriate garments, playing the part of different court officials whom children are free to engage with.

Where it is assessed that some children require a greater degree of assistance they will be asked to attend individual preparation sessions. Counselling of the child is undertaken by a different staff member to prevent blurring of functions.

Court support work with children is undertaken in conjunction with support to their caregivers and siblings (if required). While the children's Saturday programme is underway caregivers also attend question and answer sessions with the legal panel comprising the legal professionals and member of the SAPS. These deal with concerns around the investigation of matters and their preparation for trial and often lead to panel members following up to address blockages in individual matters. There is also a support group for caregivers in need of more therapeutic support. Parents are encouraged to seek individual counselling and referred as necessary.

Staff based at the courts perform additional duties, largely related to liaison with the prosecutors and police. They also follow up on postponements and ensure that specialised equipment such as the closed-circuit television system is functioning.

CS Organisation 1 also undertakes forensic assessments and prepares victim impact reports for court. These differ from VIS in that they are professional assessments undertaken by either a social worker or psychologist.

CS Organisation 2

CS Organisation 2's court workers assist victim of domestic violence with completing their affidavits to support their applications for protection orders. The service largely emerged in response to Xhosa-speaking women's struggles with legal processes conducted largely in English and in 1999, at the request of a number of magistrates' court, the organisation formally established its court support programme which is now predominantly available in the Western Cape (with a few courts in Gauteng and KwaZulu-Natal also starting to offer the service).[273] The organisation's target group is women aged 18 years and older.

The court support service operates from a room in the Magistrates Court building, with court support workers offering assistance to anyone who approaches the court for a protection order. The service is available during court hours (08:30- 15:30) at 11 courts in Western Cape for 3 days a week at each court. One to two court supporters are allocated at each court depending on the caseload but also the amount of funding available. The service was initially available five days per week at each court but then reduced to three days per week due to funding cuts.

The court support service is a stand-alone programme located within a broader offering of psycho-social services or 'continuum of care' provided by CS Organisation 2. Supplementary services include: education and information sessions around intimate partner violence to court attendees; and awareness raising in

[273] Vetten 2017. Background Country Paper for UN Report Progress of the World's Women.

communities surrounding courts (see demand below).[274] Court support workers are not responsible for following up with clients as they are lay counsellors and not able to offer long–term counselling. The organisation's social workers and social auxiliary workers attached to the courts are responsible for follow-ups.

CS Organisation 4

CS Organisation 4 is based in an informal settlement and works with the one court serving this community. As the most legalistic of the services described it employs two attorneys (one of which is the Director), a legal officer (a law graduate) and a legal assistant (who is completing her LLB). Their psychosocial staff component comprises a drama therapist and social worker.

Beneficiaries typically arrive at the office and will either consult with the legal officer or assistant, or are referred to either the drama therapist or social worker. If beneficiaries wish to report the sexual offence or incident of domestic violence CS Organisation 4 will accompany them to the local SAPS station and/or the local clinic for treatment and completion of the J88. If the case is one of rape the FCS will be called and the organisation will wait with the client. In domestic violence matters the organisation will explain the application process and assist with the completion of forms. Once granted by the courts the interim order will be served by the police. The organisation will then prepare the applicant for the final hearing and, if the order is opposed by the respondent, then represent the applicant at court. Much of their other work around domestic violence focuses on ensuring the police comply with their duties in terms of the DVA and, to this end, they report individual officers for misconduct in terms of the Act but also run capacity-building workshops with the local station to improve enforcement of the Act. These two activities illustrate some of the ways in which they try to bring about systemic change.

In relation to criminal matters the organisation's legal team routinely follows up with investigating officers to keep beneficiaries abreast of progress on their cases. They will also ensure that DNA evidence is being processed and any other necessary evidence gathered. During this period complainants will attend individual therapy sessions with the social worker (as needed) as well as support groups, with individual counselling provided by the drama therapist. Both the drama therapist and social worker organise monthly psycho-educational workshops for children's caregivers in collaboration with CS Organisation 1.

In preparation for the trial staff arrange a pre-trial conference between themselves, the prosecutor, the KBL CPO and the complainant (who is also provided with a court pack and travel fare). While court preparation is undertaken by the CPO, the organisation's psychosocial staff will address fears and anxieties through individual counselling sessions. In special cases the drama therapist and social worker will also attend the trial with the complainant. What is more usual is for one of the legal personnel to sit in and monitor court proceedings. Finally, in the attempt to address the systemic challenges that can undermine individual cases, the organisation also attends monthly court case flow management meetings.

Number and type of staff

The table below captures the number and type of staff providing court support. The number of Court Support Workers per court depends on the caseload at a particular court.

Table 50: Court support - number and type of staff

Organisation	Number and type of staff
CS Organisation 1 (4 courts	▪ 9 social workers ▪ 10 SAW ▪ 19 volunteers
CS Organisation 3 (5 courts)	▪ Full-time Court Support Workers + 1 stand-in worker – Lay Counsellors ▪ 1 full-time Court Support Coordinator – Social Worker ▪ 1 follow-up piece-worker – SAW - responsible for following-up with those who attended court to check if they continued with counselling. ▪ 1 Administrator (unclear if full-time or part-time)
CS Organisation 2	▪ 16 Court Support Workers - Lay Counsellors

[274] ibid.

(11 courts in WC)	▪ 1 Programme manager ▪ 4 social workers responsible for coordinating the courts in their areas (courts are divided into zones)
CS Organisation 5	▪ 13 Court Support Workers - Lay Counsellors (2 x Khayelitsha; 1 x Wynberg; 3 x Cape Town; 2 x Atlantis; 5 x Paarl) ▪ 4 SAWs spread across courts

Ideal number of staff: CS Organisation 2

Based on previous demand, CS organisation 2 has estimated that its programme should ideally operate with two court support workers per court. This would allow workers to cope with demand, avoid burnout and provide collegial support.

> *There is a huge emotional toll the work takes on the court support worker – especially if working in a court like Khayelitsha. From the moment the court opens, you do not even have 10 minutes to process…in an ideal world we would have a minimum of two in every court*.
> (Interview, Western Cape)

However, if there is in excess of 300 beneficiaries per quarter at the court, then the ideal number would be three to four court supporters.

CS Organisation 2 describes the process of their work as follows:

- Cases are mostly self-referrals – those arriving in court for protection order applications; or those seeking out the service following awareness raising sessions in the community;
- By 8h00 there are long queues of people waiting at the Magistrates Court. The referral for court support services differs across courts;
- In some courts, the PO applicants start with the clerk of the court who will conduct screening, provide the application form and make the relevant referral to court support workers;
- In other instances, the court support workers will conduct a general information session in the morning to share criteria for those who qualify for court support for DV PO;
- Individual sessions are held with each individual which include:
  - Crisis counselling;
  - Assistance with completing the application form including the affidavit and ensuring this captures the relevant detail on the extent of the abuse. In some instances, the court support worker writes the affidavit for the client if they are illiterate or if English is not their mother tongue. It is often the case that the level of detail required in the affidavit is not captured due to English being the second language;
  - Needs assessment to assess nature of violence, level of risk and immediate needs;
  - Referrals to NGOs, shelters, SASSA, other local referral networks.
- The applications are submitted to the clerk of the court who submits to the Magistrate to make a decision on whether an interim order should be issued. In most instances this decision is made on the same day but the applicant may need to return the following day.

Note: the court support worker has no control over the decision of the Magistrate to grant the application. In a very few cases the Magistrate may not grant the PO and the court support worker would then need to go to the Chief Magistrate to 'fight the case'.

5.5.11 Government departments' commentary

Court support programmes become under-utilised if there is poor collaboration between NGO court support programmes and NPA. It is necessary to win prosecutors' trust in the competency of the court support worker before prosecutors will make referrals to the service, or engage with any suggestions offered by the court support worker:

> *One of the challenges is lack of understanding of the court support workers and not creating opportunities for use of the service. Especially the NPA who think we are replicating what they are doing….. we meet with them and explain what we do and they realise the need for what we do, but they do question the organisation providing the service and the credibility of the service*.

(Focus group discussion Western Cape)

There is also limited space at courts to provide services effectively – a problem shared with the CPO services.

5.5.12 Cost of service – expenditure analysis

Three organisations' expenditure information can be compared in this section. CS Organisation 1's programme runs on a cost of R1 275 per beneficiary per year and is the most intensive of the programmes, offering multiple individual and group sessions, as well as to care-givers.

Table 51: Court support expenditure, Organisation 1

	Number	Unit cost	Total cost Annual
Recurring cost			**R 837,993**
Staff			
Court supporters	7		R 785,561
Stipends			R 32,160
Operating expenditure			
Refreshments			R 4,814
Transport			R 7,277
Telephone			R 4,196
Other			R 3,985
Once off cost			**R -**
% of once off cost (20%)			**R -**
Total cost of service			**R 837,993**
Number of beneficiaries			**657**
Service cost per beneficiaries			R 1,275

CS organisation 2 offers a very cost-effective service due to the high volume of beneficiaries it assists annually. Over eleven thousand beneficiaries in three provinces are assisted in a year on a budget of R1.5 million a year. It should be noted that all staff, who are not formally qualified, are paid well above the minimum wage, illustrating how a cost-effective service need not come at workers' expense.

Table 52: Court support expenditure, Organisation 2

	Number	Unit cost	Total cost Annual
Recurring cost			**R 1,596,480**
Staff			
Management	2	R 21,000	R 252,000
Court workers	12	R 83,340	R 1,000,080
Admin		R 7,500	R 90,000
Operating expenditure			
Transport			R 28,400
Telecommunication			R 18,600
Food and refreshments			R 39,000
Printing			R 18,000
Supervision and debriefing			R 23,400
Administration cost			R 10,000
Other			R 117,000
Total cost of service			**R 1,596,480**
Number of beneficiaries			**11,418**
Service cost per beneficiaries			R 140

CS Organisation 3 manages a budget of R304 814 per month which mainly includes payment for staff. It manages on a high volunteer system (it is not clear whether these volunteers are paid a stipend or not). Service cost per beneficiary equals R653 based on 467 clients.

Table 53: Court support expenditure, Organisation 3

	Number	Unit cost	Total cost Monthly
Recurring cost			**R 304,814**
Staff			
Management			
Social Worker	3		
Social Auxiliary Worker	3		R 253,167
House mother			
Volunteers	15		
Operating expenditure			
Awareness raising materials			R 36,217
Refreshments			R 8,145
Travel reimbursements			R 4,386
Other			R 2,899
Once off cost			**R -**
% of once off cost (20%)			**R -**
Total cost of service			**R 304,814**
Number of beneficiaries			**467**
Service cost per beneficiaries			R 653

5.5.13 Concluding summary

Supporting with navigating the courts is core. Two approaches have developed in response to this need: court preparation and court support. Both derive in recognition of the same problems and while sharing some similarities in theoretical approach and method also differ in important ways.

KBL, the court preparation programme offered by the NPA, is a narrow and specific intervention tightly proscribed by norms and standards coupled to accredited training. It is also strongly oriented towards the goals of the criminal justice system. KBL's theory of change is well institutionalized in policy and straightforward to cost. As a complete theory of change, it is a good candidate for an impact evaluation or other forms of research examining programme effectiveness.

Court support, which is offered by NGOs, demonstrates greater variation in theory and method. Being closely tied to NGO counselling services, it is more therapeutic in orientation than court preparation, as well as one part of a greater whole. Broadly speaking, two different methods of support are evident in the programmes focused on the criminal court. One largely stresses supportive accompaniment throughout trial proceedings, while the other emphasises court readiness activities undertaken in groups and/or individual sessions. These differences in method suggest that organisations have identified slightly different mechanisms as bringing about change. These different mechanisms, including that of KBL, should be further researched in terms of their comparative effectiveness, as they entail different costs.

Court support to those applying for protection orders in terms of the DVA is not formalised in policy and there are very few such programmes relative to the number of individuals seeking such orders. As the literature review noted, while only a few thousand rape cases reach trial stage and require assistance at court, well over 200 000 applications for protection orders are made annually. As with the programmes in the criminal courts, two approaches can be discerned, one whose focus is supportive and educative while the other is far more legal in nature (and relies on legal professionals). On that basis, while important, we have not included these more legalistic approaches in the set of core services. The more support-based programme is rooted in a solid theory of change (but for its resources) and is therefore also a good candidate for impact evaluation. It also requires some kind of formalisation that involves clearly defining the roles of the clerk and those of the court support worker, as well as the scope of the clerk's duties. This determination of roles could be set out in regulations similar to those issued around the sexual offences' courts.

6 CONCLUSIONS

The Constitution of the Republic of South Africa represents a set of aspirations both forward-looking and developmental. It guarantees rights to equality, dignity and freedom and security of the person and anticipates the realisation of different socio-economic rights, from health care, to housing and social security. Care and support services embody this vision and there is a duty on the state to make these services both increasingly available, as well as to a wider range of people. To support the realisation of this goal the study reviewed seven kinds of services and recommended six as core, with these being:

- Telephonic helplines
- Community-based counselling services
- Safe houses and shelters
- Containment and first responder services based in health facilities
- Containment and first responder services based at the SAPS' victim-friendly rooms
- Support with navigating both the criminal and civil courts through court preparation and court support programmes.

While there may be a place for rapid response emergency team interventions, we have not prioritised these as a core service. A modality of intervention which is premised on an understanding of GBV as akin to a humanitarian disaster, we have argued, is unable to reach all the very many women and children who fall victim to GBV daily. Instead, we suggest locating care and support services at health facilities which would have the effect of reaching a greater number of survivors, as well as being more cost-effective.

Based on the study findings, four strategies are suggested to consolidate and strengthen these core services.

1. **Investing in the staff who provide services**

Supporting individuals who are stressed, traumatised or in crisis is profoundly dependent on the skills and personal qualities of the people who provide these services and those engaged in this work of care and support should themselves not be stressed or overwhelmed. When they are, this adversely affects their ability to provide good help to survivors. With the study suggesting that the quality of assistance on offer may not always be of the desired standard, we recommend the following, seeking to steer a middle course between professionalisation and deskilling.

- The inclusion of community members in the provision of services is endorsed. 'Community' in this instance should be understood broadly to encompass both those living within a geographical area, as well as those who share experiences in common (such as violence, forced migration or discrimination on the basis of their sexual orientation and/or gender identity). The involvement in service of members of diverse communities is a principle that may add to the acceptability of services, function as a mechanism of change and encourage social cohesion.
- Creating a qualification and occupational category, possibly termed a 'support worker' is recommended. Their scope of practice may include psychological first aid and containment, crisis counselling and support, and social assistance - referring to forms of practical assistance such as applying for grants and court orders, or developing beneficiaries' ability to generate an income. Recognition of prior learning should be built into the process. Additionally, we suggest that ways be found to fast-track this process, the process of accreditation is reported to be so convoluted, difficult and time-consuming that a previous move in this direction was abandoned.
- In tandem with these recommendations, we suggest that all staff have access to regular training, supervision and debriefing.
- All staff should be paid commensurate with the value of their work and active steps should be taken to standardize subsidy amounts, as well as increase professional staff's pay to 80 per cent of the equivalent DPSA rate.

2. Reviewing and refining the VEP and associated policies

The VEP is the overarching policy framework guiding the provision of care and support services. As such it needs to be considerably developed and expanded upon. The health sector needs to be accorded a more significant role in the VEP and services based at police stations and courts better described and standardised. New policy is required to guide the establishment and management of safe houses and shelters. Community-based counselling services are especially in need of strengthening. More attention must be paid to determining referral pathways between victim empowerment services, mental health services, and social services broadly, including housing

In revising the VEP policy makers should draw on the rich and multi-layered matrix of theories of change evident across services. These address the design, physical organization and layout of services; identify the kinds of features in counsellors that bring about change, or consider the ways in which the relationship between help-giver and help-receiver inhibited or encouraged change; and reflect on the nature of justice, as well as the relationship between individual help and collective change. In addition to the focus on the criminal justice system, policy must pay attention to the ways socio-economic circumstances contribute to and maintain vulnerability. A strong framework of norms and standards needs to govern the provision of care and support services to ensure quality services are equitably available, and they deliver the intended benefits.

3. Ensuring equitable access to services

Services are not universally available nor equally accessible. The problem is not just one of prejudice, or a lack of information; limited funding and restricted access to skilled, knowledgeable staff is also preventing people from receiving care and support. Enabling services to embrace a wider range of beneficiaries requires different strategies. In the case of people with mobility-related disabilities or sight impairments, this entails ensuring that the built environment is accessible – people are able to gain entry into buildings, move between different levels and use toilet facilities. Other barriers require service providers to be trained around sexual orientation and gender identity, as well as ways of working that are not heteronormative. Information materials about services should also reflect a wide diversity of users, while organisations should seek to increase the

acceptability of their services by employing staff reflective of diversity of backgrounds, including in relation to ability, sexual orientation and gender identity.

Access to a range of services must also be facilitated for those whose needs are complex and require specialized attention. On that basis we recommend the creation of specialised shared services to give access to a range of skills that are often out of reach due to their cost.

4. Planning for the progressive realisation of services

There are too few care and support services to meet the need in South Africa[275] - including in relation to rape and IPV. But between the literature review and the study findings we found there to be almost no guidance around how to progressively increase these services to ensure that they reach both more, as well as a wider range of survivors; only shelters seem to have been made the focus of attempts to estimate need. The table below provides a brief sketch of existing sites and notes the extent to which they currently offer care and support services.

Table 54: Current availability of different core services

Service	Number in existence	Comments on service availability
Telephonic helplines	3 national lines	Some organisations also offer telephonic support to the area in which they are based.
Community-based support services	Unknown	Unknown
Shelter	At least 90	The use of different terminology for shelters (i.e, one stop centre, Khuseleka, safe house, crisis centre, White Door) and the changing numbers provided for these makes it difficult to be definitive.
Designated health facility-based services	281	47 of these facilities currently offer NGO care and support services
Victim-friendly rooms	1 043 police stations	984 stations currently include victim friendly rooms, with another 86 offered at other points of reporting. It is unknown how many victim friendly rooms have access to volunteers or NGO support
Court services	106 sexual offences courts	The number of courts with access to CPOs or NGO court support workers is unknown. It is also unknown how many civil courts offer support with obtaining a protection order

A system needs to be developed to plan for the equitable rollout of services. While the table sketches what is in existence it does not answer the larger question of the sufficiency of these numbers relative to the need. Indeed, individual preferences and processes of change, coupled to under-reporting, make it extremely difficult to calculate need with pinpoint precision. Even so, the rollout of care and support services can be informed by:

- The prevalence of GBV in each province / district
- The size of the provincial population and key population centres
- Measures of poverty in a province and district
- The volume of cases dealt with by individual police station stations, courts and designated facilities

The scale at which services are required means it is impractical for government to be the sole provider of services. The study has pointed to the costliness of government services, as well as government's limited experience in this field. Partnering with civil society is key. Care and support services are a community asset, for and by their constituency and the use of existing resources, infrastructure, knowledge, skills and interventions must be enhanced by government support.

[275] DSD, 2016

From one service flows the potential of many benefits that both contain the original harm and prevent new and compounding difficulties from seeping into their beneficiaries' lives. These include ending repeat victimisation; limiting children's exposure to violence and its repetition and re-enactment in their (adult) lives; and linking to livelihoods, income, social security and housing. Others include the prevention of infection with HIV, as well as linking to treatment; skills to cope with the challenges of testifying of court; and linkages to other services, including mental health. More intangibly, services promote social solidarity and provide communities with the opportunity to support each other. These benefits are not being realised to their full extent. We hope this report will be the first step towards changing that.

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8 ANNEXURES

Annexure 1: Domestic, international regional legal framework

The domestic legal framework

The South African Constitution is the departure point for this discussion. As the highest law of the land it defines the rights to which all citizens are entitled and establishes a set of overarching principles with which all law and policy must comply.

A number of provisions in the Bill of Rights apply to care and support services in the context of violence.

Section 9: Equality

The equality clause states that everyone is equal before the law and has the right to equal protection and benefit of the law. The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. No person may unfairly discriminate directly or indirectly against anyone.

The Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA), 4 of 2000, was enacted to give effect to Section 9. One of its objects is also to comply with South Africa's international treaty obligations, including the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). Section 8 of PEPUDA prohibits discrimination of any kind on the grounds of sex, gender or sexual orientation and makes clear that GBV is a prohibited form of discrimination. Notably, this section also prohibits limiting women's access to social services and benefits, such as health care, education and social security. This significance of this clause will become more apparent in the discussion around section 27 of the Bill of Rights.

Section 10: Dignity

Section 10 states that everyone has the right to human dignity and the right to have their dignity respected and protected.

Two key Constitutional Court decisions recognise GBV as violating the right to dignity: *S v Baloyi and Others*[276] ("Baloyi"), which deals with domestic violence; and *Carmichele v Minister of Safety and Security*[277] ("Carmichele"). In both decisions the Court found that the right to dignity, as well as the other infringements of rights evident in these two matters, imposed positive duties on the state to provide appropriate protection to everyone through laws and other means. It could well be argued that care and support services provide an avenue through which dignity may be restored.

Section 12: Freedom and security of the person

This section of the Bill of Rights has the most obvious relationship to violence and states that everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either private or public sources.

Again, both Carmichele and Baloyi have led the way in establishing that sexual offences and domestic violence violate the freedom and security of the person, their bodily and psychological integrity, as well as the rights of everyone not to be subjected to torture, nor to be treated or punished in a cruel, inhuman or degrading way. Further, when the right to be free from all forms of violence is read with section 7(2) of the Constitution, it imposes a direct duty on the state to take steps to protect the right of everyone to be free from private or domestic violence.

The Domestic Violence Act (DVA), 116 of 1998, represents the most comprehensive attempt to give expression to this duty to date. The Act empowers the courts to prohibit particular forms of conduct and places a range of

[276] *S v Baloyi and Others* 2000 (2) SA 425 (CC).
[277] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC)

duties on the police to address complaints of domestic violence – including assisting applicants to find shelter from their abusive partners, as well as have access to counselling and medical care. Even if there is no reciprocal legal obligation exists compelling the DSD to make shelter and counselling services, it can be inferred from the fact of their reference in law that they ought to exist. Certainly, in providing women with a place of safety, shelters very tangibly instantiate the right to be free from all forms of violence.

The Older Person's Act, 13 of 2006, provides another, different example of how section 12's obligations can be translated into legislation. In terms of section 25 of the Act any person who is involved with an older person in a professional capacity, and who on personal observation concludes that the older person is in need of care and protection, must report such a conclusion to the Director-General of the DSD. Any other person who is of the opinion that an older person is in need of care and protection may report such an opinion to a social worker. The Act further notes that an older person living in circumstances conducive to seduction, abduction or sexual exploitation, qualifies as someone in need of care and protection. In addition, any person who suspects that an older person has been abused or suffers from an abuse-related injury must immediately notify the Director-General of the DSD, or a police official of his or her suspicion.

Similar duties apply in relation to children and persons with intellectual disabilities. In terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA), 32 of 2007 any person who has knowledge that a sexual offence has been committed against a child, must report such knowledge to a police official. It is also obligatory for any person with knowledge, or a reasonable belief, or suspicion, that a sexual offence has been committed against a mentally disabled person to report this to the police.

Law thus establishes a duty of care to older persons, children, and people with intellectual disabilities. This duty is not met by the mere reporting of harm; such reporting, if it is to have any purpose, must surely go hand-in-hand with creating safer alternatives to the person's current situation, including through the provision of a set of services.

Section 26: Access to adequate housing

According to section 26 of the Bill of Rights everyone has the right to have access to adequate housing and the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

The constitutional duty of the state to 'progressively realise' the right to have access to housing was first considered and interpreted by the Constitutional Court *in Government of Republic of South Africa v Grootboom*[278] ("Grootboom"). An obligation to make shelters available is implicit in this decision; women forced to flee their homes in search of safety must surely fit the description of persons in 'desperate need' of alternative accommodation as contemplated in the Grootboom judgment.

Further basis for treating IPV as a violation of the right to adequate housing is provided by the UN Special Rapporteur on adequate housing's 2005 report. In this he observed that women living in situations of domestic violence inherently lived in inadequate housing – thus explicitly linking violence against women and the right to adequate housing.[279] He made this point again in his mission to South Africa at the invitation of the government in 2007. The lack of affordable housing and timely access to public housing, as well as inadequate government provisions for long-term safe housing, particularly in rural areas, he noted, forced women either to remain in, or to return to, situations of domestic violence. He also observed that there was no specific housing programme to address vulnerable groups.[280]

Existing legislation does create the scope to address abused women's housing needs. The Housing Act, 107 of 1997, requires all spheres of government to provide for the special needs of vulnerable groups in all housing policies and programmes. The Housing Act states that '[n]ational, provincial and local spheres of government must … promote the meeting of special housing needs, including, but not limited to, the needs of the disabled'.

[278] *Government of Republic of South Africa v Grootboom* 2000 (1) SA 46 (CC)
[279] UN doc E/CN.4/2005/43, paras 41 and 43.
[280] Special Rapporteur on Adequate Housing. (2008). 'Report of the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-discrimination in this Context,' Miloon Kothari: Addendum: Mission to South Africa, UN Doc A/HRC/7/16/Add.3.

Section 2(1) (a) of the Housing Act establishes the 'general principles applicable to housing development' and creates an obligation on the government 'to give priority to the needs of the poor in respect of housing development'; to 'promote the meeting of special housing needs, including but not limited to, the needs of the disabled'; and to promote 'the housing needs of marginalised women and other groups disadvantaged by unfair discrimination'. In 2015 a Special Housing Needs Policy and Programme was indeed finalised by the Department of Human Settlements. This has yet to be approved by Cabinet.

The Social Housing Act, 16 of 2008, provides a second avenue for addressing women's housing needs. According to the Act priority must be given to low- and medium-income households in social housing development. It obliges the government and social housing institutions to ensure that their 'respective housing programmes are responsive to local housing demands and that special priority must be given to the needs of women, children, child-headed households, persons with disabilities and the elderly.'

Section 27: Health care, food, water and social security

This section contains key elements of socio-economic rights and states that everyone has the right to have access to health care services, including reproductive health care, as well as access to social security, including, if they are unable to support themselves and their dependents, access to appropriate social assistance. No person may be refused emergency treatment and the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to social security and social assistance.

It is important to read this section with Chapter 11 of the National Development Plan (NDP), the four decisions handed down between 2010 and 2014 in *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC for Social Development, Free State and Others* ("NAWONGO"), and section 8 of PEPUDA (referred to earlier).

Chapter 11 of the NDP positions social protection as a critical part of public policy, understanding this to provide support that reduces vulnerability, alleviates and ultimately prevents poverty, and empowers individuals, families and communities through a range of social development services.[281] Social protection measures cover the entire life cycle of individuals from conception (by ensuring that pregnant mothers have adequate nutrition) up to old age. The NDP envisages the development of a social protection floor which will prescribes a standard of living below which no one should fall – this should include access to basic social welfare services. This minimum guaranteed level of entitlement to social benefits would provide a set of norms, standards and criteria for the basic level and types of social development services and specify who would benefit.

While the inclusion of social welfare services in social protection brings care and support within the ambit of section 27, the NAWONGO decisions result in the explicit recognition of such services as constituting socio-economic rights.

In 2010 Free State NGOs instituted legal action against the Free State DSD and successfully obtained a structural interdict compelling the department to revise its policy on financing welfare services.[282] The final August 2014 decision noted:

The Department has a statutory and constitutional obligation to achieve, within its available resources, the progressive realisation of the applicable socio-economic rights, which it must fulfil by striving to progressively increase the resources available for the provision of social welfare services.[283]

[281] Department of Social Development. (2016). *Comprehensive Report on the Review of the White Paper for Social Welfare, 1997.* Department of Social Development.
[282] *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC for Social Development, Free State and Others* (1719/2010) (5 August 2010)
[283] *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC for Social Development, Free State and Others* (1719/2010) [2013] ZAFSHC 49 (28 August 2014) at 8 (11.6.2).

This provision is important for the way it recognises social welfare services to constitute socio-economic rights, rather than luxuries. The judgement also set out the duty on the department to ensure the increasing availability of such services over time:

Availability of resources is therefore an important factor in determining what is reasonable, but lack of funds cannot be used as a lame excuse. Resources must be provided as far as reasonably possible. Reasonableness must also be understood in the context of the Bill of Rights as a whole. Whilst the very nature of progressive realisation of rights entails that full realisation will only be achieved in time, those whose needs are the most urgent should not be ignored in the policy, nor should a significant segment of society be excluded. Progressive realisation means that the rights in question must over time be made accessible to a larger number of people and a wider range of people. The department is obliged to take reasonable measures progressively to eliminate or reduce the deprivation of rights.[284]

Arguably, when PEPUDA's prohibition against limiting services to women is taken into account, it could also be argued that failure to make GBV services increasingly available amounts to discrimination.

Finally, one aspect of section 27 has been clearly legislated and that is the right to emergency treatment. Chapter 5 of the SOA provides for services to victims of sexual offences, specifically post-exposure prophylaxis (PEP) to prevent their infection with HIV and HIV testing of rape suspects. The relevant provisions stipulate that victims of sexual offences must receive, at state expense and within 72 hours of the offence, PEP for HIV infection, medical advice surrounding the administering of PEP, or be referred to a public health establishment which can provide these services.[285] Only designated health facilities may prescribe the drug regimen.

Section 28: Children

Children are entitled to all rights stipulated in the Bill of Rights (such as freedom and security of the person). Every child has the right to family care, or parental care, or an appropriate alternative; to basic nutrition, shelter, basic health care services and social services; amongst others. The latter set of rights are immediately realisable rather than subject to progressive realisation within available resources. In addition, all children are to be protected from maltreatment, neglect, abuse or degradation. A child's best interests are of paramount importance in every matter concerning the child.

The Children's Act gives effect to the rights of the child as stipulated in the Constitution, such as the protection from maltreatment, abuse and neglect. The Act provides for a continuum of care and emphasises the need to strengthen prevention and early intervention services for children and their families, as well as therapeutic services to reduce the long-term impact of abuse.[286] Measures aimed at healing children after violence are specified in Section 144(1)e of the Children's Act which states that the government must provide psychological, rehabilitation and therapeutic programmes for children (although described as an early intervention and prevention programme). Additionally, Section 146(1) stipulates that the provincial departments of social development must provide and fund therapeutic services for child victims and witnesses of violence.[287]

The Children's Act Regulations contain the National Norms and Standards for Child Protection[288] in therapeutic programmes (section 3) and after care services (section 4) which are relevant for care and support services. The National Norms and Standards for Prevention and Early Intervention Programmes also provide some guidance on care and support services.

According to section 110 (1) of the Children's Act (as amended by the 2007 Act) any teacher, medical practitioner, psychologist, dentist, registered nurse, physiotherapist, speech therapist, occupational therapist,

[284] *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC for Social Development, Free State and Others* (1719/2010) [2013] ZAFSHC 49 (28 August 2014) at 13.
[285] Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[286] Mathews S, Berry L & Marco J (2016) An Outcome Assessment of a Residential Care Programme for Sexually Abused Children in South Africa: A research report. Cape Town: Children's Institute, University of Cape Town.
[287] Proudlock P (ed) (2014) South Africa's Progress in Realising Children's Rights: A Law Review. Cape Town: Children's Institute, University of Cape Town & Save the Children South Africa
[288] Annexure B, Part III

traditional health practitioner, legal practitioner, social worker, social service professional, minister of religion, religious leader, member of staff at a partial care facility, shelter, drop-in centre or child and youth care centre, labour inspector or police official who on personal observation concludes that a child has been sexually abused, deliberately neglected or abused in a manner causing physical injury must report that conclusion to the provincial department of social development, a designated child protection organisation, police official or clerk of the children's court."

International and regional legal frameworks for adult and child survivors of violence

While domestic law and policy provisions are primary, they are buttressed in important ways by South Africa's regional and international obligations – as is evident from the previous section.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

South Africa ratified CEDAW without reservation in December 1995. While CEDAW does not address GBV as such, the Committee tasked with overseeing the implementation of CEDAW has issued *General Recommendation Number 19* which sets out how CEDAW should be interpreted to cover violence against women and explains the nature of government obligations to address such violence. As its point of departure, the Committee states that violence against women constitutes discrimination and thus falls within the purview of the Convention.

Among other measures, General Recommendation Number 19 requires States Parties to ensure that laws against sexual violence give adequate protection to all women and respect their integrity and dignity. It notes that legislative measures should be accompanied by appropriate protective and support services for victims, as well as gender-sensitive training for those providing these various services and responses.[289]

Copenhagen Declaration on Social Development and Programme of Action

The Declaration on Social Development was issued in 1995 at the conclusion of the Summit on Social Development in Copenhagen. This was the first such declaration ever issued by the United Nations and intended to promote peace and security, especially by challenging poverty, unemployment and social exclusion. Ten commitments were issued at the conclusion of the conference, with commitment six having particular bearing. This was to promote and attain the goals of universal and equitable access to quality education, the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability.[290]

One section of the Programme of Action is addressed to meeting the basic human needs of all. Recommended actions it recommends in this regard include:

- Ensuring full and equal access to social services, especially education, legal services and health-care services for women of all ages and children, recognising the rights, duties and responsibilities of parents and other persons legally responsible for children, consistent with the Convention on the Rights of the Child;
- Providing appropriate social services to enable vulnerable people and people living in poverty to improve their lives, to exercise their rights and to participate fully in all social, economic and political activities and to contribute to social and economic development.[291]

Beijing Declaration and Platform for Action

The *Beijing Declaration and Platform for Action* was issued at the conclusion of the 4th UN Conference on Women held in 1995 and builds upon the Copenhagen Declaration issued earlier in the year. In terms of this document, which South Africa has committed itself to, governments are called upon to take certain actions to address violence against women. Of particular relevance to this review are the following:

[289] Par 24(b).
[290] Copenhagen Declaration on Social Development - A/CONF.166/9
[291] United Nations (1995). *Report of the World Summit for Social Development, 6 – 12 March 1995*. A/CONF.166/9

- Creating or strengthening institutional mechanisms so that women can report acts of violence against them in a safe and confidential environment, free from the fear of penalties or retaliation;
- Creating, improving or developing and funding training programmes for judicial, legal, medical and police personnel to sensitise such personnel to the nature of gender-based acts of violence so that fair treatment of victims can be assured;[292] and
- Providing well-funded shelters and relief support for girls and women subjected to violence, as well as medical, psychological and other counselling services and free or low-cost legal aid, where it is needed, as well as appropriate assistance to enable them to find a means of subsistence.[293]

As a signatory to CEDAW, South Africa is required to report on the steps the country has taken to meet these obligations every five years. In its 2011 concluding observations the CEDAW committee noted with concern "that social support services, including shelters, are inadequate due to inappropriate budgetary allocations." Accordingly, it recommended that the necessary funds be made available in future to support the implementation of social support services.[294]

Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power[295]

The Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power was issued in 1985 by the United Nations Office on Drugs and Crime. It too makes provision for care and support services, stating that victims should receive the necessary material, medical, psychological and social assistance through governmental, voluntary, community-based and indigenous means. Victims should be informed of the availability of health and social services and other relevant assistance and be readily afforded access to them. Police, justice, health, social service and other personnel concerned should receive training to sensitize them to the needs of victims, and guidelines to ensure proper and prompt aid. In providing services and assistance to victims, attention should be given to those who have special needs.

South Africa's Victims' Charter draws a great deal from this Declaration.

Sustainable Development Goals

Goal 3 of the Sustainable Development Goals (SDG) aims to ensure healthy lives and promote well-being for all at all ages. Target 3.4 aims to reduce premature mortality from non-communicable diseases by one-third by 2030, including by promoting mental health and well-being.

Goal 5 aims to achieve gender equality and empower all women and girls. Many social welfare services, and in particular those relating to children, older persons and persons with disability, link to clause 5.4 of goal 5 on gender equality and women's empowerment. This goal calls for recognition and valuation of unpaid care through the provision of public services, infrastructure and social protection policies. The strong link with gender equality and women's empowerment exists because, where accessible public services are not available, it is women who bear the primary responsibility for doing this work unpaid in their homes.[296]

Goal 5.C refers to adopting and strengthening sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels. Care and response services are one element of such policy and legislation.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

In terms of this protocol, states must adopt and implement appropriate measures to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence. Article 4 of the Protocol focuses on violence against women and calls for a number

[292] All provisions taken from paragraph 124.
[293] Par 125(a).
[294] CEDAW Committee Concluding observations of the Committee on the Elimination of Discrimination against Women CEDAW/C/ZAF/CO/4 (2011) paras 25-26.
[295] United Nations. (1985). Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power General Assembly resolution 40/34 of 29 November 1985.
[296] Department of Social Development. (2016). *Comprehensive Report on the Review of the White Paper for Social Welfare, 1997.* Department of Social Development

of state measures to address both public and private violence, including identification of the causes of violence against women, the provision of accessible services for victims and the punishment of perpetrators.

South Africa has shown a commitment to uphold and support the rights of the child through the ratification of a range of international and regional human rights legal frameworks, including the United Nations Convention of the Rights of the Child in 1995 and the African Charter on the Rights of the Child in 2000.

International declarations and conventions often use the 'Three P's' classification system for the division of rights: provision, protection and participation. Provision rights speak to the provision for the welfare of the child (e.g. food, health care, education); protection rights refer to the right to be guarded from harmful acts; and participation rights refers to the right of the child to be heard (e.g. right to be consulted, access to information, freedom of speech).[297] For the purpose of this analysis, protection rights will be of primary focus. Below each instrument is expanded on and analysed within the specific context of child protection.

United Nations Convention of the Rights of the Child (UNCRC)

The UNCRC further provides a framework to which all government policies can be measured against[298] and to which they are accountable too. The UNCRC stipulates that the state must ensure the protection and care of the child (Article 3) against all forms of violence.

The Convention further states that children should be protected from sexual exploitation, sexual abuse, torture, or any other cruel, inhuman or degrading treatment (Article 34 and 37), and that the institutions, services and facilities which are responsible for the care and protection of the child shall confirm to established standards (Article 3). Additionally, Article 39 speaks to care and support services, stating that "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment of punishment; or armed conflicts. Such recovery and reintegration shall take places in an environment which fosters the health, self-respect and dignity of the child".

African Charter on the Rights and Welfare of the Child (ACRWC)

The ACRWC stipulates that children should be protected against child abuse and torture, as specified in Article 16. The Charter further states that State Parties shall protect children from all forms of sexual exploitation and abuse including: coercion or encouragement of a child to engage in sexual activity; prostitution; and child pornographic activities, performances and materials. Analysis of Article 16(1) shows similarities to Article 19 of the UNCRC and Article 27 of the Charter to similarities to Article 34 in the Convention.[299]

Essential Services Package for Women and Girls Subject to Violence[300]

The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (a partnership by UN Women, UNFPA, WHO, UNDP and UNODC) provides a comprehensive framework for a multi-sector response to violence. According to the framework, establishing essential services will require an integrated response by: a) health, b) justice and police, and c) social services. The 'package' of services can thus be used by countries as a tool to ensure high quality service, which are characterised by being both woman and child-centred. The services must, at a minimum, secure the rights, safety and well-being of any woman or girl who experiences gender-based violence. Services across these sectors should be available, accessible, acceptable and of quality.[301]

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[297] Hayes, N. and Bradley, S., 2009. *Right by Children: Children's Rights and Rights Based Approaches to Policy Making in Early Childhood Education and Care: the Case of Ireland.*

[298] Hayes, N. and Bradley, S., 2009. *Right by Children: Children's Rights and Rights Based Approaches to Policy Making in Early Childhood Education and Care: the Case of Ireland.*

[299] Gose, M. 2002. *The African Charter on the Rights and Welfare of the Child.* Children's Rights Project. Community Law Centre. UWC

[300] UN Women, UNFPA, WHO & UNDP, UNODC (2015). *Essential services package for women and girls subject to violence*. New York: UN Women.

[301] UN Women, UNFPA, WHO & UNDP, UNODC (2015). *Essential services package for women and girls subject to violence*. New York: UN Women