EVALUATION SYNTHESIS – VIOLENCE

Gauteng Planning Commission
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FINAL REPORT

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Contents

List of Acronyms

Child sexual abuse	CSA
Civilian Secretariat of Police	CSP
Cognitive behavioural therapy	CBT
Commission on the Status of Women	CSW
Declaration on the Elimination of Violence Against Women	DEVAW
Department of Social Development	DSD
Domestic Violence Act	DVA
Emergency contraception	EC
Fight with Insight	FWI
Greater Rape Intervention Project	GRIP
Herpes simplex type 2 virus	HSV-2
Intervention with Microfinance for AIDs and Gender Equity	IMAGE
Medical Research Council	MRC
Men as Safety Promoters	MASP
National Crime Prevention Strategy	NCPS
Out-patients' department	OPD
Planned Parenthood Association of South Africa	PPASA
Post-exposure prophylaxis	PEP
Post-traumatic stress disorder	PTSD
Protection order	PO
Randomised control trial	RCT
Rape Crisis Cape Town Trust	RCCT
Reconstruction and Development Programme	RDP
Rural AIDS and Development Action Research Programme	RADAR
Saartjie Baartman Centre for Women and Children	SBCWC
South African Stress and Health	SASH
Sexual Assault Evidence Collection Kits	SAECK
Sexual Offences and Related Matters Amendment Act	SOA
Sexual Violence Research Initiative	SVRI
Sexually transmitted infection	STI
Sisters for Life	SFL
Small Enterprise Foundation	SEF
Support Programme for Abuse Reactive Children	SPARC
Thuthuzela Care Centres	TCC
Violence against women	VAW
Voluntary counselling and testing	VCT
World Health Organisation	WHO

Chapter 1: Introduction to the Evaluation Synthesis

Violence against women has been an entrenched feature of the South African social landscape for a number of decades. While the problem was largely ignored by the apartheid government (Segal and Labe, 1990; Kaganas and Murray, 1991; Vogelman and Eagle, 1991), its extent and seriousness were recognised early within the democratic era. Gender equality, along with the right to be free from all forms of violence, was entrenched within the interim Constitution of 1993, as well as the final Constitution of 1996 and the Reconstruction and Development Programme (RDP) noted that "special attention" needed to be paid to violence against women and children (Ministry in the Office of the President 1994: 8). Government further committed itself to addressing such violence through its participation in the 1995 Beijing Platform of Action and also prioritised violence against women and children through the National Crime Prevention Strategy (NCPS) of 1996. In the same year government also invited the UN Special Rapporteur on Violence Against Women to investigate the high levels of sexual violence in the country (Coomaraswamy, 1997).

These policies and interventions built on the efforts of a range of women's organisations which had led to the establishment in 1977 of the first rape crisis centre in Cape Town (Rape Crisis Cape Town Trust) (Russell, 1989) and, in 1984, the first shelter exclusively designed to assist abused women, set up in Johannesburg by People Opposing Women Abuse (Park, Peters and De Sa, 2000). These and other organisations had been at the forefront of counselling and other interventions addressing both rape and domestic violence and post-94 entered into a range of partnership with government departments to combat violence against women. Yet rape and domestic violence have persisted and there is little evidence suggesting that the numbers have declined significantly over the years despite these significant state and civil society efforts.

This report has been commissioned by the Gauteng Planning Commission to strengthen the impact of existing programmes and policies and ultimately reduce occurrences of violence against women (VAW) and child sexual abuse (CSA) in Gauteng. The aim of this evaluation synthesis is three-fold: to catalogue and critically assess research undertaken to date in this field; to extract key learnings around effective programming in this area; and identify gaps for future research, including interventions that require evaluation. The report thus also provides a critical assessment of the state of programme evaluation and identifies areas of future intervention for the Planning Commission in Gauteng.

The remainder of this chapter sets out the methodology employed in compiling this synthesis, with the next set of chapters structured as follows: Chapter 2 details the scope, magnitude and consequences of VAW and CSA and also provides an overview of research investigating the drivers of violence. Chapter 3 introduces the first set of findings of the evaluations and focuses largely on civil society responses while Chapter 4 details the range of responses by government to VAW and CSA, as well as evaluations of their implementation and impact. The concluding chapter of the study then provides a synthesis of the recommendations culled from the various pieces of research and identifies those programmes, policies and laws requiring evaluation.

Conceptualisation of violence against women and child sexual abuse

Violence against women is an umbrella term for a range of different acts committed within a variety of relationships and a diversity of settings. Article 1 of the 1993 Declaration on the Elimination of Violence Against Women (DEVAW) defines it as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (United Nations, 1993).

This conceptualisation recognises how gender influences the experience of violence, its perpetration and its extent. It is also a conceptualisation of violence that highlights how women and girls’ vulnerability to particular forms of violence is not innate but arises in social contexts where power relations between men and women are unequal. In such societies, social norms encourage an attitude of sexual entitlement in some men, or the belief that they enjoy irrecusable claims of access to women’s and girls’ bodies. These beliefs are further reinforced when societies either refuse to sanction violence, or do so in a weak, ineffectual manner that merely encourages a sense of impunity.

Violence against women may also operate to maintain the boundaries between male and female gender categories. Rape can therefore function as a sexualised act of humiliation and punishment of women who fail to conform to feminine gender stereotypes (by drinking and going out, or wearing particular types of clothing, for example). These arguments about the relevance of gender to sexual violence are no less pertinent to understanding men’s sexual victimisation. In popular thinking, as well as early writing on the subject, the sexual assault of men was treated as a subset of homosexual behaviour. But as the growing body of research and writing in this field argues, male sexual assault can also be viewed as an expression of patriarchal power relations. Like female sexual assault, it too is closely connected to traditional sex-role socialisation and the gendered power relations that exist between men, particularly in settings as masculinised as prisons and the military. Indeed, adult male rape victims who are unsuccessful in defending themselves from the attack may be perceived as “failed men” and feminised accordingly (Gear, 2007). Children are additionally subject to the authority of adults and it is this lesser social status that contributes to making boys vulnerable to sexual violence.

While it is important to recognise the sexual victimisation of men and boys, women and girls nonetheless constitute the bulk of victims of sexual violence. Domestic violence in South Africa is also largely perpetrated by men against women (Kaminer et al, 2008) and while we have no equivalent South African data, international research indicates women are six times more likely than men to be killed by an intimate partner (Stockl, et al 2013). It is this singling-out for violence at men’s hands that has led to the recognition that VAW constitutes a form of gender discrimination. It is now established both in South African case law and statute that VAW must be treated as a form of gender inequality. This understanding is also reflected in African human rights instruments and United Nations’ Conventions. DEVAW, for example, frames violence against women as a manifestation of the historically unequal power relations between men and women which have allowed men to dominate over and discriminate against women. Violence has been highlighted as a social mechanism crucial to forcing women into positions subordinate to men and its continuing and endemic nature noted as limiting women's opportunities to achieve legal, social, political and economic equality.

Definition of terms

Violence against women and children can take a range of forms which depend on both social and historical context. This report will take as its focus domestic violence perpetrated by women's intimate partners, as well as sexual violence perpetrated by non-partners. Given the wide range of maltreatment children are exposed to (a subject in of itself), the report will confine itself to CSA. It is outside the scope of this report to explore trafficking, child maltreatment generally, as well as witchcraft accusations and violence and cultural practices such as *ukuthwala.*

Sexual victimisation takes different forms and exists on a continuum ranging from unwanted sexual comments, to rape. Indeed, between the remnants of the 1957 Sexual Offences Act and the 2007 Sexual Offences and Related Matters Amendment Act (SOA), some 59 different sexual offences can be identified, including:

- rape and compelled rape;
- sexual assault, compelled sexual assault and compelled self-sexual assault;
- incest, bestiality and sexual acts with a corpse;
- sexual exploitation and grooming of children, as well as persons who are mentally disabled;
- compelling or causing children to witness sexual offences, sexual acts or self-masturbation;
- exposure or display of pornography, or child pornography, to persons who are mentally disabled and using people with mental disabilities for pornographic purposes, or benefiting therefrom; and
- exposure or display of pornography, or child pornography, to children and using children for pornographic purposes, or benefiting from child pornography

This report focuses chiefly on rape, largely because it results in the most serious consequences (Kaminer et al, 2008) and because little data is available for the many other offences – in of itself a gap requiring further research.

As with South Africa's sexual offences legislation, the 1998 Domestic Violence Act (DVA) is similarly broad in its approach to domestic violence and includes physical, sexual, economic, emotional, verbal and psychological abuse; intimidation, harassment, stalking, damage to property, and entering the victim's home without permission within its ambit. Economic abuse, as defined by section 1(ix) of the Act, comprises unreasonably depriving complainants of economic and financial resources to which she is entitled by law or necessity, or unreasonably disposing of household effects or other property. Emotional, verbal and psychological abuse are described by the Act as a pattern of degrading or humiliating conduct towards a complainant including repeated insults, ridicule, or name calling; repeated threats to cause emotional pain; or the repeated exhibition of possessiveness or jealousy which is such to constitute a serious invasion of the complainant's privacy, liberty, integrity or security. There is no crime however, termed 'domestic violence.' Such acts are captured instead within charges of assault, pointing a firearm, intimidation or attempted murder (among other things).

As these laws illustrate, it is possible to define sexual offences and domestic violence in ways that are both narrow and broad, with obvious consequences for how the scope of the

problem is determined. This is well illustrated by the various surveys summarised in Chapter 2.

Methodology

A range of key research questions have been identified for this particular synthesis including:

- What is known about the scale and manifestation of violence against women and child sexual abuse in South Africa?
- What is known about the costs and consequences of such violence?
- What is known about the primary and intermediate causes of VAW?
- What is known about the social drivers of VAW, as well as those factors which either predispose individuals to violence, or are protective of violence?
- What forms does the government response to VAW take?
- What forms does the civil society response take?
- What evaluations have been undertaken of all these various types of intervention?
- What key learnings and promising practices have been identified by the various evaluations?
- To what extent have these recommendations been implemented?
- What research and evaluation gaps have been identified?

Search strategy

To explore these questions the researcher reviewed both quantitative, population-based studies and smaller-scale qualitative studies produced between 2000 and 2013. To eliminate publication bias, both published and unpublished reports were included. Articles and reports were sourced from journals, as well as reports falling within the grey literature produced by diverse organisations and institutions.

A web-based literature search using the search engines PubMed and PsycINFO was undertaken to identify relevant journal articles. Key words included VAW South Africa, GBV South Africa, rape South Africa, sexual violence South Africa, domestic violence South Africa, intimate partner violence South Africa, child sexual abuse South Africa and prevention South Africa. The reference lists of articles identified in this way were then hand-searched for additional articles of relevance. In addition the following databases were searched chiefly for overviews and syntheses of international research: the Sexual Violence Research Initiative (SVRI); SafetyLit; and the databases of the Cochrane and Campbell Collaborations. Given the enormous body of literature available internationally on VAW and CSA, the international overview largely concentrated on systematic reviews undertaken to examine the effectiveness of health and social interventions into the problem.

To ensure that unpublished reports were not excluded, the researcher wrote to organisations working to address rape and domestic violence asking for copies of any evaluations of their programmes and projects. A similar request was also sent to donors with a particular interest in funding VAW work such as the Joint Gender Fund, USAID and Irish Aid. A third letter was distributed to provincial and national departments requesting copies of any evaluations they may have commissioned. Most organisations and government departments responded positively to this call. However, repeated attempts to obtain evaluations of the Thuthuzela Care Centres (TCC) proved unsuccessful so this report comments only minimally on their functioning, even though they represent one of government's flagship interventions into VAW and CSA.

Criteria of inclusion and exclusion

Interventions whose primary goal was to address one or other aspect of VAW or CSA were emphasised by this study. While it is possible that generalised interventions addressing violence broadly may have an impact on VAW, these studies were not included in the synthesis.

For purposes of convenience and manageability (given the wealth of data in this field) systematic reviews, which generally include only random and quasi-random control trials, were prioritised in the search for international studies. Six studies were identified in this way. This approach was not applied to South African evaluations on a range of grounds. First, it excluded far too many studies from consideration, only a handful of randomised control trials (RCT) having been conducted in South Africa. Further, while RCTs are useful in sorting the effective from the ineffective, they simultaneously tell us little about why interventions succeed or fail, how change is accomplished, as well as the conditions required for interventions to work. Additionally, participant samples, as well as treatment success, are often narrowly defined within these studies, raising questions around their applicability to a broader range of people with a more complex set of difficulties. In the case of counselling and other therapeutic interventions, is also open to debate whether or not evidence-based or empirically-supported treatments are preferable to indigenous practices which have not been studied and which may even prove effective if studied (Campbell 2008: 710).

Secondly, this synthesis represents a meta-summary of South African research in VAW and CSA. While many good, local studies have focused on particular aspects of VAW and CSA, no prior attempt appears to have been made to synthesise these studies as a whole. Given the multi-dimensional nature of VAW and CSA, such reflection would be important for the development of multi-disciplinary approaches, as well as to discern patterns and identify gaps. This synthesis may thus be described as exploratory in that it seeks to plot an initial overview of the local evaluation terrain. On this basis the net was cast broadly to include qualitative and mixed methods studies and a range of different sorts of evaluations, except where their focus was chiefly on perceptions of the internal functioning of organisations, or where they measured outputs rather than outcomes. Studies which included an evaluative component, even if this was not the chief focus of the paper, were also considered in this attempt to provide an initial overview of programme evaluation. Finally, because a number of programmes have generated multiple papers, only programmes were counted and not articles. A further 46 programme evaluations were identified in this way, bringing the total to 52 evaluations.

Assessment of the robustness of individual evaluations, those taking the form of surveys specifically, was based on choice of sampling method and selection of participants, these two features of study design affecting the extent to which findings can be treated as valid, reliable and generalizable. Questionnaire design was also assessed where a copy of the data schedule had been included in the report. Because it is well-accepted by now that interviewing women about violence is complex and not well-addressed through generalised surveys, the writer also examined the extent to which researchers drew on validated tools such as the World Health Organisation's (WHO) questionnaire dealing with VAW.

Analysis of all these various documents was guided by the following:

- *Evaluation design:* nature of research design, selection of participants, demographic features of the sample;
- *Type of intervention*, including nature, aim and length;
- *Type of outcome measures*
- *Recommendations*

Chapter 2: The scope and magnitude of violence against women and child sexual abuse in South Africa

The use of violence as a tool to manage social relations is well-entrenched in South Africa. This history begins with the colonisation of the country in 1652 and the numerous conflicts and social disruption this provoked, processes of dispossession given further impetus by the rapid industrialisation that followed the discovery of South Africa's mineral wealth in the 19th century. With the introduction of apartheid in 1948 formal racism was entrenched and policies of social exclusion and subordination actively and violently enforced. While the advent of democracy contributed to significant decreases in political violence and state-sponsored oppression, levels of inter-personal violence remain astoundingly high, with South Africa's homicide rates amongst some of the highest in the world (the decline over the last few years notwithstanding) (Norman et al, 2007; Seedat et al, 2009). Deaths as a result of road traffic are about double the global rate and suicide rates double that for the African continent (Norman et al, 2007).

The concentration of wealth in the hands of a small racial elite also consigned that portion of the population designated 'non-white' to abject poverty and residence in degraded, under-serviced and inadequate living environments. Through the Group Areas Act black[1] women and men were either located on the periphery of cities or, in the case of many black Africans, relocated to 'homelands.' This spatial dislocation and fragmentation was further enforced through buffer zones, usually vacant lots of land, which also served to maintain the separation of communities and resulted in unsafe environments offering many opportunities for crime and violence. An enduring consequence of this history is a Gini coefficient for South Africa that is the most unequal in the world (Seedat et al, 2009). Although national income inequality is only inconsistently associated with the murder rate (but strongly correlated with population health, particularly life expectancy and infant mortality) (Babones, 2008), such a finding prompts speculation around the extent which South Africa's high levels of income inequality may be playing a role in its rates of violence.

While the contribution of income inequality to violence may still be contested, researchers have argued that status inequality – and gender inequality specifically – plays a very significant part in both VAW and CSA (Jewkes et al, 2002; Kalichman et al, 2005). This chapter now turns to describing the extent of VAW and CSA in South Africa. Specifically it seeks to map responses to the first set of questions for this synthesis:

- What is known about the scale and manifestation of violence against women and child sexual abuse in South Africa?
- What is known about the costs and consequences of such violence?
- What is known about the primary and intermediate causes of VAW?
- What is known about the social drivers of VAW, as well as those factors which either predispose individuals to violence, or are protective of violence?

[1] Unless distinguished as black African, 'black' in the report includes all those people who by virtue of their skin colour were systematically dispossessed and disenfranchised (although to varying degrees) by the former National Party government. This includes those groups classified as 'black', 'coloured' and 'Indian'.

The scale and manifestation of sexual offences in South Africa

Around the world women and girls are disproportionately the targets of sexual violence, as well as intra-familial abuse. South Africa is no exception, as both administrative and survey data shows.

All forms of sexual offences are not defined as crimes in South African, with some acts falling within the ambit of behaviour treated as misconduct. These acts typically fall under the rubric of labour law and regulations, as well as institutions' disciplinary codes. Given this range, it is difficult to obtain a picture of the full scope and extent of all forms of sexual victimisation in the country. There is also very little nationally-representative data available and in some instances, no information at all regarding the experiences of particular categories of victims. Nonetheless, what does exist is set out below.

At its most lethal, rape culminates in homicide. A national, retrospective study undertaken at a sample of 25 medico-legal laboratories sought to estimate the prevalence of rape homicide in South Africa in 1999, suspecting such homicides in 16.3% of the female homicides. This gave a rape homicide rate of 3.65/100 000 women over the age of 13, a prevalence rate higher than that of all female homicides in the USA (Abrahams et al, 2008). Rape homicides have also showed no statistically significant indications of decline. In 2009 the rate was calculated as 2.5/100 000 (Abrahams et al, 2013).

Administrative data in the form of national police figures for rape post-1994 have shown an initial upward trend that has now plateaued. Between the period April 1994 to March 1995, 44 751 rapes were reported to the police. By 2010/11 the figures had risen to 56 272. By contrast, SAPS data for Gauteng specifically showed that the rate of reported sexual offences declined by 43.3% in Gauteng between 2008/09 and 2012/13 (South African Police Service 2013: 18). However, it is not clear whether the police data are measuring a reduction in the number of rapes reported to them, or an actual reduction in the incidence of rape. Interviews conducted in Gauteng in 2010 by Gender Links and the Medical Research Council (MRC) found that one quarter of women in the study had been raped in the course of their lifetimes while almost one in 12 women had been raped in 2009. But one in 13 women raped by a non-partner reported the matter, while only one in 25 of women raped by their partners reported this to the police (Machisa et al., 2010). This particular study also presents the intriguing situation where more men admit to raping, than women admit to being raped: 31.0% of men in Gauteng disclosed having raped a woman who was not their partner (*ibid*).

The Gender Links and MRC study points to how extensively under-reported rape may be in Gauteng. Other research estimates different rates of under-reporting, with an earlier national study finding that only one in nine women who had been raped and also had physical force used against them subsequently reporting the attack to the police (Jewkes and Abrahams, 2002). By contrast, the Victims of Crime Survey covering the period January to December 2011 found 94.1% of rapes reported to the researchers to have also been reported to the police (Statistics South Africa 2012: 39). However, Statistics South Africa notes that the survey under-represents the extent of rape, given the sensitive nature of the topic. The caution they imply in relation to their figures is warranted by the fact that the survey captured fewer rapes than the number reported to the police during the same time period (32 000 vs 56 272) (*ibid*).

These findings around under-reporting suggest that a distinction needs to be drawn between the *disclosure* and the *reporting* of a sexual offence. Disclosure refers to those cases in which someone other than a police officer is told of the sexual offence and reporting to the formal lodging of a complaint with an authority. Both disclosure and reporting may be delayed, meaning that others may only come to know of the incident weeks, months or even years later. Further, in the case of pre-adolescent children in particular, no disclosure may take place at all, with a sexual offence being suspected either from changes in the child's behaviour or because symptoms are reported that correspond with sexual victimisation. In a study of 2 068 rape cases reported to the police in Gauteng in 2003, one in three reports for girls aged 11 years and younger were made under such circumstances (Vetten et al, 2008).

Factors affecting the likelihood of reporting

While some police officers have been known to refuse to accept complaints from victims (Francis, 2000; Vetten et al, 2010), other factors also contribute to the non-reporting of sexual offences. Age is a particularly important variable in this regard and children, given their dependence on adults (who may also be the same adults abusing them), experience very particular barriers to reporting. Surveys conducted both locally and internationally have identified other barriers to reporting, collated in Table 1 below.

Table 1: Factors affecting the reporting of sexual offences

Reasons for not reporting a sexual offence[2]	**Reasons for reporting a sexual offence[3]**
• fear of not being believed or being accused of lying • feelings of shame, guilt, humiliation and embarrassment • feelings of pity and love towards the person abusing • problems of physical access to police or social workers • fear of retaliation or intimidation by the abuser, especially when combined with a lack of confidence that the legal process will result in a conviction • fear of legal processes, including experiencing rudeness and poor treatment by the police • fear of having to relive the trauma in court and during the investigation • fear of upsetting the stability of the family • fear of the power and authority of the abuser • fear of loss of economic support by the abuser • preference for cultural means of resolving disputes (such as the payment of damages by the abuser)	• the belief that sexual assault is a serious offence that should be reported; • to ensure personal safety and future protection from the offender; • to prevent the offence from being repeated, or the offender harming others; • to make the offender take responsibility for his/her actions; • to ensure the offender is brought to justice and punished; • to obtain help; • to regain a sense of control; and • to gain compensation.

[2] This column represents a compilation of findings from research by Jewkes et al, 2005; Lievore, 2003, Tjaden and Thoennes, 2006, Kelly, Lovett and Regan, 2005; and Jewkes and Abrahams, 2002.
[3] Compiled from Lievore, 2003; Kelly, Lovett and Regan, 2005.

• fear of ostracism or ridicule by peers • Wanting to avoid the stigma attached to being raped (being labelled as 'damaged')	

Child sexual abuse

No national study has successfully measured violence against children in South Africa, and very few violence studies include CSA. The use of different definitions of CSA utilised by researchers also produces different estimates of the problem in South Africa. These self-reported measures of sexual victimization, or forced first sex, are summarised in Table 2 below and indicate levels of child abuse ranging from 7.3% to 39.1% for girls, which are higher than those for boys.

Table 2: Levels of sexual victimisation in childhood and forced first sex in South Africa

Author/year	Sample	Location / size	Study design	Sexual victimization by a man %
Jewkes, Dunkle, Nduna, Shai, Puren (2010)	Adult men and women aged 18+	Eastern Cape (rural) 1,367 male and 1,415 female; 2003-4 data	Baseline survey for a cluster randomized controlled trial of behavioural intervention	39.1% women and 16.7% men had experienced contact sexual abuse; 18.8% of women and 1.4% of men had been tricked or forced the first time they had sex when aged under 18 years
Jewkes, Vundule, Maforah & Jordan (2001)	Pregnant and non-pregnant young women aged <19 years	Western Cape: 191 cases 353 controls; 1995-6 data	Case (pregnant) control (non-pregnant) study	31.9% pregnant women and 18.1% non-pregnant women had experienced forced first sex
Dunkle, Jewkes, Brown, Gray, McIntyre, Harlow (2004)	Women aged 18+	Gauteng (n=1366); 2001-2 data	Antenatal clinic cross-sectional survey	7.3% had experienced forced first sex; 8% had been raped as a child (before age 15)
Machisa et al 2011	Women aged 18+	Gauteng (n=488); 2010 data	Population-based survey	8.5% had experience forced first sex;24.4% had experienced unwanted sexual touching

While baby and toddler rape attract considerable public concern, little is known about the phenomenon. However, an analysis of a random sample of 2 068 rapes reported to the SAPS in Gauteng in 2003 included four victims (0.2%) aged a year or less, another 19 who were two years old (0.9%) and 35 victims three years of age (1.7%). In total, victims aged three years and younger accounted for 2.8% of all victims in the study where an age could be determined (Vetten et al, 2008).

Sexual assault is also a feature of girls' homicides. A national, retrospective mortuary-based study of child homicides recorded between 1 January to 31 December 2009 estimated that 1018 such homicides had occurred that year, with one quarter of girls' homicides (as opposed to 1.5% of boys) related to sexual assault (Mathews et al, 2013a).

Rape and marginalised groups of women

Additional barriers to reporting exist for those who belong to 'invisible' or socially marginalised groupings. There is also a paucity of data on these groups of women and girls' experiences. 'Corrective rape' for example, while attracting a good deal of public attention has attracted little research attention and only one study could be found in this regard. A convenience sample of 591 women, largely recruited by community-based organisations in Botswana, Namibia, South Africa and Zimbabwe, found 31.1% to have had an experience of forced sex – 14.9% by men only, 6.6% by women only and 9.6% by both men and women (Sandfort et al, 2013).

Analysis of 2 068 rape cases reported to the police in Gauteng showed 41 (or 1.9%) of victims in the study to have some form of disability (Vetten et al, 2008). These figures fall below the prevalence of disability in Gauteng, calculated as affecting 3.8% of the female population in the province in the 2001 Census (Statistics South Africa, 2005). It is impossible to know whether these figures reflect under-recording of disability on the J88s and dockets; under-reporting of rape of disabled victims; or a lower vulnerability to rape amongst disabled people. The last explanation seems unlikely. Research internationally has found the incidence of sexual victimisation experienced by women with disabilities to be either similar to, or greater than that reported by non-disabled women (Groce, 1999; Saxton et al., 2001). Factors which may inhibit or prevent women with disabilities from reporting sexual abuse include high levels of dependency on caregivers, who are often the perpetrators of the violence; social isolation and discrimination against women with disabilities; and a lack of information and inadequate support services.

Violence and abuse has also been recorded in South African women's prisons. Findings from a three prison survey in Gauteng, South Africa, showed that during the last 12 months of imprisonment one in three (34%) women had experienced physical violence, 47% some form of psychological abuse, and 3% sexual abuse, primarily at the hands of another prisoner (Haffejee, Vetten and Greyling, 2006).

Finally, where victims are in conflict with the law, any perceived benefits to reporting may well be outweighed by the risk of bringing themselves to the attention of the law. This barrier may apply to undocumented migrants (who potentially run the risk of deportation) and women engaged in illegal activities (such as sex work). Small, non-random surveys of sex

workers would suggest considerable violence is perpetrated against this group by clients and police officers (Watt et al, 2012; Wojcicki, 2002a; Wojcicki, 2002b; Wechsberg et al, 2005).

Characteristics of sexual offences in South Africa

The risk of being sexually victimised alters significantly over the course of an individual's life span. The Gauteng study found 60.2% of reported cases to involve adult victims. Teenage girls (defined as girls between the ages of 12 – 17) comprised one in four victims (25.2%) and girls aged between 0 - 11 years one in seven (14.6%) victims. The rape of very young children was also identified in this study, with victims aged three years and younger accounting for 2.8% of all victims where an age could be determined. The average age of a victim who reported rape in this study was 20 years (Vetten et al, 2008). Findings from the Gender Links and MRC study in Gauteng (which included women who had not reported) present a slightly different profile. Most women in this study experienced rape for the first time as a child, with 64.7% of women aged 17 and younger at the time. Just under one in five (19.6%) were aged between 18-24 while 15.7% were 24 years and older (Machisa et al, 2010).

Age also affected other characteristics of reported rape in Gauteng. While 61.8% of rapes took place in a home (usually that of the perpetrator), girls younger than 11 were more likely to be raped in their own homes (28.5%) than either adolescent girls (17.1%) or adult women (19.6%). Half (49.5%) of the rapes perpetrated against adults involved an abduction where the perpetrator encountered the woman in one place and then forcibly took her elsewhere. Adult women were the group most likely to be attacked outdoors with more than one in four rapes occurring in an open space (24.9%) and a further 7.8% occurring in an alleyway or by a road. More than one in ten of the adult women was raped during a house-breaking (Vetten et al, 2008).

The relationship between perpetrator and victim also reflected differences along age lines. While strangers, or those known only by sight, accounted for just under one in seven rapes (14.6%) reported by girls, almost half of adult women (48.1%) reported being raped by this group. By contrast, half of the young girls (52.1%) were raped by those who fell into the friend/acquaintance/neighbour category. This was double the percentage of adult women (24.8%) attacked by this group. Relatives were also very much more likely to rape girls of all ages than they were to rape adult women (31.8% of young girls and 14.0% of adolescents versus 3.4% of adults). Almost one in five adult women (18.8%) was raped by their current or former intimate partner (*ibid*).

The Gauteng study also provides some information about those suspects arrested for rape. Suspects ranged in age from 6 years to 76 years, with 27 being the average age. In this study, one in eight suspects (13.1%) was a child offender aged 17 years and younger. More than four out of five (81.2%) child offenders fell between the ages of 12 – 17. Pre-teenage child perpetrators all acted against young pre-teenage girls. The majority of suspects for whom information was available were first-time offenders. However, almost one in five (17.8%) of those arrested had previously been found guilty of other crimes, with one-third of these previous convictions (6% in total) being for rape (*ibid*).

The effects of sexual offences

Recognition of the highly adverse effect of sexual offences upon women and girls' health and well-being is still emerging in South Africa.

Mental health consequences

While all victims of crime experience some form and degree of distress as a consequence of their experiences, this distress is particularly marked amongst survivors of sexual offences. Drawing on nationally-representative data, the South African Stress and Health (SASH) study found rape to have the strongest association with post-traumatic stress disorder (PTSD) among women, affecting 6% of those who identified as having been raped (Kaminer et al, 2008). This percentage is lower than that found in the Gender Links and MRC study where 28.1% of women raped by non-partners were reported to have suffered from PTSD and 15.4% of women either sexually or physically abused by their partners to suffer from PTSD (Machisa et al, 2010). The latter study does not report on the measures used to assess PTSD.

The likelihood of developing PTSD appears to be heightened when rape victims perceive their lives to be at risk during the assault, when the rape results in injury and when peri-traumatic anxiety is present (Ullman and Siegel, 1994; Kilpatrick and Acierno, 2003).

Repeated sexual abuse may have a more complex psychological impact upon victims, especially when it occurs within a close relationship in which there is a reasonable expectation of protection. Studies attempting to explore whether the impact of rape perpetrated by strangers differs to that perpetrated by known offenders have found little difference in the levels of psychological distress experienced by victims of either type of rapist (Koss et al, 1998; Ullman and Siegel, 1993). Women raped by their intimate male partners demonstrate similar levels and types of psychological distress to those women raped by acquaintances or strangers (Bennice and Resnick, 2003). The WHO Multi-country Study on Women's Health and Domestic Violence Against Women conducted in ten countries[4] in 2005 found that all women who had ever been subjected to physical or sexual violence at the hands of their partners reported significantly higher levels of emotional distress than their non-abused counterparts. They were also more likely both to have thought about, as well as attempted, suicide (WHO 2005: 16).

However, it is not only women who have been sexually assaulted by their intimate partners who are at greater risk of engaging in self-harming behaviours; other studies have found that women who experienced sexual assault, whether as children or adults, were also more likely to attempt or commit suicide (WHO 2002:163). In Gauteng a quarter of women (25%) raped by non-partners reported attempting suicide while 19.1% of women either sexually or physically abused by their partners had attempted suicide (Machisa et al, 2010).

[4] These included the countries of Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand and the United Republic of Tanzania.

National data detailing the psychological impact of CSA would not appear to exist in South Africa. However, a small qualitative study of 30 children aged between 8 to 17 and their care-givers, recruited from two dedicated sexual violence services based in Cape Town, provides some insight into these effects (Mathews, Abrahams and Jewkes, 2013b). At the first interview (conducted four weeks post-rape) 67.7 % of children had symptoms indicative of full PTSD, while 29.3% exhibited partial symptoms. Anxiety of a clinically significant degree was identified in 45.2% of children, while high scores of depression were evident in 35.5% of children. A third interview conducted between 16 and 20 weeks post-rape showed depressive symptoms to have declined to 13.3%, anxiety to 23.3% and full-symptom PTSD to 43.3%, while partial symptom PTSD affected 30.0% of children (*ibid*). The study did not attempt to measure caregivers' distress, but this appeared to be considerable. Concerningly, by the third interview, it seemed that a number of caregivers' relationships with their children had become troubled and difficult – to the extent that initial support was withdrawn from the child (*ibid*).

An experience of childhood sexual coercion has other long-term consequences. A population-based study undertaken at a clinic in Soweto and consisting in interviews with 1 395 women, found CSA to be associated with an increased risk of being subjected to physical and/or sexual violence at the hands of an intimate partner. Forced first intercourse was also associated with increased risk of physical and/or sexual partner violence (Dunkle et al, 2004). Teenage pregnancy is also associated with sexual violence. Research conducted in the Western Cape into the causes of teenage pregnancy found sexual abuse to be the third most-common reason girls fell pregnant. Girls in the study whose first sexual experience was forced were 14 times more likely to be pregnant than their peers (Jewkes et al, 2001).

Consequences for women's physical health

Reported rapes in a Gauteng study found a number of these cases to have resulted in physical injury and, in general, to have entailed more violence to the genital region than rape in other countries. More than one in four cases (28.0%) (rising to 39.1% of adult women's reports) resulted in a non-genital injury while genital injuries were documented in more than half of cases (57.5%), rising to 66.2% of adolescent girls (Vetten et al, 2008). The Gender Links and MRC study provides further insight into the effects of rape on women's reproductive health, with 5.3% of women raped by a non-partner reporting they had tested HIV-positive and 35% saying they had been diagnosed with a sexually transmitted infection (STI) (Machisa et al, 2010).

Sexual violence also affects women's physical health and may lead to an increase in health problems in the acute, short and long-term stages. These may include urinary tract infections, genital irritation, vaginal bleeding and infection, fibroids, chronic pelvic pain and pain during intercourse. Drug and alcohol abuse is also associated with experiences of sexual violence (WHO, 2002).

Overall, women with histories of sexual assault are more likely to perceive their health as poor, suffer increased rate of chronic diseases as well as be more likely to use health care services than non-victims (Golding, 1994; Golding et al 1988; Ullman and Brecklin, 2003). The WHO Multi-country Study found that women who had ever been physically or sexually

abused by their intimate partners were significantly more likely to describe their health as poor or very poor in comparison to women who had never experienced partner violence (WHO 2005: 15). More induced abortions were also reported in the majority of settings by women who had ever experienced physical or sexual violence by their partners. They were also more likely to report having had a miscarriage (ibid: 16 – 17).

Sexual violence and its association with other social problems

The factors leading women and girls into conflict with the law have not been well-explored. A study conducted amongst women and girls incarcerated in the three women's prisons in Gauteng found fifteen percent of the sample had been raped before they were 15, meaning that they were seven times more likely to have been raped as children than the female population generally.[5] One in ten women had been raped by a non-partner after the age of 15. Such violence may well play a role in women's conflicts with the law, this same study having found a statistically significant relationship between the experience of sexual abuse at the hands of women's last partner before imprisonment and the commission of murder or attempted murder (Haffejee, Vetten and Greyling, 2006).

The chapter now sets out equivalent data for domestic violence.

Prevalence and reporting of domestic violence

In 1998, one in four (25%) women in the provinces of Limpopo, Mpumalanga and the Eastern Cape reported being physically assaulted by a male partner over the course of their lifetimes, while one in ten (10%) had experienced such violence in the past year (Jewkes, Levin, Penn-Kekana, 2001). These exceptional figures have not declined significantly with time. Indeed, their ubiquity was only confirmed by the national SASH survey where domestic violence emerged as the most common form of violence experienced by women – and one reported by 13.8% of women as opposed to 1.3% of men (Kaminer et al, 2008). Most recently, in 2010, just fewer than one in five (18.13%) women in Gauteng reported an incident of violence by an intimate partner (Machisa et al, 2010). An average of 42.3% of a sample of 1 378 men working in Cape Town municipalities reported perpetrating physical violence against a partner in the last 10 years, while 8.8% admitted to committing such violence in the last year (Abrahams et al, 2006a).

At its most lethal domestic violence will result in death. In 1999 South Africa's female homicide rate was six times that of the global average, with half of these deaths caused by women's intimate male partners (Seedat et al, 2009). In more everyday terms, this translated into four women killed every day by the men in their lives (Mathews et al, 2004). A decade later when this analysis of female homicides was repeated in 2009, a reduction in the female homicide rate overall was found. However, even though the prevalence of intimate femicide (or men's killing of their intimate female partners) decreased from 8.8/100 000 in 1999, to 5.6/100 000 in 2009, this decline was not statistically significant, whereas that for non-intimate partner was (Abrahams et al, 2013). Because the rate of intimate femicide did not decrease as rapidly as the proportion of non-intimate homicides, intimate femicide is now the

[5] The South African Demographic and Health Survey found that 2% of women had been raped before the age of 15 (Department of Health, 1999).

leading cause of female homicides, having accounted for 50% of female homicides in 1999 but 57% in 2009 (*ibid*).

Like rape, domestic violence is significantly under-reported as data from Gauteng suggests. Between April 2008 and March 2009, a total of 12 093 women reported an assault by an intimate partner to the police in the province. This represents 0.3% of the adult female population of Gauteng. By contrast, during the same time period 18.1% of women in the province reported an experience of violence at the hands of intimate male partners to researchers (Machisa et al, 2010).

A case study conducted in one locality in Mpumalanga further illustrates how police statistics underestimate the incidence of domestic violence in any one area. Between 1 January 2006 to 31 July 2007, 942 reports of some form of domestic violence were made to one local police station and hospital, as well as the courts serving the area, with the greatest proportion of these reports (44.6%) identified from police records. However, no more than 6.7% of these 942 reports ever made their way into official statistics as only 63 women pressed charges (Vetten et al, 2009a). This data also implies that abused women, perhaps to a greater extent than rape survivors, seek assistance from a variety of institutions.

The effects of domestic violence

Like rape and other forms of sexual victimisation, domestic violence results in a range of adverse mental health consequences for women, in addition to affecting their sexual and reproductive health.

Mental health consequences

South African research has found domestic violence to be associated with the greatest number of PTSD cases amongst women at population level (Kaminer et al, 2008). In Gauteng PTSD was reported by 15.4% of women who had experienced sexual or physical intimate partner violence (Machisa et al, 2010). High levels of depressive symptoms (34.2%) were reported by women in the sample and 10.1% had attempted suicide while 10.8% had suicidal thoughts in the last four weeks (*ibid*).

Systematic reviews and meta-analyses conducted internationally confirm associations between domestic violence and a range of adverse mental health outcomes. A systematic review and meta-analysis of 41 studies (3 from Africa) concluded that that there was a high prevalence and increased likelihood of being a victim of domestic violence across all diagnostic categories of mental disorders, such as depressive and anxiety disorders, PTSD and psychoses. However, the absence of longitudinal studies meant direction of causality could not be determined (Trevillion et al, 2012). A second systematic review and meta-analysis conducted by most of the same authors (Howard et al, 2013) examined 67 papers (none from Africa) to test the associations between domestic violence and perinatal mental disorders. This found high levels of perinatal depression, anxiety and PTSD to be significantly associated with experiences of domestic violence. A third systematic review and meta-analysis of 16 longitudinal studies (none deriving from Africa) examined domestic violence and incident depressive symptoms and suicide attempts (Devries et al, 2013). This found an association between domestic violence and incident depressive systems, as well as a reverse association between depressive symptoms and domestic violence. Domestic

violence was also associated with incident suicide attempts (*ibid*).

Consequences for women's physical health

There are other general long term implications for women's health associated with domestic violence. In Gauteng 25.4% of a sample of physically abused women reported being injured, with 11.8% of women being bedridden as a result of their injuries and 12.4% taking leave from work as a result of their injuries (Machisa et al, 2010). Analysis of the national SASH data indicated that abused women were 1.7 times more likely to report ever smoking and 1.9 times more likely to report current smoking. They were nearly twice as likely to report ever drinking and 2.4 times more likely to report regular drinking and non-medical use of sedatives. Lifetime and past-year non-medical use of analgesics was almost double for abused women and use of cannabis (or *dagga*) ever 3.8 times more likely than non-abused women. Use of cannabis was 48 times more likely in the last year. Compared with non-abused women, women experiencing domestic violence were 1.5 times and nearly twice as likely to visit a medical doctor and traditional healer respectively (Gass et al, 2010).

A 2003 ante-natal survey of women attending one Durban hospital found that 35% of users had experienced domestic violence during their current pregnancy (Mbokota and Moodley, 2003). A systematic review of 19 African studies sought evidence of the extent of domestic violence against pregnant women, yielding an overall prevalence of 15.23% (Shamu et al, 2011). A subsequent study undertaken in Zimbabwe yielded a particularly high rate of domestic violence in pregnancy, reported by 63.1% of women sampled (Shamu et al, 2013).

South Africa's status as the epicentre of the HIV epidemic in sub-Saharan Africa has significantly shaped research around VAW. A survey among 1,366 South African women showed that women who were beaten by their partners were 48 percent more likely to be infected with HIV than those who were not (Dunkle et al, 2004). Women who had experienced CSA and domestic violence were also more likely to engage in sexual behaviour that increased their risk of HIV infection (Dunkle et al, 2004).

Research conducted with young rural women in less permanent relationships suggested that while domestic violence was not directly associated with HIV-infection, it was strongly associated instead with behaviours that placed young women at risk of HIV-infection, such as having an older sexual partner, and an increased number of sexual partners (Jewkes et al, 2006). Another study examining the relationship between domestic violence, rape and HIV sero-prevalence, found perpetration of domestic violence by men under 25 to be associated with HIV sero-prevalence, which helps explain why women in abusive relationships are more likely to be HIV positive than women in non-abusive relationships. There was no such association in older men however. By contrast, while men who raped had high levels of HIV prevalence, this was not associated with the perpetration of rape (Jewkes et al, 2011).

Domestic violence and its association with other adverse consequences

Despite the oft-noted recognition of women's economic dependence upon abusive men, little local research has been undertaken to examine this relationship or the economic cost of violence to women. However, small scale studies point to how episodes of domestic violence threaten women's security of tenure in a variety of ways. In one study (Vetten and Hoosain,

2006), 14 out of the 32 women interviewed had been forced by their abusive partners to leave the place in which they were living many times during the relationship. A retrospective review of a random sample of 2 208 applications for protection orders in Alberton and Temba between 2000 and 2001 found that 4% of applicants cited their fear of being evicted as their reason for requiring urgent protection. A further 9% said the application was urgent because the respondent needed to pay for the accommodation and support of the family (Schneider and Vetten, 2006).

Patterns of employment and wage-earning in South Africa are such that women generally earn less than men and are also less likely to be in full-time, permanent employment (Statistics South Africa, 2012). As a result, women are frequently economically dependent on men and in the absence of alternative, affordable accommodation, effectively trapped with their abusive partners: Yet even when women do leave to stay in a shelter, or with family members, they may ultimately return to their abusive partners because they have nowhere else to go when their allotted time in the shelter has lapsed, or overcrowding in family members' homes becomes unbearable (Mathews and Abrahams, 2001).

Women who cannot afford any form of accommodation are also at risk of becoming homeless. While the extent of abused women's particular homelessness is often disguised because they are more likely to move between family, friends and shelters in their search for accommodation, some women do literally end up sleeping on the streets – a circumstance which places women at risk of violence. Dladla et al's interviews (2004) with 28 homeless women living in transitional housing schemes and the various abandoned buildings dotting inner-city Johannesburg, found that some women had entered into relationships specifically to secure accommodation, as well as their personal safety. While some of these women had been moderately and even severely injured by their partners, they nonetheless saw their partners as protecting them from other men in the homeless community.

Domestic violence may also contribute to women's impoverishment. Vetten and Hoosain's (2006) small-scale, exploratory study showed how in some women's relationships, abusive partners took women's money and property from them, and also prevented women from seeking or maintaining employment. Those men who refused to uphold their duty of support also effectively created two households under one roof: one occupied by women and their children in which they might be denied adequate shelter, nutrition and health care; and another for the man in which he maintained himself. Such women were placed in the invidious position of having to choose between greater personal safety, along with homelessness and destitution, or dependence on others; or violent and dangerous personal circumstances - but with some degree of economic and material support for themselves and their children.

The next section of the chapter examines the various factors identified as being associated with men's perpetration of violence towards women and women's experience of victimisation.

Risk factors associated with both the perpetration and experience of VAW

Some cross-sectional studies have been undertaken to examine both women's risk of violence, as well as factors associated with men's perpetration of VAW. As noted earlier

most have also sought to understand these risk factors within the context of South Africa's HIV pandemic. Table 3 summarises these factors largely in relation to men's perpetration of VAW.

Table 3: Risk factors associated with men's perpetration of VAW

Author/year	Sample (incl. location & size)	Study design	Significant risk factors
Abrahams, Jewkes, Laubsher, Hoffman (2004 & 2006a)	Adult men working in Cape Town municipalities (n=1 378)	Cross-sectional	<u>For men:</u> no post-school training, witnessing parental violence in childhood, involvement in workplace and community fights, drug and problem alcohol use, perceiving it acceptable to hit women, frequent conflict, including over women's alcohol use, sex and the man's infidelity Sexual violence towards female partner associated with having more than one partner
King, Flisher, Noubary, Reece, Marais, Lombard (2004)	Students in Grades 8 to 11 at non-private high schools in Cape Town (randomly selected from 2 946 students taking part in 1997 South African Community Epidemiology Network on Drug Use.) (n=939)	Cross-sectional study seeking to identify substance abuse and other behavioural correlates of sexual assault among South African adolescents.	<u>Girls and boys:</u> Children living with a single parent, or one biological parent and one step-parent more likely to experience rape Other significant behavioural correlates included alcohol use, anti-social behaviour (such as stealing, damaging property, bullying others or being in physical fights), suicidal dialogue and suicide attempts
Kalichman, Simbayi, Kaufman, Cain, Cherry, Jooste and Mathiti. (2005)	STI clinic, Cape Town (N=415 men and 127 women)	Cross-sectional study	<u>For men:</u> Association between HIV infection, perpetration of sexual violence, acceptance of rape myths and a history of substance abuse.
Jewkes, Dunkle, Koss, Levin, Nduna, Jama, Sikweyiya (2006)	Men aged 15-26 drawn from 70 villages in rural Eastern Cape (N=1 370)	Baseline survey for cluster randomised trial	<u>Rape of partner and non-partner:</u> Ever physically violent to partner More partners Transactional sex with casual partner Adverse childhood experiences <u>Non-partner rape:</u> Gang membership Peer pressure to have sex Drug use Associated with wealthier and

			relatively more socially advantaged men
Dunkle, Jewkes, Nduna, Jama, Levin, Sikweyiya, Koss (2007)	Sexually experienced men aged 15-26 drawn from 70 villages in rural Eastern Cape (N=1 288)	Baseline survey for cluster randomised trial	Perpetration of domestic violence of women other than main partner associated with men giving and getting material goods from female partners
Jewkes, Sikweyiya, Morrell, Dunkle (2011)	Men aged 18-49 drawn from three districts in KwaZulu-Natal and Eastern Cape (n=1 737)	Cross-sectional household study	Risk of raping: Associated with childhood adversity, higher maternal education, having been raped by a man; Less equitable views on gender relations and more gender inequitable practices (domestic violence, transactional sex), multiple partners; Drug use and gang membership
Jewkes, Nduna, Jama Shai, Dunkle (2012)	Men aged 15-26 drawn from 70 villages in rural Eastern Cape (n=1 147)	Prospective study drawing on men enrolled for cluster randomised trial	Risk of re-offending and new rapes: Ever used drugs 8 or more lifetime partners Physically violent towards female partner Rape perpetration at baseline

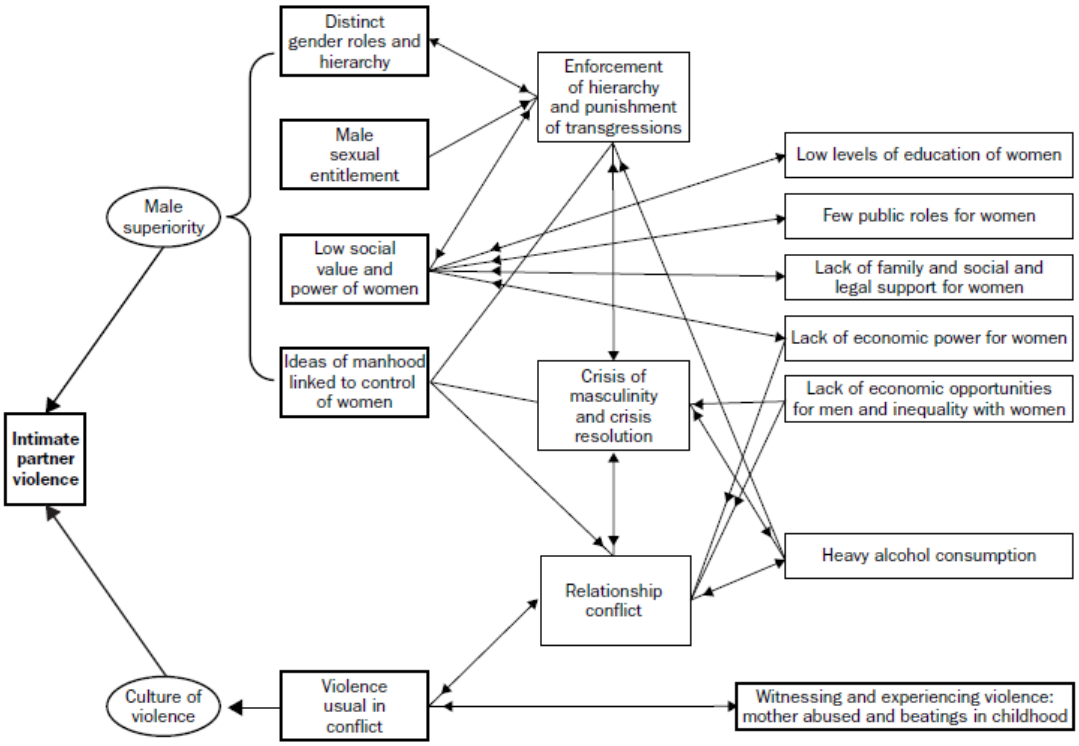
While none of these studies is national, they do point to a cluster of themes associated with men's perpetration of violence, including adherence to patriarchal and gender inequitable norms (see also the qualitative, small scale studies by Wood, 2005; Ragnarsson et al, 2008; Wood, Lambert and Jewkes, 2007; Fox et al, 2007; Wood, Lambert and Jewkes, 2008); experiences of childhood adversity; the abuse of drugs and alcohol and gang membership. They also suggest that violent men frequently perpetrate both rape and domestic violence and also engage in multiple, concurrent sexual relationships.

An economic dimension to violence is also visible, most obviously manifested in relationships marked by transactional sex (see also Jewkes et al, 2012). Other studies examining the exchange of sex for alcohol in shebeens or taverns have also highlighted how this practice places women at risk of violence. Accepting a drink from a man within this context is considered equivalent to consenting to sex, with 'failure' to deliver on this agreement resulting in rape or other forms of abuse (Watt et al, 2012; Wojcicki, 2002a; Wojcicki, 2002b).

Alcohol also emerges as a risk factor for women's victimisation in a cross-sectional study undertaken in Limpopo, Eastern Cape and Mpumalanga (Jewkes, Levin and Penn-Kekana, 2001). Risk factors significantly associated with the experience of domestic violence included women experiencing violence in childhood; having no post-school education; drinking alcohol; possessing liberal ideas on women's roles; having another partner in the year, and having a confidant(e). Other factors included male partners' preference for male children; conflict over the man's drinking, as well as frequent conflict generally; and either partner financially supporting the home. No significant associations were found between

domestic violence and partners' ages, employment, financial disparity, migrant status, urbanisation, marital status, crowding, the man's education or his having other partners, household possessions, or the woman's attitudes to violence or her perceptions of cultural norms on women's roles. The authors concluded that domestic violence is strongly related to social acceptance of violence as a means of managing conflict generally, as well as the low status of women (*ibid*).

Figure 1 examines the interplay of various factors thought to contribute to domestic violence (Source: Jewkes, 2002).



This chapter concludes by examining gender inequitable norms and their relationship to violence in more detail.

Myths, norms and stereotypes and their contribution to VAW

Research examining the contribution of rape myths to a culture of male sexual entitlement and the normalization of rape suggests that a high level of rape myth acceptance coincides with very high levels of rape (Chiroro et al, 2004). Further, it would also appear that the higher an individual man's level of acceptance of rape myths, the more likely he is to report a proclivity to rape (Viki et al, 2006). Relatedly, the proclivity to rape is strongly related to the desire to sexually dominate women (Chiroro et al, 2004). Finally, men who demonstrate a proclivity to acquaintance rape have also been shown to score highly on scales measuring hostile sexism (Viki et al, 2006).

Hostile sexism refers to beliefs that women are inferior and seek to take over men's rightful place, while benevolent sexism manifests as ideas about women's specialness and their need to be cherished and protected. Individuals may hold both sets of beliefs, producing polarised views of women described as ambivalent sexism. An illustration of this is the idea that modern women are hard-working and intelligent but also cold, aggressive and selfish (Shefer et al, 2008: 159). This conceptualisation of how gender prejudice expresses itself is highly pertinent to South Africa, the country having taken part in a 19-nation study that sought to measure aspects of sexism (Glick et al, 2000). While not necessarily representative of an individual country (the samples having largely been drawn from college students), country studies can be compared with each other because they were sampled from similar cohorts (Shefer et al, 2008).
On the Hostile Sexism scale, South African men were second only to Cuba while South African women had the highest mean of any group of women. South African women scored even higher than their male compatriots on the Benevolent Sexism scale, who scored third amongst men overall. In fact South African women's scores on Benevolent Sexism were the highest in the entire group of samples (Glick et al, 2000). This finding on the limited extent of feminist consciousness amongst South African women is further explicated in largely ethnographic work which points to a diversity of femininities in South Africa, many of which are conservative and supportive of the prevailing gender regime (Jewkes and Morrell, 2012; Jewkes, Wood and Duvvury, 2010; Shefer et al, 2008; Kalichman et al, 2005).

South Africa therefore manifests a high degree of ambivalent sexism (Shefer et al, 2008), which may explain why so much public rhetoric around VAW and CSA focuses on protecting women and children, rather than transforming unequal social relations, as well as the significant apportioning of blame to those victims of rape and domestic violence who appear to have violated conventional norms for feminine behaviour.

These myths and stereotypes considerably worsen the lot of victims of sexual offences, not least because they trivialise the harm of sexual victimisation and blame victims for its occurrence. The consequence of these ideas may be unsympathetic, disbelieving and inappropriate responses to victims of sexual assault by society in general, as well as at each stage of the criminal justice process. For example, in a survey carried out at 31 health facilities around the country which treat rape survivors, one in three (32.6%) health practitioners said they did not consider rape to be a serious medical condition (Christofides et al, 2006). An evaluation of 26 medico-legal services in Gauteng also referred to the "unsympathetic, judgemental and impatient attitude" demonstrated by health workers towards the women (Suffla et al, 2001).

As the preamble to the Sexual Offences Act, 2007 notes, the law too has been complicit in the discriminatory treatment of survivors of sexual offences. For example, common law elevated many of the previously-mentioned stereotypes to the status of legal fact through the application of the cautionary rule to the testimony of sexual offences victims. This rule obliged judicial officers to treat rape complainants' evidence with caution and invited them to speculate about possible reasons for the falsity of rape allegations.[6] The existence of this

[6] See for example *S v Balhuber* 1987 (1) PH H22 (A); *R v Rautenbach* 1949 (1) SA 135 (A); *R v M* 1947 (4) SA 489 (N); and Hoffman and Zeffert 1998: 579 – 580.

rule ensured that survivors of sexual offences were the only crime victims to have been treated as inherently deceitful.

Domestic violence is also shrouded in victim-blaming stereotypes. The 1998 MRC three-province survey explored different dimensions of women's perceptions of gender relations. More than a decade later a survey conducted in Gauteng in 2010 using the same attitudinal scales produced a very different picture. In 1998, for instance, 58.1% of women agreed with the statement "my community thinks that if a wife does something wrong her husband has the right to punish her." This percentage had more than halved by 2010 with only 26.9% of women agreeing with the statement (Machisa et al, 2010). Data from the 2011 Quality of Life Survey (Gauteng City-Region Observatory, n.d.) nuances the picture for Gauteng even further.

At first glance tolerance of domestic violence appears extremely low across the province. On a scale consisting in five measures asking about the circumstances in which it was permissible for a man to beat a woman, only 1% of the Gauteng population agreed that a man can beat a woman if she burns the food, while up to 5%, the greatest proportion, agreed that a beating was permissible if the woman was unfaithful. However, once sub-divided into 10 localities, a different picture emerged, with up to one in 10 respondents in Westonaria (10.8%) agreeing that a man could beat a woman if she burnt the food. In Emfuleni one in five (20.5%) agreed with a man beating an unfaithful woman (*ibid*).

Conclusions

No data are available on the extent of VAW and CSA nationally. However, population-based studies of sound design suggest that both are widespread in South Africa and result in a range of highly adverse consequences for women and girls' mental health, as well as their physical, sexual and reproductive health. Women and girls' risk of violence is also mediated by a range of factors, increasing the likelihood of victimisation for some groups of women but not others. Research conducted largely within the context of South Africa's HIV epidemic has also begun explicating some of the complex associations between the behaviours and circumstances which place some men at risk of perpetrating of violence. This data provides a useful diagnostic to inform the development of programmes and policies. However, because many of these studies are localised and population-based, they are not necessarily generalizable. They also present somewhat different results to one another and while this can be explained by different methodologies and definitions, it is also possible that factors and conditions at local level may be introducing particular nuances and complexities. This would suggest that tailoring of programmes may be required in certain instances. Finally, as this overview suggests, a multiplicity of factors contributes to the pervasive problem of VAW, making it clear that no single intervention in of itself will magically eradicate the problem.

Chapter 3: Overview of Evaluations' Findings

Chapter 2 largely functioned as a diagnostic in that it sought to map the scale of the problem, its consequences and the factors thought to contribute to VAW and CSA. In this and the next chapter evaluations of a range of interventions attempting to address one or other aspect of the problem are presented. The findings in this chapter focus, for the most part, on interventions developed by research institutions, as well as NGOs, and therefore set out the civil society response to VAW and CSA. Discussion of the various evaluations is organised thematically with the results of formative research intended to inform intervention design, or provide a baseline, dealt with in the overview contained in Chapter 2. This summary is introduced by a brief discussion of dominant frameworks for thinking about responses to VAW and CSA, including the prevention of such violence.

Ecological approaches to thinking about violence

As the outcome of a complex interplay of factors, VAW and CSA require multi-layered responses that adequately take into account the individual, relational, social, cultural and environmental factors that contribute to its manifestation (Dahlberg and Krug 2002: 12). One such model is the ecological framework briefly described below.

An ecological model comprises the following four levels:

- *Individual* factors contributing to violence include those characteristics such as substance abuse and a prior history of aggression and abuse that increase the likelihood of being either a victim or perpetrator of violence.
- The next level of the model considers the role of individuals' *inter-personal relationships* in constraining or promoting violence. This would include considering how family members or peers may encourage violent and controlling behaviour, or the extent of support and assistance they are willing to offer to individual women who have experienced violence.
- The third level of the model examines the *community contexts* in which victims and perpetrators are embedded. The workplaces, neighbourhoods and other settings that women and men occupy may, through their design and management, offer opportunities for violence. Fragmented communities may also be unable to mobilise around preventing or challenging violence.
- The final level to the model considers the influence of *societal factors* upon violence, such as the extent to which societies accept male dominance over women, or how cultural norms support violence as an acceptable means of solving problems. Also included here are the legislative and policy interventions developed to address social problems (*ibid*: 12 -13).

Variations on this approach may distinguish instead between biological, behavioural, proximal societal, distal societal and structural factors (eg Matzopolous et al, 2010; Petersen, Bhana and McKay, 2005). The biological refers to factors such as gender, age and mental and physical impairment, while the behavioural includes problems such as hyperactivity, impulsiveness, misconduct and attention problems. The effects of substance abuse are also primarily demonstrated at this level. The proximal societal dimension includes family-related factors, the influence of friends and the social integration evident in any given community.

Distal societal factors refer to socio-cultural norms and inequalities, as well as political structures such as the courts and health system. Structural factors include demographic shifts associated with migration, urbanisation or modernisation, as well as socioeconomic status.

The public health approach

Where an ecological model looks at the multiple factors contributing to the manifestation of sexual offences, a public health approach emphasises three different stages in the development of the problem and targets these levels accordingly.

- Addressing VAW and CSA at primary level involves identifying the underlying risk and protective factors for violence, as well as actions to address those factors. This is with the aim of intervening before any violence occurs. Primary prevention interventions to address VAW include strategies to improve gender equality; changing social norms regarding violence, masculinity and gender roles and relationships; reducing poverty and strengthening economic and social safety nets; promoting healthy and equal relationships; reducing alcohol and drug misuse; having a particular focus on young people; and preventing children from being exposed to violence. Increasingly, work with men and boys is also being undertaken to prevent sexual violence. Other interventions considered to constitute primary prevention include paying attention to how physical and social environments may create opportunities conducive to violent behaviour. But regardless of the intervention type, these programmes are targeted at the population generally.
- Secondary prevention, by contrast, aims to target those at particular risk of becoming either victims or perpetrators. This might include selecting particular communities with poor lighting for improvement to their infrastructure or creating educational and job opportunities in deprived areas to enable future employment that is outside the scope of illegality.
- Tertiary prevention efforts are concentrated on those who have become actual victims or perpetrators. As such their emphasis is two-fold: reducing recidivism by focusing on rehabilitation; and developing responses to reduce the harmful consequences of incidents of VAW or CSA after they have occurred.

Both models provide a useful heuristic for thinking about violence interventions but are not usefully treated as rigid prescriptions for action. This is because they are difficult to test, the weight, direction and impact of each level of the ecological model relative to others, for example is unclear, as is the various levels' interaction and effect upon one another. For policy makers (and particularly those operating within the context of scarce resources) this presents a challenge as it is not immediately evident where effort should be prioritised and focused, nor what is likely to bring about the most substantive and enduring changes. Further, given that at least some human behavior is irrational, unpredictable and contingent it is debatable how amenable it is to prediction and control. This concern is particularly applicable to behavioural interventions developed and tested under closed, ideal conditions, which may not always translate perfectly into the messiness of everyday life.

Against this backdrop, the chapter presents an overview of evaluations of civil society programmes, first summarizing interventions addressing men and then examining what may

be described as education and awareness-raising initiatives. The chapter then presents an overview of services largely developed for women and girls including counselling and shelter services, as well as economic empowerment programmes. The chapter concludes by examining the only intervention found that focused on environmental factors.

Programmes working with men

Two systematic reviews (Smedslund et al, 2011; Ricardo, Eads and Barker, 2011) were identified, along with five programmes run by academic institutions (Jewkes et al, 2008; Kalichman et al, 2009), NGOs (Dworkin et al, 2012; Draper, 2011; Rangasami. Stewart and Maharaj, 2013) and a government department (DSD, 2009). While the Gauteng Department of Community Safety has initiated a 'Men as Safety Promoters' (MASP) project, this would not appear to have been evaluated. Another programme not considered is Men as Partners, a five day workshop programme implemented in Southern Africa which addresses VAW, attitudes towards women and HIV/STI risk (Peacock and Levack, 2004). This is because no evaluation has tested its outcomes.

Systematic reviews

One systematic review of 6 small trials, all conducted in the USA, was found examining the effectiveness of cognitive behavioural therapy (CBT) for men who abuse. Trials including men who attended treatment voluntarily, as well as those whose participation was court-ordered, were included. The reviewers concluded that too few RCTs existed to draw any conclusions regarding the effectiveness of CBT as an empirically supported treatment for men who abused their intimate partners (Smedslund et al, 2011).

Ricardo, Eades and Barker (2011) provide a systematic review of 65 evaluated interventions with men and boys. Given the very few RTCs in existence the review also included non-randomised studies with a treatment and control group. Studies were categorised according to six outcomes: reduction in perpetration of sexual violence (n=9); reduction in perpetration of other forms of VAW (n=16); improvement in attitudes towards violence (n=47); improvement in attitudes towards gender roles and/or intimate relationships with women (n=25); increase in bystander behaviours (n=5); and improvement in bystander attitudes, efficacy and/or intentions (n=14). Eight studies were categorised as 'strong', 21 as 'moderate' and 36 as 'other'. Two South African studies qualified for inclusion, Stepping Stones (categorised as strong) and Soul Buddyz (categorised as moderate). Workshops were the most common methodology, with some also including girl participants, and mostly took place in school settings.

In terms of the six outcomes, the eight strong studies demonstrated statistically significant positive effects as follows:

- reduction in perpetration of sexual violence – 1 study (with a second study, Stepping Stones, demonstrating some effects);
- reduction in perpetration of other forms of VAW – 3 studies (including Stepping Stones)
- improvement in attitudes towards violence – 2;
- improvement in attitudes towards gender roles and/or intimate relationships with women – none;
- increase in bystander behaviours – none; and

- improvement in bystander attitudes, efficacy and/or intentions – 2.

The most effective programme (resulting in significant effects on three outcomes) appears to have been 'Safe Dates' which was conducted in the USA with mixed sex groups of 11 – 17 year olds and followed up four years later. The intervention ran over ten sessions and included interactive school-based educational and art activities, as well as a theatre production (Foshee et al, 2004). While Stepping Stones also demonstrated some positive effects, Soul Buddyz demonstrated no significant effects on any of these outcomes.

Ricardo, Eades and Barker (2011) note that while a number of programmes do appear effective in changing boys and young men's attitudes to VAW and gender stereotypes, evidence of their effect on behaviour is less clear-cut. Indeed, they argue that changes in behaviour cannot automatically be inferred from changes in attitude.

Interventions developed by research agencies

Stepping Stones, first utilised in Uganda in 1995, is an HIV prevention programme that aims to "improve sexual health through building stronger, more gender equitable relationships" (Jewkes et al., 2008: 2). It has been applied in over 40 countries, translated into 13 languages and adapted for 17 settings (including South Africa in 1998). Drawing on participatory learning approaches which include role play, drama and critical reflection on the everyday circumstances of participants' lives, it is run over a period of 50 hours spread over 6 to 8 weeks. It takes the format of 13 three-hour sessions for single sex groups, run in parallel. These are complemented by three meetings of male and female peer groups and a concluding community meeting. Programme content explores how and why participants act as they do; conception and contraception; sex and love; taking risks and sexual problems; unwanted pregnancy; sexually transmitted infections and HIV; safer sex and condoms; gender-based violence; motivations for sexual behaviour; dealing with grief and loss; and communication skills (Jewkes et al 2008: 3).

Following its adaptation, the Stepping Stones programme was evaluated in South Africa through a cluster randomised trial conducted between 2002 and 2006 by the MRC. For reasons of cost, that component of the programme addressing older men and women, as well as the peer groups encouraged to continue meeting after the programme's conclusion were dispensed with. The intervention was set in 70 villages in the Eastern Cape and included 1 360 men and 1 460 women aged 15 – 26 who were mostly attending school. Project staff were drawn from the Planned Parenthood Association of South Africa (PPASA) and selected on the basis of their open mindedness and gender sensitivity. Facilitators who provided the actual intervention were trained for three weeks, which included running two practice groups, while those who facilitated the control group were trained separately for four days to prevent contamination. The control intervention consisted in a three-hour session on safer sex, HIV and condoms, with content taken from Stepping Stones (Jewkes et al 2008: 2-3).

Analysis of the trial's results showed that while Stepping Stones reduced the incidence of herpes simplex type 2 virus (HSV-2) (a risk factor for HIV), it did not reduce the incidence of HIV. The programme also resulted in important and significant changes to male participants' behaviour but had no positive effects on female participants – who, in fact, reported more

transactional sex at 12 months than the control group. While this effect was reduced at 24 months, there was a suggestion that unwanted pregnancies had increased by 24 months. By contrast, male participants reported less transactional sex at 12 months, as well as less problem drinking. At two years, men were also reporting lower levels of perpetration of intimate partner violence. The researchers speculate that the programme's impact might have been strengthened had the programme been implemented in full to include older adults and the ongoing peer discussions (Jewkes et al, 2008).

A second quasi-experimental field trial conducted in Cape Town also shows some promise. Kalichman et al (2009) tested a five session intervention designed to reduce both VAW and HIV risk factors (n=242) and compared its effects with a single three hour alcohol and HIV risk reduction session (n=233).These programmes were tested in only two communities in Cape Town and relied on self-reported change. Participants were not randomly selected but recruited through active and passive word of mouth techniques, producing a sample socially connected to each other within (but not between) communities.

Follow up with participants occurred over a six-month period post the intervention. One month after the intervention men participating in the VAW/HIV intervention demonstrated significantly less acceptance of violence than the alcohol/HIV group, with the difference no longer significant at three and six months (suggesting this initial effect was short-term only). They were also significantly less likely to have lost their temper with a woman one month and six months after the intervention and significantly less likely to have hit or pushed their sexual partner at six months. However, the alcohol/HIV group reported less unprotected sex, fewer alcohol-related sexual encounters and greater condom use than the VAW/HIV group. The researchers suggest that an intervention addressing HIV, VAW and alcohol may be particularly effective with men (Kalichman et al, 2009).

NGO and government programmes for men

The Sonke Gender Justice Network ('Sonke') developed the One Man Can campaign to reduce the spread and impact of HIV/AIDs and violence against women. The Campaign combines participatory workshops with community action team efforts which aim to promote gender equality in communities. The workshops aim to examine the links between gender, power and health (alcohol use, violence, HIV/AIDS); reflect on masculinities practised in relationships with women, other men and participants' communities; and promote rights-based approaches to reducing VAW and both men and women's HIV risks (Dworkin et al, 2012). The article reflecting on its impact discusses self-reported change only and provides neither outcome measures nor baseline data. The sample of 60 men was also not randomly selected from all workshop participants but recruited by organisations which are invested in gender equality and health matters and which are also Sonke partners. This is therefore not a group likely to be representative of men more generally and while it presents interesting data on how some men grapple with change, its impact is unknown.

DSD has provided an evaluation of their strategy for engaging men and boys (DSD, 2009). This strategy appears to have been developed by the South African Men's Action Group – North West and sought to bring together in dialogue boys and men between the ages of 12 to 40, who were then expected to transfer whatever they had learned from each other to their peers. The actual project involved 16 young men between the ages of 16 and 20 chosen from three different schools. No information is available regarding the criteria informing

selection of participants, who then went on to select 13 father figures between the ages of 22 and 53. After attending a three day camp and three workshops with these father figures, the young men went on to each conduct an activity at the three different schools they attended.

The external evaluation of the project lacks both a baseline, as well as clear, measurable outcome indicators for assessing the project's impact and effectiveness. The report is also poorly written and frequently uses terminology incorrectly thus making it difficult to understand. However, what can be gleaned from the evaluation is that most of these young men had significant personal difficulties and required help themselves (raising questions around the extent to which they could act as peer educators to others), were unable to transfer information outside of their school environment and were afraid to intervene in those incidents of gender-based violence that they had observed. Father figures also "cascaded information very scantily" (DSD 2009: 43-44)

Support Programme for Abuse Reactive Children

The Support Programme for Abuse Reactive Children (SPARC) was instituted by the Teddy Bear Clinic to divert children away from the criminal justice system and into a therapeutic environment (it was unknown when the programme was introduced). Its target population is children classified as low to medium risk sex offenders and aged between 6 to 18 years. Children may either be enrolled on a voluntary basis by their care givers, or instructed to attend the programme following legal proceedings (Rangasami, Stewart and Maharaj, 2013).

SPARC's design draws on clearly articulated psychological theory and research, in combination with clearly defined programme objectives and goals. The programme comprises individual sessions (the number determined with reference to each individual child's needs); 12 consecutive weekly group sessions for child participants, coupled with 12 consecutive weekly sessions with the participating children's caregivers; 12 consecutive weekly sessions of either boxing, art, dance or music therapy; a psychological assessment and recommendation; and follow up at three, six and 12 months (*ibid*).

Two evaluations have been conducted of the programme: an outcome evaluation seeking to determine whether or not SPARC had reduced recidivism among 497 child sexual offenders who had graduated from the programme between January 2009 and December 2011 (*ibid*); and the other a process evaluation focused specifically on the Fight with Insight (FWI) sub-component of SPARC, which comprised weekly sessions of both boxing and CBT (Draper, 2011).

The outcome evaluation sought to make use of both quantitative and qualitative data sources but was hampered in doing so by inadequate record keeping on the part of the organisation, including very significant gaps in the pre- and post-intervention test data, as well as the follow up forms. The evaluators then contacted 494 caregivers telephonically instead and succeeded in contacting 316 (64%), with 30% not contactable due to having moved, their telephone numbers no longer being in use (or incorrect), or the call being unanswered. But of those who responded, 95% said their child had not reoffended. As the evaluators pointed out, these results had low validity because they relied on self-reporting and could not be verified against Department of Correctional Services' data, which does not keep independent data recording recidivism. Additionally, for ethical reasons, care givers could only be contacted by SPARC staff and during working hours, both factors which may

have affected caregivers' responses. Further, those caregivers who were contactable were also seen as more stable by SPARC staff, suggesting that those who could not be contacted may have been caring for children more likely to reoffend (*ibid*).
The process evaluation of FWI (Draper, 2011), begins to sketch what contributes to programme effectiveness. According to the evaluator, it is not boxing *per se* which contributed to the programme's success but the interplay of a range of factors including the physical nature of boxing, the four principles emphasised by the boxing coach (first impressions, compassion, consequences to action and moving on from results) and the themes addressed by CBT. In addition, the evaluator highlighted the qualities and skills of the main boxing coach as also playing an important role in bringing about change (*ibid*).

Given the high degree of reliance upon workshops as a methodology for change, the next section examines evaluations which critically reflect upon training and awareness interventions.

Educating and training for change

Three articles were located that provided critical reflection on the design and implementation of programmes seeking to change gendered social norms. One derived from the Stepping Stones project (Jewkes, Wood and Duvvury, 2010), a second from the IMAGE intervention (Hatcher et al, 2011) while the third evaluated a series of Soul City which took domestic violence as one of its major themes (Usdin et al, 2000; Usdin et al, 2005).

As noted earlier, *Stepping Stones* had little impact on the women who participated in it. Qualitative research comprising in-depth interviews prior to the intervention and follow up interviews and focus groups 9 – 12 months after the intervention examined how the programme influenced participants' lives. The authors suggest that individually focused interventions which seek to alter gendered social norms and behaviours are likely to be limited in effect in the absence of supportive structural interventions (Jewkes, Wood and Duvvury, 2010). They also note than within the context of masculinist domination, it may be easier for men to change their behaviour because it entails fewer negative costs and consequences. In-depth qualitative interviews accompanying the intervention suggest that it encouraged participants to be 'better', rather than different, men and women (*ibid*). Indeed it is their contention that Stepping Stones may have created a more 'benign patriarchy' that encouraged men to be less violent and anti-social, rather than a transformed gender order that provided a greater choice of life opportunities and circumstances for women and enabled them to embrace a feminist consciousness (*ibid*). The IMAGE programme, by contrast, focused only on women and was able to achieve a 55% reduction in domestic violence through a combination of microfinance and training to promote critical consciousness (Hatcher et al, 2010).

IMAGE sought to promote critical consciousness through Sisters for Life (SFL), a ten week programme focused on gender equality, power, domestic violence and HIV. On completion of SFL women from each loan centre chose 'natural leaders' to attend a week-long training programme designed to engage them in additional reflection and leadership strategies. Centres then designed action plans responding to issues of local importance (Hatcher et al, 2010).

The process evaluation suggests that SFL encouraged participants to devise solutions to local problems, create the space to share common problems and provide mutual support to one another and create new, deeper understanding of issues. While some community mobilisation occurred in the form of marches and the establishment of committees against rape, certain assumptions about community mobilisation were not borne out with testing. Individual action in the form of sharing information with others was more manageable for women who faced competing demands on their time (including the imperative to work in order to repay their loan), resistance from some local leaders and a lack of financial resources to implement their plans (Hatcher et al, 2010).

The final evaluation is that for Soul City Institute for Health and Development Communication, a prime-time radio and television series which uses edutainment (the integration of education and social issues into popular entertainment formats) to bring about social change. *Soul City 4* was set in a community clinic in the fictitious township of Soul City and had domestic violence as its major theme (Usdin et al, 2000: 61). This particular series had three goals: encouraging shifts in social norms (specifically the view that domestic violence is a private matter); promoting collective action against domestic violence; and facilitating the creation of a legal environment more responsive to women in abusive relationships. In relation to the last aim, *Soul City 4* sought to speed the implementation of the 1998 Domestic Violence Act (Usdin et al 2005: 2435). Impact was tested 8/9 months after the programme through a variety of methods, including a pre- and post-intervention survey with a sample of 2 000 adults aged between 16 and 65. In addition 29 focus groups and 32 in-depth interviews were conducted amongst Soul City's target audience and community membership. In total, data were collected from six provinces.

Reach was considerable, with 86%, 25% and 65% of people addressed through television, print media and radio respectively. Some attitude shifts were observed, with a 10% increase in the proportion of people disagreeing that domestic violence is a private matter. Some positive shifts in a few norms accepting of domestic violence were also observed. The sample size was too small however to analyse whether or not Soul City affected the perpetration of abuse. Soul City would appear to have played an important role in speeding the operationalization of the DVA (Usdin et al, 2005).

Programmes for survivors of rape and domestic violence

The dearth of well-designed evaluations of counselling and support services is striking, given the deleterious effects described earlier of rape and domestic violence on women's and girls' mental health. Two systematic reviews were identified for this section, as well as five evaluations which reflect on questions of access to services and the impact of services. Evaluation of two programmes seeking to address the relationship between women's economic circumstances and domestic violence are also reviewed.

One systematic review examines the success of different treatment interventions in reducing PTSD among rape survivors (Regehr et al, 2013). Six treatment interventions, all undertaken in large urban settings in the USA, were identified which found tentative evidence that cognitive and behavioural interventions, particularly Cognitive Processing Therapy, Prolonged Exposure Therapy, Stress Inoculation Therapy and Eye Movement Desensitisation and Reprocessing can be associated with decreased symptoms of PTSD.

The second systematic review examined 10 trials testing advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women experiencing domestic violence. Nine were conducted in the USA and one in Hong Kong. All of the interventions, but for one, were new and non-established modes of care within the settings in which they were tested (Ramsay et al, 2009).

In this review advocacy referred to the provision of safety planning advice; facilitating access to and the use of community resources such as shelters, emergency housing and psychological interventions; and the provision of legal, housing and financial advice. The authors conclude that the weakness of the current evidence base does not allow for adequate judgement of advocacy interventions per se. This caveat aside, the review noted that intensive advocacy (12 hours or more in duration) for women recruited from domestic violence shelters may reduce physical abuse one to two years after the intervention. It was unknown whether the interventions improved women's quality of life or mental health. It was also unknown whether less intensive interventions in healthcare settings were effective for women still living with the abuser (Ramsay et al, 2009).

The next section reports on data examining children's access to CSA services (2 articles) and then summarises evaluations of three organisations' support services, with those undertaken on behalf of Ekupholeni Mental Health Centre demonstrating the most thoughtful design. Those undertaken on behalf of the Greater Rape Intervention Programme (GRIP) and RCCT are not comprehensive but offer some useful snippets of information.

Children's access to services

Collings' analysis (2009) of 200 consecutive cases of child rape referred for medico-legal assessment at one state hospital in Durban, KwaZulu-Natal audits the provision of state-supported counselling and social work services to those children. In the three-month period studied (October to December 2004), just under half (49%) of children were seen either by a hospital social worker (45.5%) or an external agency referred to by the hospital (3%). However, this service was largely restricted to a single intake interview, provided on the day of initial presentation in 21.6% of cases; between two days and one week after initial presentation in 20% of cases; a further 10.5% being seen between one week and one month later; and 7.5% more than a month later. All children attended to by an external agency were seen more than a month after initial presentation (*ibid*: 142).

Two factors were predictive of a child being provided with services: presenting at the hospital during standard working hours; and the child being resident at a fixed street address. Thus children presenting after-hours and children living in informal settlements were significantly less likely to receive counselling and social work services. Collings (2009) also suggests that the findings are suggestive of unintegrated and non-reciprocal professional engagement which did not allow for either children or their caregivers to play a meaningful role and where few safeguards existed to prevent the failure of systems of referral. These included procedures to provide feedback to attending physicians regarding whether or not the child had received services, as well as procedures to re-establish contact with children's caregivers when children did not arrive for appointments. Also absent was reciprocal

communication between hospital services and external agencies confirming whether or not children had received subsequent services (*ibid*: 144).

Mathews et al's small-scale study in the Western Cape (2013b) suggests similarly-limited access to services. In this study a number of children received only a single session of debriefing and were not referred to specialised services. Structural and institutional barriers also limited their use of these services.

Greater Rape Intervention Project (GRIP)

GRIP was established in 2000 in Nelspruit, Mpumalanga and bases many of its services in care rooms located at police stations, court and hospials in the province. It currently manages
29 care rooms spanning two districts and served 2,151 survivors of sexual and domestic violence at its care rooms in 2010.

Programme evaluators considered four questions in relation to GRIP: to what extent was the organisation able to meet the needs of survivors of VAW in its target areas; how did its stakeholders perceive the quality and accessibility of the programme; what were the most significant changes brought about by GRIP to the well-being of survivors of VAW; and what hindered or enhanced the programme's workings. Seventy-three individuals drawn from six sites participated in the evaluation, either through individual interviews or focus group discussions. This included 15 individual interviews with rape survivors and five interviews with caregivers (Mazars, Hidayati and Mofolo, 2012).

Overall, the perception of GRP and its services was favourable but perhaps the most suggestive observation – and one which requires further exploration – is the evaluators' finding that the number of victims withdrawing their matters declined from 22.9% in 2008, to 12.0% in 2011 (*ibid)*. It would be important to investigate whether this change was brought about by an unrelated change in policing practices, or was the result of GRIP's interaction with survivors.

Rape Crisis Cape Town Trust (RCCT)

The counselling model employed by RCCT is described as a feminist empowerment model of crisis intervention and is limited to 12 sessions provided by lay counsellors. No systematic effort to test its impact has been instituted. However, interviews over the years with both survivors and counsellors (CASE, 2003; Maart, Crawford-Cousins and Doo, 2006) provide some insight into the workings of the model.

First, clients both under- and over-attend the service. It is speculated by counsellors that under-attendance may be due to insufficient funds for travel to the office; that the initial session may not have met survivors' expectations; and that counselling is not a mode of intervention helpful to all. Indeed, in some communities counselling may be perceived as a 'self-indulgent luxury' in the face of numerous other social and economic challenges. Over-attendance on the other hand, appeared to coincide with those survivors needing assistance to prepare for court, as well as those whose lives are marked by poverty or continuous trauma (CASE, 2003). These perceptions were corroborated to some extent by the very small number of survivors interviewed. For instance, one survivor's interview illustrated the

hope that counselling would provide a quick and immediate fix for her distressing memories. Because it had not, she discontinued counselling (after having tried a number of different agencies in search of a fast cure). Many survivors' lives are complex and the rape may be far from the only difficulty they are experiencing (Maart, Crawford Cousins and Doo, 2006).

What can also be discerned from these evaluations is the complexity of the social service intervention required to address rape. This range of assistance provided, including court support and accessing medical and policing services was appreciated by the survivors interviewed. Poverty and its associated problems – such as hunger, unemployment, ill-health and a lack of shelter – also required a focus (CASE, 2003)

Echoing Collings (2009), the RCCT evaluators also found that the organisation did not have a system for following up on those cases it referred (CASE, 2003). It was also noted that the needs of adolescents may differ from those of adults and RCCT was recommended to refine its service accordingly. Echoes of this recommendation emerge in the evaluation of the Ekupholeni Mental Health Centre's ('Ekupholeni') project for survivors of sexual abuse.

Ekupholeni Mental Health Centre

Ekupholeni is based on the East Rand of Gauteng and was founded in 1994 to address the political violence in the area. It has expanded its focus since and now address VAW and CSA, HIV/AIDS, bereavement and youth at risk. The organisation also provides counselling services to the TCC located at Natalspruit Hospital.

Phuma Sekota Ilanga, Ekupholeni's project for survivors of sexual abuse, comprises four groups:

- Together as One – girls aged 12 to 18
- Spice Buddyz – girls aged 8 to 12 years
- Red Roses – girls under the age of 8
- Mothers' Tears – mothers of girls in the Red Roses and Spice Buddyz' groups.

Together as One was not evaluated and had not functioned effectively in over a year, care workers having struggled to recruit girls to the group. Girls' attendance was erratic and follow-up complicated by girls providing false addresses and phone numbers. Conflict disrupted sessions, with girls also resistant to retelling their stories. Most had difficult relationships with their parents (Clacherty and Donald, 2008).

Clacherty and Donald's evaluation (2008) of Mothers' Tears and Spice Buddyz contains no description of the programmes' content, duration and design, confining itself solely to reporting on the study's impact measures. In design the evaluation was a quasi-experimental control study consisting in 11 participants who had completed Mothers' Tears and 11 mothers about to enrol in the programme; and 16 girls who had completed Spice Buddyz with a control of 18 girls about to start the programme. There was no random assignment to the groups and no report on the demographic characteristics of each group.

The Trauma Symptom Checklist was administered in isiZulu to the two groups and while the control group scored more highly on this, the difference was not statistically significant. The Strengths and Difficulties Questionnaire however, showed the control group to be

experiencing a statistically significant higher level of difficulties than the programme group, as well as significantly more indicators of emotional disturbance (evaluated through an activity entitled 'Draw a Person'). Other indicators of impact were assessed through interviews with mothers and a participatory workshop with the children. Children in the programme were reported as demonstrating less emotional stress, as well as engaging in less acting out (although difficulties remained). They also appeared to have a wider social network marked by deeper levels of interaction than the control group who had withdrawn from their peers and whose networks were more restricted.

Mothers' adjustment to their child's rape was measured through the Edinburgh Post-Natal Depression Scale and found a just-significant difference between the two groups, mothers who had been through the group demonstrating lower levels of depression. They also demonstrated greater knowledge of the effects of sexual abuse and were therefore better equipped to assist their children.

Overall, while some children and their caregivers who had participated in the groups were still experiencing difficulties, the children demonstrated fewer negative emotional symptoms and negative behaviours than those in the control group. Caregivers also demonstrated some emotional adjustment to the sexual abuse and appeared better able to communicate with their children. The limitations of the evaluation report and design notwithstanding, Spice Buddyz and Mothers Tears appear promising and deserve closer attention.

Tsogang Basadi was a programme of group-based creative arts activities run over approximately 11 months for women drawn from domestic violence counselling organisations in greater Johannesburg. An arts facilitator worked with a psychologist and counsellors from the Reginald Orsmond Counselling Service and Ekupholeni Mental Health Centre to develop a weekly programme including activities such as drawing, painting, writing, fabric printing and starch resist techniques (Clacherty and Kola, 2007). The programme purpose was threefold: to facilitate a therapeutic process of healing; to encourage the development of creative abilities; and to provide women with skills that could improve their economic position.

A quasi-experimental comparison group design was implemented to evaluate the programme. This included a focus group discussion with the women who had completed the programme (n=13) and the women about to start the programme (n=20); the administration of the Self Reporting Questionnaire 20 items (SRQ20), a mental health screening tool developed by the WHO; and review of process notes maintained over the course of the programme. The economic component of the programme was not evaluated.

The women who had been through the programme demonstrated statistically significant better scores on the SRQ20 than the control group – a finding limited however, by the small size of the group. The qualitative measures also suggested that the intervention group, through the combination of therapy and art activities, did seem to be managing their circumstances better than the comparison group (Clacherty and Kola, 2007). As with Spice Buddyz and Mothers' Tears, Tsogang Basadi is another promising programme warranting closer attention.

Domestic violence shelters

Two studies were found evaluating the impact of shelters in abused women's lives, neither of which is well-designed.

The baseline victim empowerment study of Ikhaya Lethemba and selected station-based victim empowerment centres was commissioned by the Gauteng Department of Community Safety (du Toit, 2010). At best this is a convenience sample, reflecting the views of only 4.5% of the total, contactable number of abused women who were resident in Ikhaya Lethemba between 2006 and 2010 (the cut-off dates for both years is not provided). It is therefore neither random nor representative, rendering null the generalisation of these interviews to Ikhaya Lethemba residents as a whole. Indeed, no demographic profile of Ikhaya Lethemba residents over the four-year study period is provided, making it impossible to know how representative this sub-group is of the study population as a whole.

The questionnaire is not well-designed either. The measures for PTSD, anxiety, self-esteem and depression, for example, conform to no recognisable, accepted standards, further rendering this data and the conclusions drawn from it highly questionable. Much of the study appears to have been designed as a customer satisfaction survey so it cannot therefore say much about the impact of programmes upon Ikhaya Lethemba residents.

Moolla (n.d) sought to determine if the Saartjie Baartman Centre for Women and Children (SBCWC), a shelter in Manenberg in the Western Cape, met abused women women's needs through an intake interview. A convenience sample of 120 women resident in the shelter between October 2008 and August 2009 was interviewed, as were eight current residents of the shelter. Attempts to select a random sample proved unsuccessful due to difficulties in contacting former residents. While some of this data is not of general relevance (being concerned with what women thought of the Centre's staff and surroundings), it does provide some insight into the range of abused women's needs. The following were identified as lacunae in SBCWC's services: additional counselling, including the provision of support groups; legal services; assistance with finding permanent housing, as well as earning an income; and a range of interventions to assist women with their children. Two studies describing shelter practice and programming, one of five shelters in Gauteng (Bhana et al, 2012) and three in the Western Cape (Bhana et al, 2013), point to similar gaps in these shelter services, suggesting that a number of shelters may be unable to provide these services. These two studies also suggest that evaluating shelters' impact is hampered by the loss of women to follow up (as was the case for the Ikhaya Lethemba study), as well as the fact that some shelters' data collection systems were missing a good deal of information. Case notes were poor to non-existent, making it impossible to assess the nature of psycho-social assistance provided to women, as well as its extent and impact.

Interventions addressing women's economic dependence

Apart from these ameliorative programmes, efforts to reduce women's structural economic dependency on men have also been attempted. Two evaluations of such programmes exist, one a cluster randomised trial and the other a process evaluation of the Saartjie Baartman Centre for Women and Children's (SBCWC) attempt to introduce an economic empowerment programme at the Centre.

Intervention with Microfinance for AIDs and Gender Equity (IMAGE)

The IMAGE study (Pronyk et al., 2006) was undertaken in eight villages in Limpopo between 2001 and 2004 and subsequently scaled up during 2005-2007. IMAGE sought to test the effect of a structural intervention upon HIV infection and intimate partner violence. This took the form of microfinance provided by the Small Enterprise Foundation (SEF), combined with a gender and HIV training curriculum. The SEF programme provides loans for the development of income generating activities. While each little business was run individually, groups of five women guaranteed each other's loan and were repaid together to receive further loans. A loan centre included eight groups of women who met every two weeks to participate in the accompanying training programme, SFL (described earlier) was based on participatory learning and action principles and comprised ten sessions, followed by attempts to encourage community mobilisation.

A cluster randomised trial, the IMAGE intervention comprised the following three cohorts: cohort one consisting in 860 women eligible for SEF's microfinance programme (defined as women living in the poorest households of any community); cohort two consisting in 1 835 women and men aged 14 – 35 resident in the same household; and randomly selected community members allocated to cohort three.

Domestic violence was reduced by 55% in cohort one but did not affect the rate of unprotected sex with a non-spousal partner in cohort two. There was also no effect on the rate of unprotected sex at last intercourse with a non-spousal partner or HIV incidence in cohort three.

An unusual feature of IMAGE was its attempt to entrench the intervention beyond the life of the study. The researchers initially employed a linked delivery model, with SEF managing the microfinance component and the Rural Aids and Development Action Research (RADAR) programme of the University of the Witwatersrand managing SFL and community mobilisation. During scale up a parallel delivery model was attempted with SEF managing both components. However, both models were considered unsustainable in the long term (an academic institution not suited to becoming an implementing agency) and finally a third approach was introduced which transformed SFL into an NGO in its own right (Hargreaves et al, 2010).

The Saartjie Baartman Centre for Women and Children

The SBCWC sought to assess the effectiveness of its economic development programme which had chiefly sought to equip women with the sort of skills that would lead to their becoming more employable (Maharaj, 2006). While the project offers no outcome measures and led to very few women becoming employed, as a process evaluation it nonetheless offers some rich insights into the pitfalls and challenges of such endeavours.

An unspecified number of SBCWC staff were interviewed, along with four current on-site economic partners and two ex-partner organisations. While the researcher attempted to contact 57 former shelter residents, only nine could ultimately be traced for interviews. A further nine current residents were interviewed, as were seven non-shelter partner trainees/employees.

A key finding was that economic development programmes were unsuited to women who required emergency or short-term assistance and women needed to be resident in the shelter for at least two months to participate meaningfully in any programme. Conversely, training courses could not be lengthy as women could not afford to attend long-term training without payment. Thus women's short-term need to earn an income mitigated against their being able to participate in training programmes that would have provided them with more marketable skills in the long-term. The very low wages also paid by some of the training organisations led to relationships between SBCWC and the training organisations being severed on the basis that the women were being exploited. SBCWC ultimately needed to employ a full-time person to manage the skills development programme whose impact seems to have been greatly limited (not least because SBCWC staff did not keep records adequate to monitoring and evaluation) (Maharaj, 2006).

Creating safer environments

Urban planners have recognized the importance of designing human settlements in ways that promote their inhabitants' safety. These include providing good street lighting; avoiding the creation of deserted areas or spaces that are not peopled for parts of the day; avoiding the creation of places where women may be easily trapped such as tunnels and alleyways; and designing parks and public spaces that are open to surveillance and do not provide hiding places for attackers. Indeed, a manual commissioned in 2001 by the SAPS Social Crime Prevention Division from the CSIR's Building and Construction Technology programme, even provides a series of guidelines for crime prevention through planning and design (Kruger *et al*, 2001). This would not appear to have been tested. One study was however, identified that sought to explore how the school environment – and toilets specifically – exposed girls to sexual coercion.

The suggestion that school toilets expose girls to violence (Human Rights Watch, 2001) was explored through a pilot intervention in 2006 in the Western Cape (Abrahams, Mathews and Ramela, 2006b). While the toilets did not emerge as sites of sexual coercion, they also did not meet adequate standards of hygiene and potentially exposed learners to faecal and blood pollution. Sexual bullying by male learners and sexual harassment by male teachers in all other parts of the schools was confirmed by the research which, in this instance, was the intervention. Undertaken at three public high schools, two in an urban area and one in a semi-rural locality, with three to four days spent at each site, the study took the form of participatory action research and utilised focus groups, in-depth interviews, mapping and photography. Study participants included girls aged 16 and older, teachers and other relevant personnel (such as caretakers) (*ibid*).

Girls attended a first focus group discussion and were then divided into three groups to map environmental safety at the school. Groups then received disposable cameras and were asked to photograph those areas of the school where they felt unsafe. Cameras were returned at the end of the second day for the film to be developed in preparation for the second focus group on the third day. In this follow-up discussion the maps and photographs were used to develop potential solutions to the problems identified.

Girls at two of the schools subsequently initiated projects tackling sexual coercion. One intervention included the introduction of a balustrade into the tuck shop to separate the

queues of girls from the boys, as well as assistance to the girls and school's management with instituting disciplinary proceedings against a teacher accused of sexual harassment. A second school sought to redesign aspects of the school with girls' safety and toilet placement being key to the new plan. Lack of resources meant that a year later building had still not begun. At the third school where girls' fear of victimisation prevented them from reporting teachers' sexual harassment, programmes disguised as life skills were introduced to provide the girls with assertiveness training and counselling.

This was a cheap and simple intervention that probably succeeded because it was conducted by people outside of the school environment. As the researchers noted, teachers at these schools protected each other (Abrahams, Mathews and Ramela, 2006b). The long-term effect of the intervention was not explored.

Concluding discussion

This chapter has reviewed a heterogeneous array of programmes, which may be situated at a range of levels within an ecological approach, as well as different stages in the public health model. While almost all of the men's prgrammes, as well as the counselling services for women, focus on individual change, Kalichman et al's study, which recruited men known to another, had the potential to also effect change at the inter-personal level. Ekhupoleni's programme for child rape survivors and their caregivers, as well as the SPARC diversion programme also work at the level of the interpersonal. Both IMAGE and One Man Can, which seek to promote community mobilisation, also represent efforts to address community norms. Soul City, IMAGE and Stepping Stones each demonstrate elements of primary prevention but also demonstrated preventive effects. A few programmes also sought to promote change at the structural or environmental level.

Two robust, well-designed studies do indicate that positive behavioural change can be effected – although to varying degrees in different populations. They also suggest that some violence can be prevented whether one takes men or women as the focus of intervention. There is however, a strong suggestion that programmes for women which encourage only individual behavioural change are not effective. The evaluations also point to the need for different interventions for different populations. Adolescent girls are one group highlighted as requiring a somewhat different approach. It is also clear that the circumstance of women in urban shelters do not lend themselves to micro-finance interventions, not least because of the volatility of their living circumstances.

A further observation is that successful training and awareness programmes require considerable investment in the facilitators of those workshops. Stepping Stones facilitators underwent extensive training as did SFL facilitators, who were exposed to four weeks of intensive participatory training and close to 18 months of mentorship by two IMAGE managers. Staff were also drawn from the area and therefore intimately familiar with the local context. The influence of the facilitator on a programme is also implicitly acknowledged in Kalichman et al's quasi-experimental field trial (2009) also refers to weekly supervision meetings to discuss facilitators' adherence to the protocol and the progress of their groups. The importance of the facilitator is also emphasized in FWI. This suggests that successful replication of programmes would depend on similar levels of training and support to

facilitators. It is implicit in these evaluations that facilitator competence is an important variable.

A second question is the extent to which programmes can be adapted without interfering in their effectiveness. The Stepping Stones researchers speculate that the removal of particular components of the programme may have diminished its effectiveness – but this requires testing.

Overall, the evidence for positive change remains slim and generally little is known about programmes currently being implemented by both government and NGOs – although promising programmes can be identified. There appears to be a lack of interest in mental health interventions related to gender and rape in academic circles, which has been noted in South African psychological publications (Kiguwa and Langa, 2011; McLeod and Howell, 2013). This inattentiveness would also appear to extend into the political sphere where 28.6% of politicians' speeches made reference to the relationship between VAW and HIV but only 5.7% referred to the mental health consequences of VAW (Machisa et al, 2010). Evaluation of these programmes is also complicated by poor record-keeping practices as well as the loss of participants to follow-up.

Chapter 4: Institutional Responses to VAW and CSA

This chapter reports on evaluations undertaken of key government departments' responses to VAW and CSA, with most of these studies focusing on the implementation of law and policy in this area. The chapter begins by setting out the legislative and policy framework applicable to each before examining the health sector response. Consideration of the criminal justice system response to rape follows and an examination of the DVA concludes the chapter.

The legislative and policy framework

Sexual offences are embedded within an extensive regulatory framework, tabulated below.

Table 5: policy and legislation guiding the management of reported rape cases

Procedure	Facility/service provider	Relevant policy/documents
Reporting	One-stop centre (TCC, Khuseleka model, GDCS model)	No policy available. TCC blueprint exists and Khuseleka model (DSD) recently established
	Police station with/out VEC	SAPS National Instructions
	Hospital	DoH Directives, DoH sexual assault policy and management guidelines
	School	s54 of the SOA, *Education Laws Amendment Act 53 of 2000* *Code of Conduct of the South African Council of Educators (SACE) 31 of 2000.* *South African Schools Act (SASA) 84 of 1996*
	Other institutions for people with intellectual disabilities, the elderly	*Older Persons Act 13 of 2006* Reporting obligation in terms of SOA applicable to people with intellectual disabilities
Medico-legal examination	Casualty	DoH Directives, DoH sexual assault policy and management guidelines
	Specialised service	TCC Blueprint; DoH Directives, DoH sexual assault policy and management guidelines
	NGO/private sector	No policy
Psycho-social support	Government social worker	*Guidelines for Services to Victims of Sexual Offences* (DSD) *National Policy Guidelines for Victim Empowerment*
	NGO	
Investigation	FCS detectives	SAPS National Instructions
	ICD investigators (when the rape is by a police officer, or in police custody)	IPID Act, 2011
Pre-trial processes and prosecution	Courts	NPA Directives *Director of Public Prosecutions, Transvaal v Minister for Justice and Constitutional Development and Others*, 2009 (4) SA 222 (CC) S v Staggie and Another 2003(1) SACR 232 (C) Sections 153, 158, 170(a) and 227 of the CPA

Sentencing and release	Department of Correctional Services, parole boards	s299A of the Criminal Procedure Act, 1977, read with the Correctional Services Act 111 of 1998

The management of domestic violence is located within a far smaller body of law and policy which includes the 1998 DVA, the 2000 Firearms Control Act, the *Policy framework and strategy for shelters for victims of domestic violence in South Africa* issued in 2003 and the *Guidelines for Domestic Violence*, issued in 2010. Oversight of the police's implementation of the DVA is vested in the Civilian Secretariat for Police (CSP) via the 2012 Civilian Secretariat for Police Act.

The health sector response to VAW

Research has identified different examples of inadequate provision of health services to rape survivors, including:

- lengthy waits for medico-legal examinations;
- delays in the provision of medical treatment;
- lack of privacy and confidentiality during examination and reporting processes;
- inadequate training prejudicial attitudes towards rape survivors;
- the absence of referral systems, as well as counseling services; and
- inadequate record-keeping and documentation (Suffla et al, 2001; Christofides et al, 2006).

A range of policy interventions have been introduced in an attempt to address some of these challenges, the more significant being:

- the Cabinet decision in 2002 to provide anti-retroviral drugs to rape survivors to prevent HIV infection;
- the enactment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act number 32 of 2007 (SOA) ; and
- the Department of Health's 2005 *National Management Guidelines for Sexual Assault Care* and the *National Sexual Assault Policy*. (These may well have been updated in line with the 2007 SOA but copies of a revised policy could not be located).

A cross-sectional survey of 124 health providers in 31 hospitals distributed across all nine provinces sought to determine where the best health services to rape survivors were provided, who provided them, what providers' attitudes were towards rape survivors and what challenges might exist in providing care to rape survivors (Christofides et al, 2005a). A third of those interviewed (32.6%) did not consider rape to be a serious condition, while only 30.3% had been trained in providing care to rape survivors. Most regional hospitals (76.9%) had a private room designated for rape survivors. Factors associated with better quality of care included the practitioner being older than 40 years, having examined a higher number of rape survivors in the past, working in a clinical management facility that had a protocal guiding care of rape survivors, having worked for less time in the facility and perceiving rape to be a serious medical problem.

Quality of care depends also on the practical training provided to health care workers. The limited availability of doctors generally, some of whom also feel ill-equpped to manage rape

survivors (Nkabinde et al, 2013), has led to experimentation with nurse-driven programmes largely in relation to the provision of post-exposure prophylaxis (PEP) to prevent HIV-infection (eg. Kim et al, 2009; Roland et al, 2011).

Provision of post-exposure prophylaxis

Adherence to PEP to prevent HIV-infection after rape is uneven (Draughon and Sheridan, 2011) and South African studies have reported anything from 0% to over 90% (Vetten and Haffejee, 2005), 57% (Carries et al, 2007), 66% (Roland et al, 2011) and between 31.9% to 38.2% in another study (Abrahams et al, 2010). One study examining the provision of PEP for children in KwaZulu-Natal found that only 35.4% of 120 children eligible for PEP returned to the hospital after their initial visit for the full 28-day course of medication (Collings, Bugwandeen and Wiles, 2008).

Given that non-adherence may result in HIV-infection, a number of studies have investigated how adherence rates may be improved. This section reports on six programmes either examining barriers to PEP completion, or interventions designed to support rape survivors to complete a regimen of PEP (Vetten and Haffejee, 2005; Abrahams and Jewkes, 2010; Abrahams et al, 2010; Roland et al, 2011; Arend et al, 2013). A systematic review of such programmes in sub-Saharan Africa (Draughon and Sheridan, 2011) draws extensively on these South African studies so is not reported on extensively.

In 2004 the Gauteng Department of Health initiated what is perhaps the first South African study into PEP adherence (Vetten and Haffejee, 2005). This was a mixed methods study that included 104 interviews with health workers and rape survivors, 26 semi-structured observations at six sites and record reviews. Patients in this study defaulted due to side effects, forgetting to take their medication and not taking their medication properly. Almost all rape survivors reported side effects, some of which were debilitating and did not improve. While all health workers knew that the drugs caused side effects, the interviews found that few knew how to treat such side effects adequately. Patients were also not telling nurses about side effects, who in turn were not asking. The five to ten minutes that health workers spent with rape survivors collecting their repeats was not sufficient to enquire about patients' well-being (*ibid*).

The other key finding affecting adherence was rape survivors' lack of understanding of the drug regimen. Three reasons for this lack of understanding were suggested by the study: some health workers were unfamiliar with the drugs so it is possible that they provided patients with either inaccurate or insufficient information. Secondly, while other staff may be sufficiently knowledgeable, by their own admission, they did not spend sufficient time explaining PEP to patients. Finally, some patients were in no condition to absorb all this information in the immediate aftermath of the rape. Factors influencing adherence appeared to be dependent upon the skill, knowledge and attitudes of health facility staff, individual characteristics of the rape survivor, and the nature of support they receive in their immediate environment (*ibid*).

The Gender, Health and Justice Research Unit (GHJRU) undertook a mixed methods study to establish what, if any structural barriers rape survivors experienced in accessing health services, including PEP (Rohrs, 2011). This study covered five provinces (one of which was

Gauteng) and included interviews with police officials, health care workers and rape survivors. Data from rape survivors were gathered by NGOs. A telephonic survey conducted among different health facilities tested the quality and accessibility of information on PEP.

Several critical barriers to PEP were identified. One quarter of calls to health facilities went unanswered while health workers who did answer the phone provided inconsistent and variable information. Only 10% of the 39 rape survivors in the sample were informed about PEP by the police, who knew little about the actual treatment regimen itself. The time they spent on taking statements from rape survivors also delayed access to the medication, as did long waits in casualty. Interviews with health care workers suggested that time constraints affected the amount of information health workers could provide rape survivors, including around adherence. Lack of follow-up procedures and limited provision to rape survivors of medication to address the side effects of PEP, were also identified as barriers. Some health care workers and police officials remained suspicious of rape survivors and some health care workers even wanted to "check" whether the rape really happened before making PEP available (Rohrs, 2011).

Abrahams and Jewkes' (2010) in-depth interviews with 29 rape survivors confirm that taking PEP is a complex experience for rape survivors and note further psychological barriers to PEP completion, the stigma attached to rape, as well as HIV, being particularly powerful. Being blamed for the rape and receiving inadequate social support inhibited women's ability to comply with the drug regimen. Abrahams et al (2010) subsequently attempted a RCT to examine the impact of telephonic psycho-social support on adherence to PEP.

Two sites were chosen, one in the Eastern Cape and the other in the Western Cape and 279 rape survivors enrolled in the two arms. The intervention arm received an information leaflet and adherence diary and were provided with telephonic support by a counsellor over the 28 days. The control arm received the leaflet. While there was more adherence by the intervention arm (38.2% vs 31.9%), this was not statistically significant. Overall, adherence was greater among those who read the leaflet and used the medication diary.

A second study in the Western Cape also sought to improve adherence rates through the development of a proactive, nurse-driven follow-up system (Roland et al, 2012). The study was not randomised and followed 131 rape survivors 14 years and older over 6 months. While nurses did not provide formal adherence counselling, they were encouraged to discuss adherence strategies with study participants. Follow up visits were offered at the rape treatment centre, a research office in Cape Town, a primary care health centre in a neighbouring township, or at home. At 74%, adherence rates were high and even more survivors may have completed the course, taking into account the 14% who were lost to follow up but who had received the full 28-day course. Study authors note that substantial resources were required to achieve high follow up and high adherence rates.

An accompanying, qualitative process evaluation of the intervention (Arend et al, 2013), consisting in 10 semi-structured interviews with study participants suggests that the intensity of the nurses' follow up and the relationships engendered between nurse and rape survivor may have played an important role in supporting adherence.

The quality of health care provider interactions with patients emerges again in a discrete choice analysis study with 319 participants, 152 drawn from Cape Town and 163 from Thohoyandou. This study sought to describe aspects of post-rape health care that would most influence women's choice of service, as well as the trade-offs they would be prepared to make between different services. The study sought also to compare the views of survivors who had used post-rape services, with those of community women who may use health services in future, or who had experienced barriers to use of health facilities (Christofides et al, 2005; Christofides et al, 2006). Analysis indicated that the availability of PEP and a sensitive healthcare provider who could provide counselling were more important to women than the travel time that might be required to access such a service.

The Refentse project

The Refentse project was based at Tintswalo Hospital and the Acornhoek SAPS in the Bushbuckridge municipality of Mpumalanga. First instituted in March 2003 by RADAR, in collaboration with the Population Council, it was intended to ensure rape survivors' access to healthcare. Refentse initially set out to determine the feasibility, effectiveness and cost of implementing a nurse-driven, integrated post-rape care programme (including HIV post-exposure prophylaxis (PEP), within rural, public sector health services (Kim et al., 2009).

Phase 1 comprised a pre/post-intervention study that utilised both quantitative and qualitative methods of research including chart reviews and interviews with rape survivors, a range of healthcare workers, police and other service providers. The baseline findings uncovered systemic problems in the delivery of post-rape care and a five-part intervention was implemented at the study site in March 2004 to address these challenges. This comprised:

- establishing a sexual violence Project Advisory Committee comprising RADAR, OPD nursing management, the police, social workers, HIV services, doctors and the pharmacist and psychiatric nurse;
- instituting a hospital rape management policy;
- running training workshops for healthcare workers and other providers;
- centralising and coordinating post-rape care through a designated OPD room; and
- running community awareness campaigns through community radio and morning health talks to patients waiting in the OPD queue, as well as at the surrounding primary health care clinics.

Following the implementation of this intervention between March 2004 and August 2006, a number of improvements were noted.

Uptake and efficiency of services: Utilisation of services increased in the post-intervention phase, with the mean number of rape cases presenting to hospital increasing from 7.8 to 12.9 cases per month. In addition, interviews with patients suggested that the service had become more private and streamlined, necessitating fewer interactions with service providers. Those who reported having to see six or more service providers on their first visit decreased from 85.7% to 54.0%.

Clinical post-rape management: Both the chart review and patient interviews suggested substantial improvements across all domains measured, including the quality of history and

forensic examination and the provision of pregnancy testing, EC, STI treatment, VCT and PEP, as well as follow-up counselling and referrals. Those in the post-intervention group were three times more likely to have been given a pregnancy test, while the prescription of EC increased from 65.1% to 72.5%. Syndromic treatment of STIs also increased from 87.5% to 91.5% and those in the post-intervention group were four times more likely to have received any VCT following the assault, and three times more likely to have received it during their initial visit.

Provision of PEP: Significant improvements were also seen in provision of PEP, and those in the post-intervention group were five times more likely to have received any PEP – whether a starter pack or full 28 day course - following the assault. Whereas prior to the intervention only 15.1% had been given the full 28-day course on the first visit, this increased to 55.1% in the follow-up period. These changes in provider practice appear to have impacted positively on PEP adherence, as reported by patients. Following the intervention, patients were more likely to report having received PEP, to have received a full 28-day course on their first visit, and to have completed the full 28-day regimen. In addition, there was a reduction in the mean time interval (27.8 hours to 18.1 hours) between the assault and receiving the first dose of PEP.

An expanded role for nurses: This study showed that it is possible to substantially expand the role of nurses in the management of sexual assault. Prior to the intervention, most care was delivered by the doctor, with the nurse's role confined primarily to obtaining the medical chart, taking vital signs, and waiting to assist the doctor. Following the intervention, this role was expanded to include documenting the rape history, providing acute trauma debriefing, providing a stat dose of PEP, taking a pregnancy test, dispensing the treatment package (STI medications, EC and PEP), providing medication counselling, and making follow-up referrals.

However, while the RADAR nurse eventually gained the confidence and skill to conduct forensic examinations, she was unable to transfer these skills to other nurses in OPD. Indeed, a disappointing finding from the study was the lack of impact on training nurses capable and willing to perform the forensic examination. In general, nurses were reluctant to learn about this aspect of post-rape management and intimidated by the long time required to conduct the exam. Moreover, many felt there was a lack of clarity in current government policies that would allow nurses to present evidence in court, should they be called to testify. It is also possible that the intensity of training required to develop proficiency and confidence in this area was under-estimated.

Screening and other health services to women experiencing domestic violence

Along with their family and friends and the police, the health sector is one the most common ports of call for South African women seeking help after an incident of violence, with data from a non-random survey of 1 000 women indicating that approximately 42% of the women in the sample approached health care workers for assistance (Rasool et al., 2002). This proportion is considerably higher than those who sought legal assistance (11%) (*ibid*). This factor, taken in conjunction with the significant harm domestic violence causes to women's health, has prompted health practitioners to consider how best to integrate domestic

violence services into the health sector. South Africa is no exception and, to a limited extent, does address domestic violence in some health policy.

The *Primary Health Care Package for South Africa* of 2000 recommended the counselling and referral of survivors of domestic violence (Department of Health, 2000). In 2010 the need for a health sector response was also taken up by the Portfolio Committee of Women, Children and People with Disabilities following their public hearings around domestic violence in 2009. Domestic violence has also attained recognition of sorts within the two National Strategic Plans (NSP) of 2007-2011 and 2012-2016 for dealing with HIV and AIDS. While the first Plan did not address the health dimensions of domestic violence (only recommending that adequate resourcing be made available to effect the provisions of the DVA [South African National AIDS Council 2006: 120]), the second Plan recommended that health workers screen women for experiences of domestic violence (South African National AIDS Council, 2011). This section presents evidence from one systematic review (Taft et al, 2013), a review of health sector responses to intimate partner violence in middle and low-income settings (Colombini, Mayhew and Watts, 2008) and five articles evaluating health sector interventions in South Africa (Joyner and Mash, 2012; Joyner and Mash, 2011; Vetten et al, 2009; Joyner et al, 2007; Kim and Motsei, 2002).

Much of the debate around screening has focused on its value, impact and utility (eg Spangaro, Zwi and Poulos, 2009) and one systematic review of 11 trials, four in Canada, five in the USA and one each in Japan and New Zealand, has explored the effect of screening for domestic violence (Taft et al, 2013). The authors found that while screening increased identification of abused women, it did not increase the referral of women to support services, nor did it significantly reduce abuse. Screening did not appear to cause harm to women however. The number of studies examining each of these questions is too small to provide sufficient evidence for or against screening, leading the authors to conclude that universal screening (ie asking every female patient if they have experienced abuse) is currently not justified (Taft et al, 2013).

This recommendation does not imply that the health sector has no role whatsoever to play in addressing domestic violence and less attention has been devoted to identifying the most important entry points from which to address domestic violence in health settings, as well as what is feasible in terms of integrating responses to violence within the health sector in middle and low-income settings (Colombini, Mayhew and Watts, 2008). Review of nine programmes from middle and low-income countries (including one African country, Kenya) found these to be located at primary level, as well as secondary and tertiary levels and based within reproductive health, emergency and mental health services (*ibid*). Three different forms of integration were observed:

- selective integration of one or two service components (such as counselling) within a vertical programme (eg family planning). No external referrals are provided;
- Comprehensive integration, referring to the siting of a range of services (health, legal, welfare and counselling) in one setting. The TCCs, which have recently extended their services to encompass domestic violence (although to what extent is unknown), are a local example of comprehensive integration; and
- Systems-level integration, or multi-site linkage, where a range of services is provided, although not all at the same site. Formal systems of referral exist between the health facility and external service providers such as NGOs (*ibid*: 636-638).

While these interventions had not been systematically evaluated, strengths and limitations could nonetheless be observed. At the level of the individual these ranged from individual service providers' attitudes to and knowledge of domestic violence, to managerial and health systems challenges – such as insufficient staff training, coupled with inattention to domestic violence in national medical curricula, as well as the absence of clear policies on domestic violence. Co-ordination between actors, departments and agencies (even when located within the same setting) was not always effective either (Colombini, Mayhew and Watts, 2008).

Small-scale South African studies highlight similar concerns. First, domestic violence is not routinely recognised when patients present in health settings, even in the context of injury (Vetten et al, 2009; Joyner et al, 2007; Joyner and Mash, 2012). Both Kim and Motsei (2002) and Joyner and Mash (2012) also highlight how nurses' personal experience of domestic violence may act as a barrier to their engaging with patients about domestic violence. Training around domestic violence, both at tertiary education level, as well as in the workplace, is limited (Kim and Motsei, 2002; Joyner et al, 2007), while health practitioners' frustration around their inability to 'fix' women's circumstances, or women's perceived unwillingness to act on health workers' advice (Joyner et al, 2007; Joyner and Mash, 2012) also diminished health workers' interest in interventions addressing domestic violence. High workloads (Joyner and Mash, 2012) and poor referral systems (Vetten et al, 2009; Joyner et al 2007) also reduced the effectiveness of health sector responses.

One evaluation of a project implementing both a screening protocol and individualised care plan in the Western Cape was identified for this synthesis (Joyner and Mash, 2011). Over an eight week period primary care providers at two urban and three rural primary care facilities, screened adult women for a history of domestic violence within the previous 24 months, testing a screening protocol developed by the Cape Town-based Consortium on Violence Against Women (Martin and Jacobs, 2003). Where abuse was identified women were referred to the study nurse for assistance as set out in the study protocol. This included taking a systematic history of the abuse, as well as a comprehensive medico-legal history including previous tests for HIV and other STIs, pregnancy and previous attempts to seek assistance from the legal system. Mental health was assessed and where difficulties were suspected, patients referred to a psychiatric nurse for full assessment. Finally, women's safety was assessed and women requiring protection referred to other agencies (Joyner and Mash, 2011).

One month later researchers interviewed the women to ascertain their adherence to the care plan and their view on the intervention. 168 women were assisted, with 124 (73.8%) returning for follow up. Over 75% perceived all aspects of the care plan to be helpful, with self-reported adherence to its recommendations ranging from 40% testing for syphilis and 48.3% consulting a psychiatric nurse, to 100% obtaining a protection order. While the majority of women perceived the intervention to have made a difference to their lives (9% reporting they had ended the relationship and 45% that the relationship had improved), 31% reported no real change. The study authors suggest that two characteristics of the intervention appeared particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment, which included clinical, psychological, social, advocacy and legal components. Because follow-up was limited to one month only, it is

unknown how sustainable these initial changes were as well as whether or not further changes occurred (*ibid*).

On the strength of the evaluation the Department of Health had undertaken to pilot the intervention in the Western Cape. The current status of the pilot is unknown.

The processing of rape cases by the criminal justice system

Tracking Justice: The attrition of rape cases through the criminal justice system in Gauteng documents the progress of 2 068 rape cases reported to 70 police stations in Gauteng during 2003. A two stage sampling procedure was used in order to draw a random sample of all 11 926 cases reported in that year (Vetten et al, 2008). The study found that a sizeable proportion of victims (37%) opted out of criminal justice system processes, with two-thirds (67.2%) doing so during the course of the police investigation. Overall, 14% of victims withdrew their cases for various reasons while over one in five victims (22.9%) became untraceable. In some instances the loss of victims to the criminal justice system was attributable to poor administrative practices, such as failing to properly record victims' contact details (*ibid*).

The Gauteng study also pointed to weaknesses in the collection of medico-legal evidence. Sexual Assault Evidence Collection Kits (SAECK) were not completed as often as they should have been, particularly in matters involving girls younger than 12. All completed SAECKs were not sent to the police's forensic laboratory for analysis either. Worryingly, a report from the laboratory containing the results of DNA testing was available in 2% of dockets. This is partly explained by the fact that the suspect's blood was taken in only 8.2% of the 2 068 cases in the study (*ibid*).

Trials commenced in fewer than one in five (17.3%) of the reported rape cases analysed for the Gauteng study. A conviction for any crime resulted in just over 1 in 20 (6.2%) cases. However, some of these convictions were for lesser charges so overall only 4.1% of cases reported as rape resulted in convictions for rape. Adult women fared worst at the hands of the criminal justice system relative to girls and teenagers. Less than half of their cases (46.8%) resulted in arrests, with a trial commencing in about one in seven (14.7%) matters. By contrast one in five girls and teenagers' cases resulted in a trial. Those who raped young girls were twice as likely to be convicted (10.1%) as those who perpetrated their crimes against adults (4.7%).

The research also examined the association between documented injuries, DNA and case progression (Jewkes et al, 2009). While the presence of injuries, severe or otherwise, made no difference to the likelihood of a suspect being arrested, cases involving children were twice as likely to go to trial if there was a genital injury with a skin or mucosal tear. Injuries in adults made no difference to case progression at this stage. Among cases going to trial, a conviction for a sexual offence in adults was three times more likely if there was a bodily injury and more than four times more likely if there was a genital injury. Injuries made no difference to the likelihood of convictions in children's cases.

The availability of a report on DNA made no difference to the likelihood of conviction. However, DNA reports were available in very few cases. This was because kits were very infrequently analysed and the suspect's blood rarely taken for comparison against any DNA identified by the laboratory. The dockets indicated blood samples to have been taken from the suspect in only 16.4% of cases for which information was available. A DNA report was only available for 10 adults and there was a conviction in 3 of these cases. A report was available for 12 children's cases, with convictions resulting in 2 of these cases. The DNA report more often led to an acquittal than a conviction. In five adult and five child cases the STR profile did not match the suspect's profile, a circumstance which should obviously result in an acquittal. However, in one adult and three children's cases where the STR profile matched, the accused were still acquitted.

The Domestic Violence Act

No nationally representative study has been conducted as yet into the use and implementation of the DVA. For this reason it could be argued that developing national interventions and recommendations around the Act might be an unreliable process, given the incomplete picture we have of the Act. However, when added together, these various studies do begin to provide the outlines of such a national picture – particularly in relation to what is common across all studies, as well as what is unique. Therefore, for the purposes of creating this national picture, this review focuses only on reports presenting original research around the DVA and which also, therefore, make the DVA their exclusive focus. While other articles have been written on the DVA these have been excluded because they do not provide empirical information around the DVA's workings.

Since coming into effect in 1999, the Act has been the subject of fourteen published studies, the great majority (10) of which was published after 2004. The focus of these studies may be clustered within five broad themes:

- An examination of the resourcing of the DVA;
- The application, in practice, of the DVA's provisions;
- Women's perceptions of the DVA's efficacy;
- The perceptions of those tasked with implementing the DVA; and
- Comparing women and men's use of the DVA.

Use and perceptions of the DVA

Women constitute the great majority of PO applicants. Men made up 17.5% of applicants in a Mpumalanga study (Vetten *et al*, 2009), 14.8% of applicants at Alberton court and 22.1% of applicants at Temba Court (Schneider and Vetten, 2006). By contrast, in the Western Cape, male applicants filed 27% and 29.5% of all applications at the Paarl and Bellville courts respectively (Mathews and Abrahams, 2001). Further, applicants predominantly seek protection from their intimate partners, rather than other family members (Vetten *et al*., 2009; Schneider and Vetten, 2006). However, the ratio of intimate partner to family member applications varies across courts. The ratio of intimate partner to family member applications also differs along gender lines. More than two-thirds of women in other studies have sought protection from their intimate male partners in comparison to just over half of men (Vetten, et al., 2009; Schneider and Vetten, 2006). Unlike women men are as likely to seek protection from a family member as an intimate partner.

All other studies have also found those who seek protection from their intimate partners to be in their thirties (Mathews and Abrahams, 2001; Parenzee *et al*, 2001; Schneider and Vetten, 2006; Vetten *et al*, 2009). At 45.7 years, the Mpumalanga study also found those who sought protection from their family members to be older than intimate partner applicants (Vetten *et al*, 2009).

Applicants estranged or divorced from their former intimate partners comprise varying proportions of all applications. The proportion of former partners cited by the various studies ranged from 10.8% (Mathews and Abrahams, 2001) to 36.9% (Vetten *et al*, 2009).

References to weapons ranged from 37.2% to 48.0% of all applications (Parenzee *et al*, 2001; Schneider and Vetten, 2006; Vetten *et al*., 2009). Weapons cited in applications included knives and other sharp instruments, blunt instruments and guns. Other studies have also found that when applicants report being abused, they also report the abuse of others in addition to themselves. Reference to the abuse of others was been found in other applications, ranging from 48.8% (Vetten et al., 2009) to 69.4% of applications (Mathews and Abrahams, 2001).

Children also featured prominently in studies examining the implementation of the DVA, with predominantly-adult children most likely to be cited as respondents in the context of intra-familial abuse (Vetten *et al*, 2009). Children have also been the group most likely to be identified as being abused in addition to applicants (Schneider and Vetten, 2006; Mathews and Abrahams, 2001; Vetten *et al*, 2009). Children are a shadow presence in domestic violence. It is clear in this study, as well as others, that at the least, children are affected by their mothers' abuse – if not recipients of abuse themselves. However, children very rarely feature in interventions addressing domestic violence, while mothers are very rarely considered in interventions addressing child abuse (Nagia-Luddy and Mathews, 2011).

Some research is available exploring the role of the Act in addressing domestic violence. Twenty-three out of the 41 women interviewed for an eThekwini study said their abusers were surprised that the victims had actually obtained a protection order (PO). Following this initial surprise, some of the abusers chose to completely ignore the order while others left the home. Some women therefore felt empowered by their actions, while other women were frustrated by the lack of security that the protection order gave them. Other women indicated that the PO did have a significant effect on reducing or even stopping the abuse. In many of these cases, women indicated that their abusers had offered honest apologies for their conduct. Other women who received apologies felt that these were dishonest or manipulative (Meyer *et al*., 2006)

Some husbands were angered by the PO on the basis that it indicated disrespect or disregard for them on their wives' part. Those men who remained angry increased the intensity and frequency of the abuse. Ten out of the forty-one women indicated that their abusers had continued with the abuse and even torn up the copy of the protection order. The small but significant minority who did not feel that the PO improved their lives, indicated that abuse had continued, that their respondents had little regard or respect for the order and that police officers did not adequately enforce the order (*ibid*). Overall, a quarter of the 41 women felt that the protection order had not made a significant difference in their lives. The majority, after six months, felt that the protection order had increased their personal security,

and increased the respect of their abusers with some respondents even expressing remorse (*ibid*).

An angry response on the part of the abuser was also recorded by Matthews and Abrahams in their 23 interviews (2001). Women described their intimate partners as being 'furious' and 'angry' when they received the interim protection order. Women also reported continued verbal and psychological abuse and overt actions by the abuser to make the women feel guilty about applying for an interim protection order. One woman described that the respondent stopped the abuse when the IPO was served but continued when the applicant did not go to report to finalise. Only a few women described a change in their partner and reported that the abuse stopped.

In Artz's study (2006), more than a third of the 365 victims reported that the abuse had actually stopped after applying for a protection order, regardless of whether the order was served on the respondent or signed by the respondent. On receipt of the order, one in five women reported that the respondent 'promised' to stop the abuse, while 10% of women indicated that the respondent had begged and pleaded for the applicant not to go back and finalise the order. Family members also either attempted to mediate or dissuade the applicant from returning. More worryingly, 18% of the applicants in this study were threatened by the respondent if they returned to court and 10% indicated that the abuse had gotten worse. Applicants reported being gang-raped, having stones thrown at their windows or being locked and restrained in their homes by the abuser or other family members. Threats involved being beaten, stabbed, burnt to death in their sleep and being shot with a firearm (*ibid*).

The courts were not always helpful to women seeking to obtain their final PO either. In 16% of cases, applicants reported having to go to court three or four times, in addition to phoning the courts, to establish the outcome of their applications for interim POs. Nine per cent of the women eventually gave up trying to get their interim POs and therefore, did not return to court on the return date. Without the interim PO, they would not have been aware of the return date (*ibid*).

Vogt's study (2006) finds that the IPO did not contribute significantly to reducing women's exposure to abuse. However, the IPO did contribute significantly to a reduction in health issues for women experiencing physical abuse. On a psychological level, women reported a reduction in 'concern with physical harm', 'psychological dysfunction' and life restriction. In comparison to those women who did not apply for a protection order, those who did apply had a higher general well-being. Finally 20.5% of applicants did not receive their IPO because it was not delivered or there was no return of service.

Evaluating the implementation of the DVA: the police

A range of implementation evaluations have been conducted of the DVA, not least because the Act specifically mandates monitoring of the police's compliance with its prescripts. This duty first fell to the Independent Complaints Directorate (ICD) but as of 2012 shifted to the Civilian Secretariat of Police (CSP).

The DVA imposes two sets of duties upon the police: one being administrative and relating to the proper keeping of records[7], and the other dealing with the provision of various policing services to victims of domestic violence. In addition, the National Commissioner of the SAPS is obliged to submit to parliament six-monthly reports outlining complaints against police officers, the disciplinary proceedings instituted against those officers, as well as the police's response to recommendations made by the ICD. None of these obligations is well-adhered to by the police. Table 6 sets out the percentage of stations visited by the ICD between 2006 and 2009 which fully complied with the record-keeping obligations demanded by the DVA and National Instructions. As the table shows, the majority of stations did not meet the necessary standard (Vetten et al, 2010) – a state of affairs also noted by the Auditor-General in his 2009 report to parliament (Auditor-General South Africa, 2009).

Table 6: Percentage of stations visited between 2006 and 2009 which were fully compliant with their statutory obligations

No. stations visited	Period	% stations fully compliant with the DVA
245 stations visited for the year[8]	Jan – June 2006	2%
	Jul – Dec 2006	30%
395 stations visited for the year	Jan – June 2007	57%
	Jul – Dec 2007	28%
434 stations visited for the year	Jan – June 2008	14%
	Jul – Dec 2008	13%
522 stations visited for the year[9]	Jan – June 2009	11%
	July – Dec 2009	8%

The police's record of co-operation with the ICD regarding complaints levelled against them is mediocre. An analysis of ICD reports for 2001 to 2008 collated 1 121 complaints made against the police, with the most common being the failure to arrest the abuser (52.5% of all complaints). Other complaints included the failure to open criminal cases (14.5%); and the failure to assist survivors of domestic violence to find suitable shelter; obtain medical treatment; escort the victim to collect their personal property; and seize any dangerous weapons from the abuser (12.3%). The ICD recommended disciplinary action in 928 (or 82.8%) of the 1 121 complaints referred to them. However, the police instituted disciplinary proceedings in a scant 48 (5.1%) of these cases. In more than two-thirds of cases (68.2%),

[7] These include the 508(a) forms and 508(b) registers; the DVA and National Instructions; a list of service providers; the DVA Register; and copies of protection orders, as well as files containing the warrants of arrest.
[8] All data for the years 2006 to 2008 cited in Vetten et al, 2010.
[9] Calculations based on data presented by the ICD to the Women Youth Children and People with Disabilities PC (PMG, 16 November 2010).

the police provided either very little or no response to the ICD regarding these disciplinary hearings (Vetten et al, 2010).

On 1 April 2012 the ICD became the Independent Police Investigative Directorate (IPID) and the monitoring role formerly performed by the ICD was transferred to the CSP and the provincial secretariats for safety and security are now responsible for some of the monitoring previously performed by the ICD. The functions of the CSP in relation to domestic violence specifically are set out in sections 6(c) and (d) and comprise monitoring and evaluation of the police's compliance with the Act, as well as making recommendations to the police regarding disciplinary procedures and measures to be adopted in cases of non-compliance. While the ICD was empowered to receive complaints of non-compliance, the legislation governing the CSP is silent on this.

Following the transfer of oversight of the DVA from the ICD to the CSP, the number of complaints dropped precipitously. During the first six months of its new role (April to September 2012) the CSP received seven complaints from three provinces only and an eighth was made to CSP itself (CSP 2012: 20-21). In its second biannual report for the period 1 October 2012 to 31 March 2013, complaints once again emanated from three provinces only. In its first year the CSP thus received 22 complaints from three provinces, a 77% decline in the number (94) recorded by the ICD in its final 12 month reporting period.

Evaluating the implementation of the DVA: the courts

Studies identify a range of administrative and procedural problems dogging the court's implementation of the DVA.

- Inadequate and incomplete recordkeeping has been found at the Johannesburg family court (Naidoo, 2006), three courts studied in Mpumalanga courts (Vetten *et al*, 2009), as well as a number of Western Cape courts (Mathews and Abrahams, 2001; Parenzee *et al*, 2001).
- Problems relating to the return of service have also been identified by a number of studies (Vetten *et al*., 2009; Vogt, 2006; Artz, 2006; Vetten, Budlender and Schneider, 2005; Parenzee *et al*., 2001)
- At the majority of courts the percentage of interim POs made final is less than 50%. Only three courts have finalized more than half of POs (Mathews and Abrahams, 2001, Parenzee *et al*, 2001; Schneider and Vetten, 2006; Vetten et al., 2009).

Table 7: Number of protection orders granted from 2009 – 2011

Year	New Interim PO Application	PO Final	Warrants of Arrest for Breach
2009	226 402 (average of 18 886 per month)	79 098 (average of 6591 per month)	15 359
2010	224 486 (average of 18 707 per month)	80 714 (average of 6726 per month)	19 426
2011	217 987 (average of 18 165 per month)	87 711 (average of 7309 per month)	31 397
Total	668 875	247 523	66 182

As Table 7 shows, while many South Africans are turning to the courts for protection from domestic violence, less than half of those who apply for protection orders ultimately qualify. Admittedly there may be some applicants whose circumstances do not warrant protection orders, just as there are those who, for personal reasons, choose not to return to court (perhaps because they have reconciled with the abusive party, had a change of heart, or been intimidated). But this is not the whole picture. Two studies, one of three courts (Vetten et al, 2009) and the other of nine courts (Vetten, van Jaarsveld and Riba, 2009), have investigated factors influencing the finalisation of protection orders. These include:

- the court where the application was made;
- whether or not the interim order had been served;
- the presence of the applicant at court;
- whether or not the applicant was a victim of intimate partner violence or intra-familial abuse. The latter group was less likely to return.

These findings suggest that institutional barriers are playing a role in preventing women from obtaining the law's protection. The fact that some courts are less likely to finalise protection orders may indicate prejudice on the part of some magistrates towards applicants, or that the procedures followed by particular courts – especially in relation to serving the interim protection orders – work in such a way as to exclude applicants from court proceedings. Addressing these barriers is crucial for the law can save women's lives, as the example of firearms control shows.

The legal system's response to intimate femicide

Firearms play a significant role in the perpetration of domestic violence, including its most lethal form, intimate femicide. Cognisant of this risk, legislators sought to cross-reference the 2000 Firearms Control Act with the DVA to provide additional protection to victims of such violence. This legislative intervention would appear to have had some effect. In 1999 the rate of gunshot homicides in intimate femicide was 2.7 per 100 000 but by 2009 this had decreased to 1.0 per 100 000, a finding the researchers directly attribute to the introduction of the FCA (Abrahams et al, 2013).

There was however, no change in the conviction rate for intimate femicide between 1999 and 2009, while the conviction rate for non-intimate femicides decreased in the decade between these two years. The 1999 study had found an increased likelihood of conviction in cases of intimate femicide where a history of domestic violence formed part of trial proceedings (Abrahams et al, 2011). However, police attempts to identify a prior history of domestic violence did not alter between 1999 and 2009 There was also no change in the identification of prior domestic violence (Abrahams et al, 2013).

Concluding discussion

This review finds considerable effort to have been put into improving health services for survivors of VAW and that these interventions have demonstrated some success, especially when led by nurses. However, the absence of clear policy directives around a health sector response to domestic violence makes these initiatives difficult to embed within health facilities. It is also suggested that these nurse-driven initiatives require additional resourcing on a range of levels to succeed. Because most of these additional resources provided for these studies have come from outside the public health sector, it does raise questions

around the extent to which they can simply be incorporated into existing health facilities and programmes.

Legislation can also have a preventive impact, as the example of the Firearms Control Act shows. However, the uneven implementation of law and policy applicable to sexual offences and domestic violence makes it difficult to assess the impact of these laws. Indeed, research with women finds that the DVA does not always succeed in its aim of preventing further violence. Instead, its effect is mixed, sometimes worsening the abuse and sometimes preventing the abuse. However, it is suggested that just the act of applying for the DVA can sometimes be beneficial by increasing women's sense of agency and control over their lives. This must be contrasted with the risks women face in obtaining POs. Not only do abusive partners respond badly to POs, but so do family members who are also implicated in pressurising women to discontinue the PO process. Research examining which groups of abusers are deterred by a PO, and which not, would be helpful in this regard.
Finally, many recommendations have emerged from these studies suggesting how implementation of legislation could be improved. They would not appear to have been acted on however.

Chapter 5: Conclusions and Key Recommendations

As this synthesis has shown, a number of different sorts of evaluations of variable quality have been undertaken in South Africa. While some may be categorised as outcome evaluations, others are better categorized as process evaluations. Some point to the possibility of change while others highlight the barriers that impede or stall changes in more desired directions. Evaluations have also covered an enormous range of ground but without a body of knowledge necessarily coalescing around any one particular question – with notable exceptions. These include adherence to PEP and the implementation of the DVA.

This synthesis also points to the extent to which South Africa's HIV epidemic has significantly shaped the country's programming and research agenda, including in relation to VAW. This is evident in the significant number of studies examining adherence to PEP, as well as studies evaluating programmes for men (which almost always also include an HIV component). Both the Stepping Stones and IMAGE programmes also aimed to address HIV risk behavior in addition to VAW. This focus ensures both the dominance of a health agenda in addressing VAW, as well as a significant gap between research and practice. One consequence of this gap is that the academic peer-reviewed research seldom impacts upon programming, while that which currently exists and is being practiced is seldom subjected to robust evaluation. This points to the existence of disciplinary silos, as well as silos between academics and practitioners.

Thus there is little to suggest that the stronger studies identified in this synthesis have been taken up to any significant degree, bar IMAGE – which required the creation of a new organisation. This raises the question of the extent to which programmes subjected to RCTs can be taken up on a large scale anyway. Because they are tested under stringent conditions which do not match day to day messiness, what they would accomplish under actual conditions of operation is open to debate.

Very few evaluations consider those conditions necessary to the successful implementation of programmes – the FWI evaluation being something of an exception in this regard. This raises questions around the extent to which programmes can simply be lifted and transposed onto different settings by practitioners.

Further, what room is there for deviation from programmes? The Stepping Stones initiative for instance, did not implement the original programme in its entirety and the researchers suggest that this may have contributed to its mixed effect. This points to at least three choices needing to be made around repeating the programme: test and re-evaluate the full programme before implementing it more widely; implement the full programme without testing its effect; or implement the pared-down version which was evaluated.

While there is limited evidence of the uptake of research, there is also limited evidence for the efficacy of existing practice. The range of counselling and support services offered outside of health facilities for example, have largely been overlooked in the local academic community but studied instead by practitioners or consultancies. On the whole, because both state and organisations' evaluations of services are not generally well-designed they provide information of low validity. Where models are described, it is in terms of their constituent parts alone – what the programme does – and discussion of the theory informing the practice is absent, ensuring that how the programme works is seldom explored. Almost

no evaluations include any form of comparison with those not served by programmes and nor do they draw on baseline data where this ought to exist. Evaluation of these programmes is also made more difficult by sub-standard record keeping on the part of both government departments and NGOs.

There is evidence to show how health services can be improved but there is nothing comparable to guide how policing and court services are to be altered for the better – despite studies pointing to a range of deficiencies. There is also support for a greater role for nurses in the provision of health services to women who have experienced violence. Policy recognizing forensic nursing and prescribing the training necessary for this qualification may be an important policy intervention in this regard.

Mental health services and their effect are under-described and under-studied. It is unlikely in any case that only one model – or 'what' – can be effective and the development of flexible and adaptable approaches to the provision of social services. Although models are often described as unsuitable because of their 'Western' nature, it may be their class-based assumptions which are unsuitable, rather than the notion of counselling *per se.* Collings (2009) proffers practical recommendations to improve children's access to social work services, including the provision of services on a 24/7 basis and triaging survivors so that children without street addresses are seen by hospital social workers. Interesting counselling/treatment programmes are also evident which could be considered for additional support, including the Teddy Bear Clinic's SPARC programme and Ekupholeni's Tsoganag Basadi project, as well as Spice Buddyz and Mothers' Tears.

The IMAGE project is interesting because it suggests that domestic violence can be reduced not only through targeting men but also through interventions that both enhance women's agency and reduce their economic dependence. While the IMAGE programme highlights microfinance as an important intervention into domestic violence the SBCWC's reflections on its economic empowerment programme for shelter residents point to some of the complexities of such programmes, suggesting they cannot be uniformly applied under all circumstances.

Challenging men's practices may well represent a strategic intervention into the advancement of women's interests. However it is the discursive framing of such strategies which determines whether or not such programmes are transformatory or conservative. Reflection on the Stepping Stones' programme for instance, suggested that while it may have reduced some men's violence, it may have done so in a way that resulted in some adverse consequences for women. The study authors also suggest that the programme did not transform existing gender relations but encouraged men to become kindlier, better patriarchs. Given how men's programmes are proliferating, it is important that these be prioritised for evaluation. Key questions for consideration include how long these programmes should be to achieve sustained, rather than temporary change; whether groups ought to be single sex or mixed; and whether they should be general or targeted. Further, while a number of studies seek to pin-point factors placing men at risk of perpetrating violence, no studies examine which men are amenable to change, nor how change was accomplished amongst this group.

The evaluations also point to how many women are lost to follow-up in the course of rape investigations and in the course of entering or exiting services. This applies too to children. Interventions need to be developed that do not require fixed or permanent addresses.

In conclusion, the evaluation synthesis has identified two strong, local programmes: IMAGE and Stepping Stones and identified a third drawn from the USA – Safe Dates – which all demonstrate positive effects. Other promising interventions which require further investigation include:

- Kalichman et al's (2009) combination of an intervention addressing VAW, HIV and alcohol;
- Joyner and Mash's (2012) domestic violence identification and response programme at primary health care level.

Also demonstrating promise (but whose evaluations are not as methodologically rigorous) are the Teddy Bear Clinic's SPARC programme and Ekhupoleni's groups for sexually abused children and their caregivers, as well as that for abused women. The intervention seeking to address sexual harassment and coercion of girls at school is also of interest. The absence of sound evaluations of services generally is a significant gap.

Table 8 sets out recommendations for which government programmes require evaluation (or better-designed evaluations). While Chapter 4 identified a number of challenges regarding some government departments' execution of their various mandates, these are problems largely of implementation which require some form of intervention, rather than further evaluation. These laws and policies are therefore not considered here.

Table 8: Programming and policy requiring evaluation

Department	Programmes and policies	Report/evaluation
Department of Social Development	Khuselekha/One-stop centres and other domestic violence shelters and services	Well-designed evaluation recommended
	Social Development Guidelines on Services for Victims of Domestic Violence.	Evaluation recommended
	Guidelines for Services to Victims of Sexual Offences	Evaluation recommended
Department of Community Safety	Ikhaya Lethemba	Well-designed evaluation recommended – perhaps in tandem with evaluation of DSD shelter programmes
	Men as safety promoters	Evaluation recommended
	Monitoring of SAPS compliance with the DVA	Support to implement findings recommended
	Sexual offences docket analysis	Support to implement findings recommended
Department of Health	Health services to rape survivors (including provision of PEP to rape survivors)	Treat 2005 PEP service evaluation as baseline and add review of services in their entirety.
	Annual training of health workers to address GBV	Evaluation recommended
Department of Education	Various guidelines for dealing with sexual violence, harassment and suspected and confirmed cases of child abuse.	Evaluation recommended

Appendix 1: Overview of studies

Author/year	Sample	Study design	Study purpose
Interventions with men			
Kalichman, Simbayi, Cloete, Clayford, Arnolds, Mxoli, Smith, Cherry, Shefer, Crawford, Kalichman (2009)	475 men living in two Cape Town townships	Quasi-experimental field intervention trial with two communities, including follow-up at 1, 3 and 6 months post-intervention	Examine the effect of a five session intervention intended to reduce VAW and HIV risk behaviours
Dworkin, Hatcher, Colvin, Peacock (2012)	60 men (30 Limpopo and 30 Eastern Cape) participating in One Man Can workshops.	Qualitative interviews. No baseline, self-reported change	Exploration of impact of programme
Department of Social Development (2009)	26 men and 13 women, some of whom had participated in the intervention	Interviews, focus groups. No baseline, no outcome measures, self-reported change	Evaluate outcomes of activities and assess the feasibility of expanding the project.
Jewkes, Nduna, Levin, Jama, Dunkle, Puren, Duvvury (2008).	70 villages in the Eastern Cape, including 1 360 men and 1 460 women aged 15 – 26	Cluster randomised trial	Evaluate effectiveness of Stepping Stones
Ricardo, Eads,Barker (2011)	65 RCTs and non-randomised studies with treatment and control groups	Systematic review	Review effectiveness of interventions with boys and young men
Smedslund, Dalsbo, Steiro, Winsvold, Clench-Aas. (2011)	6 small RCTs, all conducted in the USA	Systematic review	Review effectiveness of CBT for men who physically abse their female partners.
Draper (2011)	26 adolescent males participating in SPARC; 7 parents; 6 key informant interviews	Qualitative interviews and focus groups	Describe FWI programme effectiveness and factors influencing its effectiveness
Rangasami, Stewart and Maharaj (2013).	316 telephonic follow-up calls to participating caregivers; consultations with 98 people involved in project in some way.	Record review; client focus groups; interviews with programme staff and key informants	Impact evaluation: did programme reduce recidivism amongst enrolled child sexual offenders?
Education, training, awareness-raising			
Usdin, Scheepers, Goldstein and Japhet. (2005)	2 000 adults aged between 16 and 65	Pre- and post-intervention surveys; 29 focus groups; 32 in-depth interviews	Evaluation examining impact of Soul City on social norms around domestic violence; promotion of collective action and creation of more supportive legal environment.
Hatcher, de Wet, Bonell, Strange, Phetla, Pronyk, Kim, Morison, Porter, Busza, Watts and Hargreaves. (2011).	15 RADAR staff; 26 SEF staff; 74 individual clients.	Mixed methods (interviews, observations, researcher notes, reflective diaries, focus groups); collection of both prospective and retrospective data from participants on an ongoing basis	Process evaluation examining the use of critical consciousness to prevent domestic violence
Jewkes, Wood and Duvvury. (2010).	10 men and 11 women enrolled in Stepping	In-depth interviews conducted prior to	Exploration of how participants made meaning of the

	Stones	intervention, followed up 9-12 months later, combined with 4 focus groups	programme and its influence upon their lives.
Counselling and shelters			
Collings (2009)	Convenience sample of 200 consecutive cases of child rape referred for medico-legal assessment at a Durban hospital between October to December 2004.	Prospective study comprising record reviews and telephonic follow-up	Audit provision of state-supported counselling and social work services to child rape survivors
Mathews, Abrahams, Jewkes. (2013)	30 children aged 8-17 and their caregivers recruited from 2 Cape Town-based services	Qualitative in-depth interviews	Effects of CSA on children
*Mazars, Hidayati and Mofolo. (2012)	Convenience sample of 73 respondents, including 20 rape survivors, drawn from six sites in Mpumalanga,	Review of organisational documentation; interviews and focus groups	Donor-commissioned programme evaluation documenting perceptions regarding the extent to which GRIP was able to VAW survivors' needs; the most significant change brought about by GRIP; and key enablers and barriers to meeting project objectives
*CASE (2003)	6 rape survivors; 16 counselling volunteers	Interviews with rape survivors and focus groups with volunteers	Donor-commissioned review of RCCT's work
*Maart, Crawford Cousins and Doo (2006)	5 rape survivors drawn from 'Speak Out' project; review of an unspecified number of case files; unspecified number of counsellors	Interviews; documentary reviews	Donor-commissioned review of RCCT's work
*Clacherty and Donald (2008)	22 mothers and 34 rape survivors aged 8 – 12 recruited from the Ekupholeni Mental Health Centre	Quasi-experimental control study comparing girls and their mothers who had been through the programme, with those about to start the programme	Impact of the programme
Regehr, Alaggia, Dennis, Pitts and Saini. (2013)	6 RCTs undertaken in the USA	Systematic review	Evaluate the success of different treatment interventions for rape
Ramsay, Carter, Davidson, Dunne, Eldridge, Hegarty, Rivas, Taft, Warburton, Feder (2009)	10 RCTs, 9 in the USA and 1 in Hong Kong	Systematic review	Evaluate advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women experiencing domestic violence
Du Toit (2010)	89 women either previously or currently resident in Ikhaya Lethemba	Survey (non-random, unrepresentative)	Evaluate the effect of Ikhaya Lethemba services on shelter residents
Clacherty and Kola (2007)	13 women who had completed the programme and 20 women about to start the	Quasi-experimental control study comparing women who had been through	Evaluate the therapeutic and creative components of programme for abused women

	programme	the programme, with those about to start the programme	
Moolla (n.d.)	120 former residents of the SBCWC shelter admitted between October 2008 and August 2009; 8 current residents	Record review and interviews	Evaluate the effectiveness of the SBCWC intake interview
Domestic violence and economic empowerment			
Maharaj (2006)	18 SBCWC clients, 6 partners in the economic development programme	Interviews	Process evaluation of the SBCWC economic development programmes
Pronyk, Hargreaves, Kim, Morison, Phetla, Watts, Busza and Porter (2006)	6 576 participants from 8 villages	Cluster randomised trial	Evaluate effect of micro-finance and gender rights training programme on reducing domestic violence and HIV infection
Hargreaves, Hatcher, Strange, Phetla, Busza, Kim, Watts, Morison, Porter, Pronyk and Bonell. (2010).	15 RADAR staff; 26 SEF staff; 74 individual clients.	Multi-method (interviews, focus groups, diaries, notes and observations	Process evaluation of IMAGE
Environmental interventions			
Abrahams, Mathews and Ramela. (2006b)	Unspecified number of girls aged 16+ drawn from 3 public high schools in the Western Cape	Participatory action research: focus groups, mapping, photography	Improving school environments for girls
Comprehensive health care and services to rape survivors			
Kim, Askew, Muvhango, Dwane, Abramsky, Jan, Ntlemo, Chege, Watts (2009)	16 service providers and 109 patients from a rural hospital in Mpumalanga	Mixed methods comprising baseline study, review of hospital charts and interviews	Evaluation of nurse-driven post-rape model of care and its integration into existing hospital services
Christofides, Muirhead, Jewkes, Penn-Kekana, Conco (2005)	319 women (155 rape survivors and 4 carers and 160 comparable women recruited from the community) drawn from one urban and one rural site	Discrete choice analysis of stated preferences with interviews	Describe women's experiences of and preferences for post-rape services
Christofides, Jewkes, Webster, Penn-Kekana, Abrahams, Martin (2005)	124 health providers from 31 hospitals	Cross-sectional study utilising interviews with both open and closed questions	Examine the quality of care to rape survivors, including providers' attitudes towards women
Rohrs (2011)	21 interviews at 18 health care facilities in 5 provinces; 27 interviews with police officers in four provinces; and 131 interviews with rape survivors presenting at 4 organisations	Mixed methods including telephonic survey of public health facilities and qualitative interviews	Examine barriers to post-rape health care
Health services to women experiencing domestic violence			
Joyner, Theunissen, De Villiers, Suliman, Hardcastle, Seedat (2007)	62 women and men presenting over a 12 week period in the acute aftermath of an incident	Prospective survey with a structured interview design	Ascertain the number of treatment and protection order referrals provided to victims of domestic violence; obtain a

	of domestic violence at the trauma unit of an urban public hospital in the Western Cape		profile of violent incidents and injuries; and assess self-esteem, post-traumatic and depressive symptomatology in the aftermath of injury.
Kim and Motsei (2002)	38 primary health care nurses (29 women, 9 men)	Focus group interviews; 1 week training around gender violence; structured follow-up questionnaires	Evaluation of training programme for nurses
Joyner and Mash (2012)	168 women presenting at two urban and three rural community health centres; unspecified number of health practitioners who participated in the study	Mixed methods: review of patient records; three focus groups with health practitioners; key informant interviews	Evaluate how women experiencing DV present to primary health facilities; how frequently healthcare professionals identify DV
Joyner and Mash (2011)	168 women presenting at two urban and three rural community health centres	Project evaluation: interviews with women in the study at time of intervention and follow up one month later.	Evaluation of a primary-health care intervention for women identified as abused
Taft, O'Doherty, Hegarty, Ramsay, Davidson, Feder (2013)	11 studies conducted in high-income countries	Systematic review of RCT or quasi-randomised trials	Investigate whether screening women for intimate partner violence results in health benefits or harm; and establish whether screening increases the number of women identified as abused and referred to further assistance.
Post-exposure prophylaxis			
Roland, Myer, Martin, Maw, Batra, Arend, Coates, Denny (2011)	131 rape survivors aged 14 and older presenting for care at a hospital-based rape treatment centre outside Cape Town between March – September 2004	Observational	Testing proactive, flexible, nurse-driven system of following up rape survivors to support their completion of HIV PEP
Arend, Maw, de Swardt, Denny and Roland (2013)	10 rape survivors who had participated in a prior observational study of a post-sexual assault intervention to improve PEP adherence	Qualitative, semi-structured interviews	Examination of rape survivors' experience of PEP and participation in prior observational study
Abrahams, Jewkes, Lombard, Mathews, Campbell and Meel (2010)	279 rape survivors drawn from Sinawa sexual assault service, Eastern Cape and Karl Bremer Hospital, Victoria Hospital and Simelela Centre, Western Cape	Randomised control trial	Testing of a model of telephonic psycho-social support, provision of an information leaflet and adherence diary to improve adherence to HIV PEP
Abrahams and Jewkes (2010)	29 rape survivors aged between 16 – 73 drawn from Sinawe sexual assault service, Eastern Cape and Karl Bremer Hospital, Western Cape.	Qualitative in-depth interviews	Exploration of barriers to completing HIV PEP
Vetten and Haffejee (2005)	105 interviews with rape	Mixed methods study	Examination of factors affecting

(Also Vetten and Haffejee, 2008).	survivors and health workers based at seven study sites in Gauteng.	combining record reviews, participant observation, qualitative interviews and adherence survey	adherence to PEP
Collings, Bugwandeen, Wiles (2008)	Convenience sample of 200 consecutive cases of child rape referred for medico-legal assessment at a Durban hospital between October to December 2004.	Review of case files	Audit provision and utilisation of HIV PEP to child rape survivors in KwaZulu-Natal
Draughon and Sheridan (2011)	11 studies from Kenya, Malawi and South Africa undertaken between 2000 and 2009 and examining the provision of HIV PEP after rape.	Systematic review	Assessed rates of provision of PEP and rates of acceptance, as well as PEP completion rates and patients' perceptions of PEP.
Carries, Muller, Muller, Morroni and Wilson D. (2007)	390 records of survivors presenting at one crisis centre between May 2003 and July 2004	Retrospective record review	Assessment of characteristics, treatment and PEP adherence of rape survivors
Effects of law and policy			
Abrahams, Jewkes, Martin, Mathews. (2011)	25 medico-legal laboratories	Retrospective study of proportionate sample of female homicides occurring in 1999	Investigate associations between medical practice and legal case progression and outcomes in female homicides
Abrahams, Mathews, Martin, Lombard, and Jewkes. (2013)	38 mortuaries	Weighted cluster design of proportionate random sample of female homicides occurring in 2009.	Comparison of two female homicide studies undertaken 10 years apart.
Vetten, Jewkes, Fuller, Christofides, Loots and Dunseith. (2008)	2 068 rape cases reported to 70 police stations in Gauteng during 2003	Retrospective record review of randomly selected rape cases	Evaluate case attrition and identify factors associated with case progression

Studies examining the DVA

Study title	Overview of study
Theme 1: An examination of the resourcing of the DVA	
'Show Me the Money': A Review of Budgets Allocated towards the Implementation of South Africa's Domestic Violence Act (Vetten, 2005); and *The Price of Protection: Costing the Implementation of the Domestic Violence Act (no 116 of 1998)* (Vetten, Budlender and Schneider, 2005).	This is the same study written up in two different reports. The first report emphasizes the budgets and budgeting processes followed by government departments in planning for the DVA's day-to-day implementation, while the second report highlights what it costs to implement the DVA. Sixty interviews were conducted with clerks, prosecutors, magistrates and police officers attached to nine courts in the provinces of Gauteng, Free State and KwaZulu-Natal.
Theme 2: The application, in practice, of the DVA's provisions	
The Implementation of the Domestic Violence Act: First Report (Parenzee, Artz and Moult, 2001)	The study explored two questions: • To what extent is the Act being implemented? • What are the obstacles and benefits presented by the Act?

	The study analysed a total of 616 files drawn from three courts - Mitchell's Plain, George and Cape Town. This total represented 10% of the total files handled in each court.
Combining Stories and Numbers: An Analysis of the Impact of the Domestic Violence Act (116 of 1998) on Women (Mathews and Abrahams, 2001)	This study compared and evaluated women's experiences of the PFVA in its final year of operation (1999) and compares these findings with the first year of the DVA's implementation (2000). A total of 1 044 court records were reviewed for both years from Bellville Magistrate's Court and Paarl Magistrate's Court. A 25% random sample was drawn from the total number of applicants for each year.
"Justice at a snail's pace": The implementation of the Domestic Violence Act (Act 116 of 1998) at the Johannesburg Family Court (Naidoo, 2006)	This study was based at one court (the Johannesburg Family Court). The sampling frame consisted of all the court case files from a 10 month period in 2004, from which 50 court case files were randomly selected (5 per month). The study looks specifically at the profile of those applying for protection orders, the type of abuse complained about in applications, the appearance of parties in court, the duration of the process and the type of relief granted by the court, if any.
Going somewhere slowly? A comparison of the implementation of the Domestic Violence Act (no. 116 of 1998) in an urban and semi-urban site (Schneider and Vetten, 2006)	The study was conducted at the Alberton Magistrates Court and Themba Magistrates Court. A total of 1 537 applications for protection orders were analysed from the Alberton Court and 670 PO applications from Themba Court (Themba's smaller sample size was due to the misplacement of court records and the inability of the court to account for some of its files).
An Examination into the Attrition of Domestic Violence Cases. (Artz, 2006).	This study explores why applicants who obtain interim POs do not return to court to finalise them. A total of 365 applicants from 4 Magistrate's Courts in the Western Cape - Khayelitsha, Bellville, Phillipi and Wynberg – were interviewed for the study, and their intake forms developed by the organization Mosaic also analysed.
Assessment of the Implementation of the Domestic Violence Act and its Effects on the Lives of Women Seeking Protection Orders – A Study of Abused Women at Four Courts in eThekwini (Meyer *et al*, 2007)	The study is concerned with the effectiveness of the support services dealing with domestic violence in South Africa, namely the police, justice and health systems. This study relied chiefly on the intake forms developed by an NGO working at the courts and only a small number of actual protection order files were reviewed. For the part of the study examining implementation areas of the Act, the researchers drew on the following data sources: ○ A sample of 1 600 women was selected from the intake forms collected at the Advice desk, with 400 intake forms randomly selected from each of the four courts involved in the study Verulam, Chatsworth, Pinetown, Durban. • A sample of 81 women who were applying for protection orders at one of the 4 courts. The selection method was not indicated. Forty-one of the 81 women subsequently took part in qualitative interviews around the Act.
The Implementation of the DVA in Acornhoek (Vetten, van Jaarsveld, Riba and Makunga, 2009).	Fieldwork was conducted at one police station, Acornhoek, and the three courts within whose jurisdiction the police station fell: Thulamahashe (Mhlala), Bushbuckridge and the periodic court based in Acornhoek. All 519 applications for POs made during the eighteen-month time frame covered by the study (1 January 2006 - 31 July 2007) were scrutinised.

Theme 3: Women's perceptions of the DVA's efficacy	
Combining Stories and Numbers: An Analysis of the Impact of the Domestic Violence Act (116 of 1998) on Women (Mathews and Abrahams, 2001)	Mentioned previously. The part of the study which explored women's perceptions of the DVA relied on 23 interviews with women.
*Assessment of the Implementation of the Domestic Violence Act and its Effects on the Lives of Women Seeking Protection Orders – A Study of Abused Women at Four Courts in eThekwini (*Meyer *et al*, 2007)	Mentioned previously. For the part of the study examining women's perceptions of the Act, the researchers interviewed 41 women applying for protection orders at Verulam, Chatsworth, Pinetown and Durban. The selection method was not indicated.
The Impact of an Interim Protection Order [Domestic Violence Act 116 of 1998] *on the Victims of Domestic Violence* (Vogt, 2006)	Broadly, this study aimed to: o contribute to an understanding of domestic violence in South Africa; o identify the needs of victims of domestic violence and making recommendations responsive to these needs; and o improve government's ability to protect victims of domestic violence. It utilized an experimental group comprising 884 women (dropping to 464 at second measurement) who had applied for IPOs and a control group of 125 abused women (dropping to 101 at second measurement) who had not applied for IPOs to explore the impact of an IPO.
An Examination into the Attrition of Domestic Violence Cases: Preliminary Findings (Artz, 2006).	Described previously.
Theme 4: The perceptions of those tasked with implementing the DVA	
Monitoring the Implementation of the Domestic Violence Act: First Report. (Parenzee, Artz and Moult, 2001).	Mentioned previously. For this particular component of the study, 60 interviews were conducted with various criminal justice personnel, including 24 police officers based at 11 stations in the Western Cape. One-on-one interviews were conducted with nine magistrates, nine prosecutors, six court clerks and four court volunteers from Cape Town, Mitchell's Plain and George. An additional 12 clerks were interviewed in a focus group.
Magistrates and the Domestic Violence Act: Issues of Interpretation (Artz, 2003).	The study looks specifically at the role of magistrates in their perceptions and interpreting and implementing the Domestic Violence Act. Ten in-depth interviews were conducted with magistrates from Western Cape, Gauteng, the Eastern Cape and Limpopo.
" 'Show Me the Money': A Review of Budgets Allocated towards the Implementation of South Africa's Domestic Violence Act" (Vetten, 2005).	Described earlier.
"Marriage is like sitting on red coals": A case study of domestic violence in four villages in the Moretele District, Tshwane Metropole (Hargreaves *et al*, 2006)	This study drew on the findings around the DVA for Themba magistrates' court (Schneider and Vetten, 2006), as well as eight semi-structured interviews with eight police officers based at the four stations serving Themba. A ninth interview was conducted with a member of the Tshwane Metropolitan Police Department.
Combrinck and Wakefield (2009)	
Theme 5: Comparing women and men's use of the DVA	
Equal or Different Comparing women and men's use of the Domestic Violence Act (no. 116 of 1998). (Schneider and Vetten, 2006).	Drawing on 2 208 applications for POs (1537 applications from Alberton and 671 applications from Temba) made in 2000 and 2001, this study explored whether or not women and men turned to the DVA for the same reasons and for the same protections.

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