Department of Political Studies

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Research Topic

Assessing the barriers to combatting Gender-based Violence: a perspective from the frontline

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Abstract

South African women are under constant threat of Gender-Based Violence (GBV) and the scourge continues unabated. It is well documented that South Africa has one of the highest rates of GBV in the world, but less well documented are the barriers to GBV service provision and post-rape care for survivors. Numerous studies and reports still document endemic weaknesses in GBV policy implementation and service provision. In recent years, GBV has been termed South Africa's second pandemic, after the COVID-19 pandemic and has been prioritized by the South African government and civil society organizations. Various Victim Empowerment Programmes were established and various laws on sexual assault and violence against women and children have been passed, but despite such intensified efforts, barriers remain in post-rape services. This dissertation considers the barriers to accessing victim support services and how the implementation of these services could be improved on the frontline.

It reviews the effectiveness of laws, policies and strategies to combat gender-based violence in South Africa. It specifically investigates the potential barriers facing rape survivors from accessing government services resulting from poor inter-departmental coordination, and what the implications are for developing a more effective joined-up or whole of government approach. Addressing unique barriers at service levels will ensure inclusivity and protection from GBV, which must be prioritized. Understanding the needs of survivors is essential in developing effective and inclusive GBV prevention and support services through a joined-up government approach. The research methodology was based on a qualitative, desk- top research design and four one-on-one, semi-structured interviews with key informants from GBV service providers in the Cape Town Metro and police oversight bodies. The findings suggest that one of the most pronounced barriers to effective implementation of post-rape care service provision includes the perpetuation of secondary victimization by frontline providers due to a lack of knowledge, training, negative attitudes, values and beliefs.

The fragmented response to victims of GBV was also sometimes due to institutional arrangements and resulted in poor coordination and cooperation amongst implementing agents which ultimately undermined compassionate responsiveness to victims of sexual violence. A lack of capacity, appropriate funding and incentive also posed challenges to accessing post-rape care for survivors relating to long-term counselling for survivors and implementing agents, training for specialized staff and funding for NGOs that was not prescriptive and directed for certain outcomes by funders.

All of these factors ultimately perpetuated a culture of secondary victimization, leaving victims feeling discouraged and disempowered.

Chapter 1:Introduction

One of the most important issues facing South African society today is gender-based violence which has often been termed the second pandemic and become a national priority crime. GBV has often been referred to as the second pandemic in South Africa due to its scale, severity and persistence which are similar to the crisis conditions of the major health pandemic COVID-19, which was also the period when GBV spiked.GBV involves all contact crime which is murder, rape and physical abuse against women. The prevalence of GBV in South Africa according to crime statistics for the 2022/23 financial year shows 654 053 contact crimes against people. The sexual offences category of crime shows 53 498 are attributed to rape, 7 483 were sexual assault, 2 376 were attributed to attempted sexual offences, and 859 were contact sexual offences (SAPS Crime Stats 2022-2023). South Africa's society is patriarchal and as a result, women and girl children are especially vulnerable to GBV such as rape, Femicide, sexual abuse and exploitation. In one of its meetings, the Select Committee on Security and Justice heard that rape charges are the most registered of all sexual offences charges, and in 2023/24, 74.1% of the 8 621 new sexual offences cases reported were rape cases and 1 469 of those cases were child rape cases (Parliament RSA,2025). Just over four years after the rape and murder of University of Cape Town student Uyinene Mrwetyana, there was no evidence to suggest that the government had allocated or spent the R1,6 billion that was pledged to address what had been termed the second pandemic, Gender-based Violence and Femicide (GBVF) (Gqubule,2022;Sherwood et.al.,2020). In a joint sitting of the National Assembly and the National Council of Provinces on 18 September 2019, four weeks after Mrwetyana's rape and murder, President Cyril Ramaphosa said the Cabinet had resolved to allocate R1,1 billion in additional funding in the current financial year to address GBV.

GBV is an important policy issue in South Africa, that is deeply rooted in discriminatory social and cultural beliefs or attitudes as well as religious norms or practices that tend to perpetuate inequality and powerlessness which marginalizes women and fails to protect their rights. Patriarchy is a social structure where men are placed in positions of authority and influence, leading to men having greater power, privileges, and control in most areas of life, while women and other genders experience limited rights and opportunities. Patriarchy is a source of male violence and is linked with interrelated social structures through which men exploit and have power over women (DispatchLive,2021). To combat GBV we need to understand its causes and contributing factors which are often also barriers to effective prevention and responses. The causes of GBV can be linked to general risk factors that may exacerbate GBV in South Africa which

include individual and economic factors, alcohol abuse, guns and legal factors (CSVR,2016:11; Morrison et.al,2007:27).

The social obstacles to addressing the scourge of GBV include the failure to prioritize GBV policy impact assessments, strategy development and adaptation and effective planning and programming due to a lack of information and understanding about the extent or nature of GBV. There are also weak links in assistance programmes, a lack of confidentiality, confusing and ineffective reporting and referral mechanisms and GBV service providers that are isolated, under-resourced and weak due to a lack of support from the wider community (Thobane et.al.,2020:108). Legal and Judicial risk factors to perpetuating GBV relate to the role of police in supporting the victim and arresting the perpetrator. There may also be budgetary constraints for the implementation of GBV laws and a lack of access to courts as many survivors are unfamiliar with court processes which may deter them from seeking help. A lack of cooperation among government departments in implementing GBV legislation could be an obstacle as major obligations are placed on the police in the implementation of, for example, the Domestic Violence Act, but this is often not sufficient to meet the needs of survivors which requires the cooperation of various departments such as the Department of Social Development, the Departments of Health and Justice and Correctional Services (CSVRR,2016:14).

Judicial barriers relate to a lack of access to justice institutions and mechanisms which result in a culture of impunity for violence and abuse. The lack of adequate and affordable legal advice and representation, lack of adequate victim/survivor and witness protection mechanisms, and an inadequate legal framework which includes national, traditional, customary and religious law, could discriminate against women and girls and fail to protect their rights or expose them to further harm and abuse (UNHCR,2007,Action Sheet 4; Gender-Based Violence,2).

1.1 Gender-Based Violence:The Implementation Gap

Considering the South African context of GBV, during South Africa's oppressive Apartheid past, very few legal and social structures were in place to protect women against GBV, including the judicial system which was generally unfavorable toward victims. Research conducted in 1994 showed that objects such as bottles and tin cans were used for penetration in the rape of older women. Despite this being prevalent at the time, the South African government during Apartheid, did not consider this to be rape and instead charged perpetrators with assault (George, 2020). The

Department of Justice had no sentencing guidelines for rape and other kinds of sexual assault which allowed judges to use their discretion when presiding over cases. This created bias as courts invalidated women's accounts of rape if there was no physical evidence or eyewitnesses which resulted in conviction rates of only 53% for rape and sexual assault in 1992, while the conviction rate for perpetrators of non-sexual assault was 86%. This clearly showed a subjective judiciary where women's human rights and protection was not prioritized (George, 2020). The apartheid state also condoned the physical or corporal punishment of women by their husbands thereby normalizing and legalizing a state of unrestrained domestic abuse.

To understand these patterns, it is important to situate them within the legal framework that shaped sexual offence prosecutions during apartheid. The primary statute was the Immorality Act 23 of 1957 (later renamed the Sexual Offences Act), which defined sexual crimes in narrow and discriminatory terms. Section 14 criminalised sexual intercourse with girls under 16, but equivalent protection for boys did not exist until the 1988 Amendment, which expanded the Act to include male minors and broadened what constituted unlawful sexual conduct (Law Library,1957: s.14–15). Protection for intellectually disabled complainants was also limited: section 15 framed the offence only in relation to a "female imbecile or idiot," meaning that male victims were excluded from legal protection until the amendment, and the terminology itself reflected a failure to recognise the vulnerability of mentally impaired persons in a rights-based manner (SALRC, 2002: 23–25).

Evidentiary rules in the Criminal Procedure Act further entrenched systemic bias, as sexual offence cases typically required corroboration, thereby rendering a survivor's testimony insufficient unless supported by physical injuries or eyewitnesses (SALRC,2002: 23–25). This legal context directly contributed to low conviction rates such as those recorded in 1992, demonstrating that the barriers were embedded in statutory and procedural frameworks rather than being solely the product of judicial discretion. Although significant social change has occurred in South Africa since 1994, there remains challenges in the support offered to victims of GBV. There have been many systemic and social interventions by government to address GBV, but it is multi-dimensional and presents as intimate partner violence, domestic violence and sexual violence such as rape. Marital rape was also not considered a crime in South Africa before the Prevention of Family Violence Act of 1993 which criminalized it (Kaganas & Murray,1991:287,290).

Approximately 33,9% of South African girls experience some form of sexual violence as minors (Ward *et.al*,2018:791). Also prevalent were cases of "baby rape" which became a focus in 2001

when 6 men gang-raped a 9-month-old baby leading to the investigation of child rape incidents from the 1990s and a similar case was reported as recently as 2019 (Marchetti-Mercer,2003:7; George, 2020). In addition to isolated child rape cases, broader patterns of violence against children in South Africa demonstrate that violence against children is deeply intertwined with gender-based violence more generally. According to a UNICEF situation analysis, between 2013 and 2015, a nationally representative study found that 58% of children aged 5–16 years experienced direct victimisation, while 52% experienced indirect victimisation; among them, 18% were physically abused, 13% emotionally abused, and 12% neglected (UNICEF,2024:12). These data suggest that many children live in environments characterised by violence, exploitation, and neglect, which structurally overlap with GBV dynamics. The cost to society is also significant: a Save the Children South Africa study estimated in 2015 that violence against children cost the country about R238.58 billion annually, underscoring how pervasive and costly violence against children is (Save the Children SA, 2016:2).

According to SAPS, in 2019 the reported rape rate was 90,9 per 100,000 people, but it was estimated that only 1 in 36 cases were reported to police which could indicate that more than 2 million additional rapes were unreported (BusinessTech,2017; George, 2020). South Africa's democracy is based on human rights and human dignity and since 1994, the country is signatory to United Nations frameworks aimed at protecting women. GBV requires a systematic approach which considers prevention, response and a victim or survivor centered approach to support and after care, which should be achieved through multi-stakeholder partnerships (Netshitenzhe,2024:122). Media reports and police statistics continue to highlight alarming rates of GBV and one of the hindrances in combatting GBV is imprecise statistics. To encourage victims/survivors of GBV to report this, the Department of Social Development (DSD), in partnership with the Vodacom Foundation established the GBV Command Centre, managed by Social Workers from the DSD (Netshitenzhe,2024:126).

Gwiza and Hendricks (2024) did a study on the perceptions of stakeholders and survivors on the effectiveness of GBV policies at the University of Fort Hare in South Africa. The study highlights that of 604 students at a public university in South Africa, 36,3% experienced sexual assault while 36,7% reported attempted rape and 28,9% confirmed that they were raped (Gwiza & Hendricks,2024:1,2). This indicates that despite the laws in place, GBV cases remain on the rise pointing to ineffective management and enforcement. The perceptions of participants of the study revealed the shortcomings in the implementation of GBV policies and the findings indicate a

breakdown in the implementation stage of South Africa's GBV laws which underscores the need for more robust accountability based on the inadequate support systems for survivors of GBV who often do not receive sufficient institutional guidance.

To contextualise the contrast between apartheid-era outcomes and contemporary practice, it is important to note that the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 introduced a significantly broader and gender-neutral definition of rape, modernised consent provisions, and repealed discriminatory sections of the 1957 Act. Alongside these reforms, the re-establishment of specialist Sexual Offences Courts contributed to improved conviction rates: the Department of Justice reported approximately 70% convictions in 2015/16 (DOJCD, 2016: para. 12), rising to over 72% by 2018 in courts supported by Thuthuzela Care Centres (DOJCD, 2019: para. 8). Furthermore, in the 2023/24 financial year, the Department finalised 5,269 sexual offence cases with a verdict, of which 3,806 resulted in convictions, representing a 72% conviction rate, exceeding its internal target of 70% (DOJCD, 2024:146). These figures offer an important contemporary benchmark and illustrate how modernised legal frameworks and specialised court models have shifted the prosecution landscape in ways not possible under the apartheid-era statutes.

1.2 Research Aims

The research question sets out to assess the weaknesses in GBV policy implementation and service provision as it relates to survivors of sexual violence and focuses on the difficulties of coordinating an effective implementation response to combating GBV as well as the challenges in coordinating joint policy interventions across government departments. The focus is on access to post-rape care for victims at government hospitals using Thutuzela Care Centre's as a case study. The research also aims to investigate the potential barriers facing rape survivors in accessing government services resulting from poor inter-departmental coordination and a lack of a joined-up or whole of government approach. The dissertation hopes to contribute to research through an analysis of the policy and legislative review of interventions designed to combat GBV in South Africa and the effectiveness of GBV laws, policies and strategies and what this signifies about the role and capacity of frontline providers. Approaches that may be considered to strengthen a coordinated policy response to GBV are suggested.

South Africa has legal frameworks and policy in place to combat GBV and has placed a great deal of attention on this over the years, but despite these developments, GBV remains prevalent. The

available research indicates that governments commitments for combatting GBV are not having a positive impact for victims or for how front-line providers implement policies. The aim of the research is also to determine what poor implementation practices can be attributed to and how this speaks to policy implementation. The effectiveness of a government's response to GBV should be measured on the strength of its laws and policies and its capacity to enforce these. The government has struggled to implement an effective response to GBV due to barriers in policy implementation. This has been due to various factors such as a lack of trust between implementing agents, a lack of specialised training with service providers, resource and capacity constraints and a lack of incentive with service providers, negligence in evidence collection and post-rape care procedures which all indicate a lack in coordination between GBV service providers. South Africa has one of the highest GBV rates in the world and has been referred to as the "rape capital" of the world and while much information exists on this, there is little research on the barriers to GBV service provision and post-rape care of survivors (Ballard Brief, 2020).

The research question focuses on the barriers to GBV policy implementation and how this process is affected by multiple actors as GBV policy implementers. The research centered on the difficulties in coordinating an effective, whole-of-government implementation response to combating GBV and the factors that influenced this amongst GBV service providers. A broad range of questions were posed to interview participant's, some of which were excluded or tailored as it applied to the specific service provider being interviewed. Thus, the focus differed based on the organization and the expertise of the participant to share their own insight, challenges and experiences in GBV service provision. Some of the questions posed to interview participants relate to the barriers surrounding victim assistance experienced by service providers and barriers posed by legislation which hindered service providers from properly implementing policies. The challenges victims experience when reporting sexual assault and training of GBV implementers and psychosocial support provided to both victims and GBV implementers was discussed. Questions relating to compliance with legislation, oversight and measures taken to ensure accountability across implementing agencies to ensure an effective, coordinated, joined-up government approach in tackling GBV were also considered.

1.3 Research question

What are the barriers to accessing victim support services and how can the implementation of these services be improved on the frontline?

1.4 Theoretical framework: critiquing the implementation of GBV support services from a bottom-up perspective

A bottom-up perspective on policy implementation is a useful framework for considering poor policy implementation in service provision for victims of GBV, because it focuses on the realities on the ground that are experienced by frontline providers and shows us the discretion frontline providers have in how they understand and implement policy. They may be faced with certain demands that are in conflict as well as a lack of training, resources and biases, affecting service provision for victims. This approach can also highlight why policies do not work as they lose touch with the reality on the frontline given that frontline providers shape policy outcomes.

A bottom-up perspective in policy-implementation is based on the practical experiences of front-line providers as opposed to reliance on the directives of policy-makers. deLeon & deLeon (2002:468) argue that policy implementation has often been practiced as a top-down approach and that it is more suitably practiced as a bottom-up approach, which is more participatory and democratic in considering a set of particular conditions. The bottom-up approach to policy implementation is in contrast to the top-down approach which emphasizes directives from policy-makers and does not consider the realities of frontline providers and survivors on the ground. In the context of this paper, viewing implementation through a bottom-up lens means examining policies and services offered from the perspective of the frontline providers such as the SAPS, healthcare workers and Social Workers to illuminate the challenges in delivering services to victims and show how laws and policies can fail to become the lived realities of victims.

Policy implementation means to turn policy into practice, but there is often a gap in what was planned and what actually happens during policy implementation. The Top-down model for policy implementation views policy creation and execution as separate aspects where policies are created at higher up levels and they are then communicated to frontline providers whose responsibility it is to implement the policy (Faculty of Public Heatlt,200). This approach requires certain conditions to be effective such as skillful policy implementers, having incentives and sanctions for implementers, sufficient time and resources and good coordination and communication, however it is improbable that all the pre-conditions would be in place at once and this approach disregards the role of other actors (Faculty of Public Health,2009). The Bottom-up approach acknowledges that lower level staff have a significant role in implementation and would have discretion in

reshaping policies, changing the way it is implemented. This approach views policy implementation as an interactive process that involves policy makers, policy implementers from different levels in government and frontline providers (Faculty of Public Health,2009).

The top-down approach has shortcomings in that it doesn't consider the reality on the ground, whereas the bottom-up approach considers frontline providers, and other implementers showing that policy formulation and implementation are linked (Shahi,2021:1748). In this case, the bottom-up approach may be more useful, because it is more inclusive and fills the gap that exists between policy formulation and its execution by considering the needs on the ground and tailoring the policy to a particular set of circumstances (Thomann *et.al*,2018:583). Thomann *et.al*'s (20218) study on bottom-up implementation theory and the necessity of discretion found that freedom and perceived discretion for frontline providers was necessary to ensure that policies were implemented and, the study advocated for using the experience and expertise of frontline workers to adapt policies to ensure they work.

Currently, there are problems with providing effective support to policy implementers and survivors of GBV. There are issues with the provision of effective support, underreporting, delays in prosecution, inadequate responses from police, and limitations on access to shelters and counselling for survivors. The bottom-up approach, thus emphasizes decentralized decision-making and relies on the expertise of what Thomann et al. (2018:583) describes as "de facto policy makers", who have the discretion to tailor policies based on their particular circumstances. This approach makes provision for the adjustment of policies on the basis of needs and feedback, and the participation of all stakeholders in the implementation process including those affected by GBV.

In a county with one of the highest rates of GBV in the world, it remains a concern that the GBV service provision for survivors of sexual violence still presents barriers to access. The same is true for GBV survivors with disabilities to have accessible and inclusive service provision (Van der Heijden *et.al*, 2019:2). While many rape victims found services to be helpful, they still felt post-rape care and services contributed to secondary victimization (Johnson *et.al.*,2017:8). This can be seen in victim-blaming by family, friends and the community. Examples of secondary victimization are distrust, insensitive and discouraging treatment of the victim, the lack of private spaces for victim management, errors in evidence collection and management, updating victims who are on trial as well as inappropriate and incorrect handling of cases (Johnson *et.al*.,2017:8).

This adds to the victim's initial trauma and could possibly cause the victim to withdraw charges demonstrating how secondary victimization is a barrier to quality service provision for victims of GBV.

The role of the police has often been inadequate in that studies have shown that many police officers are unwilling to assist survivors of GBV as they see the case as being a private matter between partners or as a family matter (Calvino & Matadi,2023). Police officers tend to display passive and negative attitudes which adversely affects the victim and results in secondary trauma. This plays a role in non-reporting of incidents by victims as well as the withdrawal of cases once reported (Thobane *et.al*.,2020:47). Studies have shown that legislation is good on paper, but the negative attitudes associated with it amongst police officers tend to discourage victims from seeking help and justice. This also indicates that the patriarchal attitudes of police officers must be addressed to ensure the effective assistance of victims of GBV (CSVR,2016:13). A protection order must serve as protection for the victim, but has in some instances increased a victim's risk of experiencing further violence as in some cases women who were murdered by their partners had recently obtained a protection order. A case in point which took place in Kwa-Zulu Natal relates to a man who is alleged to have stabbed and killed his wife after she obtained an interim protection order against him nine days before her death (Khubeka,2022).

This suggests that perhaps proper procedures had not been followed as the SAPS must carefully assess the potential risk faced by a victim who obtained a protection order and make a referral to a place of safety when home conditions are unsafe. Many victims may not be familiar with how courts work, which may cause feelings of fear and anxiety and could be an obstacle in help-seeking and deter women from following through with their cases given that the impression may be that court processes are not user-friendly such as with long queue's and wait times and the shortage of staff dealing with protection orders (CSVR,2016:14). In some instances, those from rural areas may not have easy access to courts or police stations and have to travel long distances for assistance. Thus, the lack of an effective justice system has also deterred women from seeking assistance for GBV related crimes. Budgetary constraints also affect the implementation of legislation as it may not be sufficient to address the needs of victims and this is an issue which would cut across multiple government Departments such as the SAPS, Social Development, Health, Correctional Services and Justice. Each Department should be allocated a budget to deal with the needs of GBV victims, but often Departments do not use the allocated budget as intended which ultimately results in the funds being returned to the National Treasury (CSVR,2016:14).

The prevalence of GBV in South Africa has currently gained national and international attention which has prompted various government and civil society responses. R1,6 billion was pledged for the ERAP on GBVF to expand GBV services and access (Sherwood *et.al.*,2020:2). Non-governmental organizations (NGOs) also play a crucial role in GBV responses relating to advocacy, prevention and response and in this way GBV services in South Africa are distinct in relation to the organizations providing these services and the services that are available. Thuthuzela Care Centre's (TCCs) are described as one-stop sexual assault centers which aim to assist in the conviction of sexual offences and provide physical, psychological and social care for survivors of rape, sexual assault and domestic violence (Sherwood *et.al.*,2020:2). The TCCs fall under the Department of Justice and Constitutional Development and are led by the NPA's Sexual Offences and Community Affairs Unit (SOCA) which is in partnership with various departments and donors. Victims access TCCs via police referrals, hospital referrals and other healthcare providers and individuals who report directly to the TCCs. Sherwood *et.al*. (2020:2) states that grey literature alludes to the fact that individuals who report directly have experienced a number of issues which include documented delays in care and inadequate privacy. TCCs have also been critiqued for being under-resourced for follow-up visits by victims and lack the resources to provide a comprehensive service where a survivor's care needs are entirely met. TCCs may meet the medical needs of survivors, but emotional support services are not likely to be offered as TCCs lack the funds, the space and Social Workers to provide this service (Sherwood *et.al.*,2020:2).

Victims perceptions of services at TCC's show that they are mostly unaware of the services offered. This is confirmed by research which identified a lack of knowledge around TCC's as being the main barrier to post-rape care as well as a lack of public education by the government and NGOs on the existence of TCCs. Some victims said they were not afforded the courtesy of receiving explanations on the procedures they would participate in related to the TCC service model (GBV Process Evaluation,2018:25) This may be due to the fact that survivors are not always attended to by a nurse or doctor when they arrive at the TCC due to the availability of the practitioners. Survivors have reported simply being examined by the doctor who would tell the victim to remove their clothes, but not thoroughly explain the services available to the victim, suggesting that a shift is required in the attitudes of practitioners as well as sensitivity training in dealing with victims of rape and GBV (GBV Process Evaluation,2018:25). Survivor's perceptions on psychosocial support received indicates dissatisfaction with long- term follow-up support services and the consistency of staff responsible for dealing with the support of victims. The fact that facilitators of the support were often changing was a negative aspect and reportedly affected the

effectiveness of sessions and whether survivors attended, because survivors now continually needed to re-establish rapport with new facilitators. Survivors also felt that more could be done to follow up with clients and offer support whether telephonically or through home visits even when a client appeared to be coping (GBV Process Evaluation,2018:26). This may be because in instances of sexual assault, the secondary trauma a survivor may experience could still be contained and managed appropriately on the survivor's initial visits to the TCC, suggesting that sustainable and long-term support is critical. Inefficiencies were also seen in the quality and amount of support provided to staff given their high workload and in particular, the severity of some cases, thus the support and supervision practices were deemed to be inadequate. Social Workers also felt the support provided to them was lacking as they felt overwhelmed by the stress of their work and were burnt-out. They also indicated that more debriefing sessions for staff should be offered (GBV Process Evaluation,2018:29,31). Some indicated that they did not receive formal supervision at all, and that supervision was infrequent, or they were sometimes unable to attend due to busy work schedules. Social Workers reported that this left them feeling unsure about whether they were managing their work as required.

1.5 Thuthuzela Care Centre's Performance

TCCs are a flagship intervention in South Africa's GBV response. Their multi-sectoral integration, survivor-centered approach, and central role in the policy framework make them an ideal focal point for studying coordinated service delivery. Thuthuzela Care Centres (TCCs) represent a pioneering multi-sectoral model in South Africa's response to sexual violence. The TCC model was chosen as the focal point of this study because it integrates medical, psychosocial, and legal support in a single location, offering survivor-centered, one-stop services that mitigate secondary victimization, accelerate case finalization, and improve access to justice (USAID, 2015:38; Hlongwa & Sibiya, 2019:2). The Department of Health has designated 265 healthcare facilities for survivors of sexual violence, of which 54 are classified as TCCs (South African Department of Health, 2021:12). This reflects the national commitment to providing comprehensive care and the strategic role TCCs play in the broader GBV policy framework.

1.5.1 Origins, Purpose, and Evolution

TCCs aim to address the social needs of victims by preventing secondary victimization, increasing conviction rates, reducing offender impunity, and reducing the time to finalize cases. With a survivor-centered approach, the TCC must address the medical, legal, and social needs of rape and sexual assault victims in the same location (USAID, 2015:38; Gevers & Abrahams, 2015:10). The first pilot TCC was established in June 2000 at GF Jooste Hospital in Manenberg, Western Cape, based on input from 15 female survivors of rape (USAID, 2015:38). The pilot operated independently, with separate ministries supporting rape victims in isolation. Following the enactment of the Sexual Offences Act (SOA) of 2007, the TCC model was systematically scaled up across South Africa, reflecting a multi-sectoral approach involving the Departments of Health, Justice and Constitutional Development, and Social Development (USAID, 2015:38). Locations were recommended from 70 hospitals and police stations based on demographics, the prevalence of rape, and provincial priorities (USAID, 2015:38). The rollout was supported by national budget allocations and strong donor support, with a goal to establish 80 TCCs to meet demand from the existing 63 across nine provinces (USAID, 2015:39).

TCCs are designed to provide integrated care that includes forensic medical examinations, psychosocial support, court preparation, and follow-up services (Hlongwa & Sibiya, 2019:4-7; Randa *et al*., 2023:15–28). Mental health support is provided by lay counsellors employed by NGOs and overseen by the Department of Health and the NPA, although resources and training vary across sites (Gevers & Abrahams, 2015:10)

1.5.2 Position within South Africa's GBV Policy Architecture

TCCs are embedded in South Africa's national GBV policy framework, operating at the intersection of health, justice, and social services (Agenda, 2011:5; Gov.za, 2011:7). They align with the SOA (2007), Domestic Violence Act (DVA), and national GBV strategies, reflecting government commitments to coordinated, survivor-centered responses. The TCCs function as multi-departmental hubs involving the NPA, Department of Health, SAPS Family Violence, Child Protection and Sexual Offences (FCS) units, Department of Social Development, NGOs, and donors (USAID, 2015:38; Shukumisa Report, 2017:5; Samuels et al., 2017:49).

1.6 Research Design and Methodology

The research methodology was based on a qualitative research design to explore the barriers to effective GBV policy implementation and the quality of care received by rape survivors in the Cape Town Metropolitan area. Four one-on-one semi- structured interviews with key informants from GBV service providers in the Cape Town metro and police oversight bodies were conducted. Qualitative research methods were selected, because the research aimed to capture experiential, contextual and process-based insights from frontline GBV service providers and oversight institutions as these are insights which cannot be meaningfully understood through quantitative measures alone. The research focus was on gathering in depth information from key informants who were chosen from GBV service providers and oversight institutions. A range of secondary research sources were used to provide context for the findings. The key informants were specifically chosen to provide insight into their work as frontline providers and to assess barriers to GBV service provision, thus a purposive sampling method was used to select participants. This sampling strategy ensured that participants with specialised knowledge and direct experience could provide rich, relevant, and practice-based insights into institutional challenges and service delivery gaps.

To provide a more comprehensive understanding of the research context, a qualitative case study approach was adopted. This approach allowed for an in-depth examination of GBV service provision within a defined geographic and institutional setting, highlighting how policies are implemented in practice and the systemic challenges faced by frontline providers. Case studies are particularly useful for exploring complex interactions between institutions, resources, and operational practices. In addition to interviews, a document analysis was conducted. Relevant documents included GBV legislation, policy frameworks, oversight reports, NGO publications, and academic literature. Documents were selected based on their relevance to the research questions and were systematically reviewed to contextualise the interview findings and insights. Key information was extracted from these sources to identify patterns related to policy implementation, institutional coordination, and service delivery challenges. A transparent research process was maintained, with clear documentation of how data were collected, how literature was selected, and how themes were developed. This creates an audit trail that allows the logic and progression of the research process to be followed and understood.

A thematic analysis was used for key informant interviews to point out themes around barriers that

emerged from the research such as on proper coordination between implementers and financial constraints. Interviews were transcribed, coded, and grouped into broader themes. The coding process included both deductive categories based on the research objectives and inductive categories emerging from participants' accounts. Prominent themes included challenges in coordination between service providers and oversight bodies, financial and resource constraints, and gaps between policy frameworks and frontline practice. Thematic analysis enabled the researcher to systematically identify and interpret recurring patterns in participants' experiences while connecting these insights to broader policy and institutional contexts. All participants provided their informed consent and remain anonymous in the dissertation to ensure confidentiality due to the sensitive nature of the research.

1.7 Document Analysis

The research was conducted using a combination of policy document analysis, reports and presentations from Parliament RSA and NGOs which provide a picture of the barriers to GBV policy implementation and access to post-rape care services for survivors:

- GBV Acts and Bills;
- Academic literature on GBV;
- SADC and OECD Regional Strategies and Framework documents on GBV;
- The Parliamentary Monitoring Group reports on meeting proceedings of the Portfolio Committee's on Police and Social Development;
- Presentations and documents on oversight of SAPS to the South African Parliamentary Portfolio Committee's on Police and Social Development;
- South African news reports on GBV, NGO Coalition Reports and Fact Sheets such as the Shukumisa Coalition which is a coalition of over 70 organizations working across South Africa against sexual violence.

This mixture of secondary and official resources, including news articles, were used as they provided contemporary perspectives from a broad range of sources ensuring that the research was broad and comprehensive. Furthermore, all these documents were used to define legal frameworks, protocol and responsibilities by various stakeholders involved in GBV policy implementation. This was also necessary to demonstrate the barriers such as underfunding, lack of coordination and accountability by comparing the intention of the policy with what is happening on the ground.

1.8 Key-informant interviews

Four, one-on-one semi-structured interviews with key informants from GBV service providers in the Cape Town metro and police oversight bodies such as the Western Cape Department of Community Safety and the Western Cape Police Ombudsman were arranged. Participants were asked to reflect critically on the main aspects which posed barriers to GBV service provision.
These organizations were chosen as their staff dealt directly with victims of GBV as a first point of contact and exercised oversight on SAPS implementation of GBV laws and investigated complaints of inefficiency within SAPS. The research focus includes data on the Western Cape as the majority of the top ten police stations where sexual assault was reported are located in the Western Cape.

Several strategies were used to enhance the trustworthiness and overall rigour of the research study. To strengthen the credibility of the findings, participants were given opportunities to confirm the interpretations of their contributions. This form of validation helped ensure that the themes developed accurately reflected their intended meanings. Interview questions were carefully phrased in neutral terms to minimise the risk of leading participants toward predetermined responses. Although the study was geographically limited, the contextual descriptions of the research environment, organisational roles, and policy structures were provided. This involved explaining the setting in which the study took place, outlining the responsibilities and positions of the various actors involved, and clarifying the policy and institutional framework that shapes GBV service delivery. By offering this depth of contextual detail, the study gives readers a clear understanding of the conditions under which the findings emerged. It also enables other researchers or practitioners to judge whether the insights generated here might be meaningful in settings that share similar organisational structures or policy constraints. The Researcher remained attentive to personal assumptions and consciously sought to minimize its influence by crafting neutral questions and cross-checking interpretations with participants where possible. The diversity of interviewees, including the implementers and oversight bodies further supported findings by reducing the reliance on any single viewpoint.

1.9 Limitations

As is typical of qualitative, exploratory research, the study was intentionally limited in scope to ensure depth. The research focused on GBV service providers and oversight bodies operating within the Cape

Town metro area. This geographical focus arose from practical realities of time, access and resource availability and allowed for a detailed examination of policy implementation dynamics within a specific context. While these insights may not be automatically transferable to all GBV service providers nationally, it offers and understanding of how policy is interpreted and enacted within an urban and metropolitan setting and this is an aim consistent with exploratory and qualitative enquiry.

The absence of interviews with SAPS officials does limit the dissertation's ability to offer station-level insights into victim experiences. However, given that policing is a national competency which allows for direct provincial oversight – which in this case involves the Western Cape Department of Community Safety and the Western Cape Police Ombudsman – the study was able to collect valuable perspectives at a systemic level.

Another limitation is that key informant interviews reflected information based on the person's area of expertise and sometimes reflected their personal views on challenges in GBV policy implementation which may reflect bias. To control for bias in my conclusions, I reviewed my results by confirming with participants whether my interpretations of the data they provided were representative of their beliefs. To further reduce bias, I avoided asking leading questions and attempted to craft the questions in a neutral way, to prevent eliciting answers that may align to my own assumptions.

1.10 Chapter outlines

Chapter 2 presents a literature review and an overview of the problem of GBV as well as a policy and legislative review of South Africa's GBV interventions touching on the international conventions that South Africa is signatory to. It looks at South Africa's earliest GBV legislation and considers the factors leading to the introduction of such legislation and how and why the legislation came to be amended. This chapter also looks at the Western Cape's provincial GBV implementation plan. It considers how GBV policies and legislation was accelerated on the governments agenda leading to the Emergency Response Action Plan (ERAP) and the National Strategic Plan (NSP) on GBV. It considered the role of South Africa's apartheid past and the way the judicial system was generally unfavourable to victims prior to 1994. It was found that the current issues with GBV prevention strategies and incorrect reporting could be traced back to the apartheid era. The Chapter further delves into the prevailing attitudes amongst GBV policy implementers such as the SAPS and

some of the gaps in policy implementation by providing a policy and legislative overview of GBV interventions in South Africa. It then focuses on the Western Cape Provincial Profile of GBV and the measures taken by the province to address GBV.

Chapter 3 looks at research from academics and advocacy organizations with a focus on comparing South African and non- South African policy responses to GBV. This chapter also discusses the lessons to be learned from GBV policy interventions and how government may effectively coordinate across departments in its response to GBV. It focused on the issues relating to policy implementation amongst GBV implementers in more detail and highlighted the experiences of GBV implementers and victims in post-rape care services. It was found that police, and healthcare providers were generally not following the national instructions on sexual offences and their responses in dealing with victims of GBV was not effectively coordinated, ultimately leading to a lack of trust in the criminal justice system and legislation failing survivors. It was also found that victims often experienced secondary victimization by GBV policy implementers due to a number of factors such as a lack of specialised training and sensitization for staff, a lack of knowledge amongst implementers on the provisions of GBV policies and negative attitudes towards victims and amongst staff. A lack of adequate resources and funding was also a challenge for GBV implementers such as those working in TCCs. It found that there was a lack of centralised mechanisms to hold GBV implementers accountable. The Chapter also considered prevention and response strategies as lessons from GBV implementation measures in other countries from a bottom-up perspective which adopts a whole of society approach to address GBV.

Chapter 4 considers the findings from key informant interviews at two GBV service providers, the Western Cape Department of Community Safety and the Western Cape Police Ombudsman and discusses the barriers to GBV policy implementation as well as the barriers faced within the criminal justice system and how this may negatively impact victims. The interview findings indicate the ineffectiveness of some structures in GBV policy implementation such as the TCCs, healthcare workers and SAPS and their lack of coordination and accountability in responses to victims of sexual violence. It revealed the hostility between service providers, and negative attitudes toward rape victims and highlighted compliance challenges in GBV laws where some service providers felt the policies itself sometimes posed a barrier to GBV implementation.

Chapter 5 is the concluding chapter and summarizes the findings of the dissertation as discussed in chapters 2,3 and 4. It also goes back to the research question of the dissertation

and suggests ways to improve the response to GBV through a joined-up coordinated response by GBV service providers.

Chapter 2: Literature review of policy, legislative and operational responses to Gender Based Violence in South Africa

2.1 Introduction

Efforts to combat gender-based violence (GBV) in South Africa are extensive on paper, encompassing legislation, policies, and awareness campaigns. However, persistent high rates of GBV demonstrate that the existence of these frameworks alone does not translate into effective protection or support for survivors (Nortje & Hull, 2024:296). Understanding the landscape of South Africa's GBV response requires examining not only the content of laws and policies but also the structural, procedural, and societal factors that shape their implementation. The following thematic areas are considered: legislative protections, multi-sectoral service delivery, prevention and awareness interventions, and accountability and monitoring mechanisms.

South Africa has developed a wide range of laws, policy frameworks and multi-sectoral initiatives intended to prevent GBV, provide survivor support and strengthen justice system outcomes. Yet, despite this extensive architecture, implementation has repeatedly been hindered by capacity constraints, weak coordination, limited accountability and persistent societal norms that undermine equality. As a result, many reforms intended to enhance justice, protection or prevention remain ineffective in practice. This chapter therefore examines the evolution of key policy and legislative interventions, the establishment of national strategic responses, and the role of state and civil society actors in shaping these processes.

Given the centrality of multi-sectoral responses to GBV, the chapter also analyses the National Strategic Plan on GBVF and its six pillars, highlighting both the collaborative structures created and the gaps that continue to impede progress. Further, the chapter explores the contribution of NGOs and social movements, whose advocacy has often driven political momentum and highlighted shortcomings in state-led interventions. As awareness and prevention efforts remain insufficiently evidence-based, the chapter also draws on literature that identifies systemic barriers from high attrition rates to secondary victimisation that continue to weaken survivor confidence in the criminal justice system.

This chapter then reviews the implementation of the Thuthuzela Care Centre (TCC) model and the operational challenges facing frontline service providers. These insights demonstrate that while

South Africa's legislative and policy landscape appears comprehensive, its effectiveness depends on day-to-day practices, institutional capacity and the extent to which state and community-based actors can work together to deliver survivor-centred, accountable and adequately resourced services.

2.2 Policy and legislative Interventions to curb GBV

Despite years of GBV activists lobbying for an NSP on GBV, the National Council on Gender-Based Violence (NCGBV) was only established by the government in 2013 to create an NSP on GBV, but the Council failed to do this, and it was not prioritized by the government after the 2014 elections (Burris, 2022:35). In 2014, a coalition of anti-GBV organizations in South Africa which included MOSAIC and Sonke Gender Justice launched a campaign to influence government to create the NSP on GBV. These GBV organizations, in consultation with 240 civil society organizations developed an NSP on GBV shadow framework report and organized marches, petitions and campaigns (Burris, 2022:35).

The first Presidential Summit on GBVF in 2018 was held in response to 24 demands submitted by the #TotalShutdown Intersectional Womxn's Movement to President Cyril Ramaphosa after 27 marches took place across the country on 1 August 2018. The #TotalShutdown demonstrated against the scourge of GBV in the country and proposed 24 demands to address this (Dlamini, 2021:588). The main demand was to have President Ramaphosa hold the first summit on GBV on the African continent. The protest action was sparked by the scourge of GBV after Stats SA found in June 2018 that the murder rate for women increased by 117 percent between 2015 and 2016/17 and the number of women who experienced sexual offences also increased from 31, 655 in 2015 to 70,813 in 2016/17 which was an increase of 53% (UN Women, 2018).

In response to the #TotalShutdown's memorandum of demands, President Ramaphosa appointed the Department of Justice and Constitutional Development (DoJ&CD) to coordinate and implement the National Summit which included a wide range of stakeholders from various sectors (GBV Summit Report,2018:6). A National Summit Steering Committee, the relevant government departments and entities, Civil Society Organization's (CS0s), the #TotalShutdown movement, sector experts and representatives from various development aid agencies supported the process. On 18 September 2019, during increased public concerns and consistent media reports of worsening incidents of GBV as well as increased pressure from civil society for President Ramaphosa to take

urgent action, the ERAP was created to fast-track:

- Access to justice for victims of crime;
- Encourage changed norms and behaviours through prevention efforts;
- Urgently respond to survivors of GBV;
- Strengthen accountability and mechanisms in response to GBV and;
- Prioritize the creation of economic opportunities for women (South African Government, 2021).

The ERAP had 39 proposed interventions and 80 targets for achievement by more than 22 government departments and state entities. The Commission for Gender Equality (CGE) assessment on ERAP'S implementation found that overall, the intended interventions and achievements under the ERAP were not achieved. Out of the 80 targets, only 17 were fully achieved, 12 targets were partially achieved and most of the targets were not achieved (South African Government, 2021). This could be attributed to important operational failures such as the coordination of stakeholders and a lack of capacity which undermined implementation.

Following the first Presidential Summit on GBVF in 2018, a Summit Declaration was drafted which officially declared GBVF a national crisis in March 2018. The rape and murder of 19 - year-old Uyinene Mrwetyana ignited protests all over the country in 2019. This led to the development of the National Strategic Plan on GBVF (NSP on GBVF) which was released in April 2020 (South African Government, 2022; EWN,2022).

South Africa's legal framework provides a broad set of instruments intended to protect women, children, and other vulnerable groups from GBV. Key statutes include the Domestic Violence Act (DVA, 116 of 1998), the Criminal Law (Sexual Offences and Related Matters) Act (SOA, 32 of 2007), and subsequent amendments (Nortje & Hull, 2024:300). These Acts define offenses such as sexual assault, domestic violence, and harassment, outline procedures for reporting and prosecution, and attempt to limit secondary victimization during legal processes. The SOA significantly expands the definition of rape beyond penile-vaginal intercourse, making it gender-neutral and inclusive of various forms of non-consensual sexual acts (WLC, 2013:97–98). Importantly, it emphasizes the role of consent and protects complainants from the use of their sexual history in court proceedings. Despite these progressive provisions, implementation gaps persist. Broad legislative definitions do not always align with community perceptions of GBV, resulting in misreporting or underreporting of offenses (Medie, 2013:386). Procedural requirements, such as the need for direct testimony in

sexual offenses, can place significant emotional burdens on survivors and reduce their willingness to participate in the justice process (Naidoo & Wielenga, 2022:17). Moreover, law enforcement and judicial systems face resource constraints, including insufficient specialized staff, high caseloads, and limited training. These systemic weaknesses result in delays, case attrition, and inconsistent application of laws, creating a disconnect between statutory protections and survivors' lived experiences (Thobane et al., 2020:84–85).

Amendments to legislation, particularly following high-profile cases, demonstrate attempts to respond to public pressure and evolving societal expectations. While these reforms strengthened protections on paper, they have not fully addressed the procedural and resource challenges that continue to undermine effectiveness (Nortje & Hull, 2024:296–297). This highlights that legal reform alone, without adequate implementation support, is insufficient to alter systemic outcomes. Following the Mrwetyana case, President Ramaphosa signed into law the Criminal Law Sexual Offences and Related Matters Amendment Act, the Criminal and Related Matters Amendment Act and the Domestic Violence Amendment Act. In 2019, the government implemented the National Strategic Plan on GBV and Femicide 2020-2030, which provides policy for the prevention of GBV, and Sexual Offences Courts have been established to deal with GBV cases relating to the Sexual Offences and Related Matters Amendment Act (Nortje & Hull,2024:300). Despite this, the perspectives of key implementers have not been included and these reforms have been insufficient (Nortje & Hull,2024:296).

2.3 Multi-sectoral Responses and NSP Pillars

The NSP on GBVF provides a framework for multi-sectoral approaches to end GBVF and create a safe space for vulnerable groups in society such as women, children and the LGBTQIA+ community and eradicate patriarchal stereotyping and norms. The NSP consists of 6 Pillars:

1. Accountability, Coordination and Leadership
2. Prevention, Rebuilding and Social Cohesion
3. Justice, Safety, and Protection
4. Response, Care, Support and Healing
5. Economic Power
6. Research and Information Management (South African Government, 2022; EWN,2022).

The focus of the first pillar is government's responsibility to lead the GBV response and

implementation of the NSP, be accountable to citizens and provide the needed technical and financial resources. The second pillar focuses on strengthening prevention initiatives and changing gender norms which perpetuate toxic masculinity. The third pillar focuses on strengthening the criminal justice system and amendments to legislation, while the fourth pillar deals with providing survivor-centered after-care and prevention of secondary victimization. The fifth pillar aims to eradicate economic inequality between men and women and the sixth pillar aims to educate citizens in the fight against GBV (Burris, 2022:35).

President Ramaphosa hosted the second Presidential Summit on Gender-Based Violence and Femicide in Midrand, Johannesburg on 1 and 2 November 2022 under the theme "Accountability, Acceleration and Amplification, Now!". The Summit considered the progress made since the first Presidential Summit on GBVF in November 2018 and reported on the successes and failures in the implementation of the NSP and considered strategies to remedy this (South African Government, 2022). Pillar meetings are held bi-weekly to discuss and manage prioritized interventions and pillar team members also attend monthly collaborative meetings (END GBVF Collective,2023).

The End GBVF Collective was established as a multi-sectoral and collaborative platform and is the informal and voluntary NSP collaborative platform open to all stakeholders in the GBVF response in South Africa and allows for stakeholders from government, civil society, development agencies and citizens to share ideas and plan for the success of the pillars of the NSP. The pillar teams aim to implement the interventions of the NSP while the Coordination and Communication Teams support the work of the pillars and the collaborative.

The government's response to GBV is seen in South Africa's laws, policies, programs and services and while South Africa has some of the most progressive laws and policies in comparison to other countries all over the world, the issue lies in its implementation of these laws and policies and providing comprehensive services to victims. South Africa's Constitution also offers guidance which aims to protect women's rights (Mpani & Nsibande, 2015:31).

South Africa's legislative and policy framework aligns to international conventions and includes the Domestic Violence Act No 116 of 1998 (DVA) and the Criminal Law (Sexual Offences and Related Matters Act No 32 of 2007 (SOA) which are two important laws relating to GBV. The National Gender Policy Framework, the Employment Equity Act (EEA) the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) relate to gender equality (Mpani &

Nsibande, 2015:31). The focus here will be on the DVA and the SOA.

The Constitution in South Africa, which was adopted in 1996 and amended in 2012 has sections which offer protection against GBV such as Sections 9,10,11 and 12. These sections deal with the right to equality before the law, equal protection and benefit for everyone, the prohibition of unfair discrimination by the state and individuals on many grounds including on the basis of gender. It also speaks to the right to human dignity, the right to life, freedom and security of the person and the right to be free from all forms of violence amongst many other provisions (UNODC,2021:21). South Africa has committed to key international and regional human rights instruments which include the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1991; The UN Convention on the Rights of the Child (CRC) in 1995; the African Charter on the Human and People's Rights in 1996; the ILO Convention 111 on Discrimination (Employment and Occupation) in 1997; the African Charter on the Rights and Welfare of the Child in 2000; the Maputo Protocol of the African Charter on Human and People's Rights on the Rights of Women in Africa in 2004; the CEDAW Complaints and Inquiry Procedure in 2005; and the Southern African Development Community (SADC) Protocol on Gender and Development in 2008. (UNODC,2021:9). As signatory to these international and regional frameworks, the South African Government is obligated to achieve the targets and principles which aim to protect the rights of women (Roberts,2024).

In addition to this, South Africa has developed legislation such as the Domestic Violence Act (No. 116 of 1998), the Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 6 of 2012), the Maintenance Act (No. 99 of 1998) and the Protection from Harassment Act (No. 17 of 2011). In 2020, there was public outrage as GBV cases increased from the start of the COVID-19 pandemic which led to President Cyril Ramaphosa signing three new GBV laws which would strengthen the fight against GBV in South Africa in January 2022. These are: the Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment, the Criminal and Related Matters Amendment Act and the Domestic Violence Amendment Act (alt.advisory,2022).

The relevant GBV laws in South Africa are: the Criminal and Related Matters Amendment Act, 12 of 2021; the Criminal Law (Sexual Offences and Related Matters Act 32 of 2007); the Domestic Violence Amendment Act 14 of 2021; the National Council on Gender-Based Violence and Femicide Act 9 of 2024 and the Victim Support Services Bill 2019. Three of these laws were considered by the National Assembly and amended as part of South Africa's legislative measures

to strengthen the country's response to GBV.

2.4 Role of NGOs and Social Movements

Medie (2013:377) refers to post-war Liberia where instances of GBV are common, but are mostly never escalated to the Courts as police tend to withdraw these cases without the victim's consent, highlighting one of the numerous factors at play in the effective translation of policies by frontline providers. Medie (2013:379) also explores the implementation of policies and the failure to implement them and suggests that the presence, absence and characteristics of particular actors, structures, resources, norms and policy instruments affect policy implementation. Medie (2013:379) states that academic experts suggest four categories to explain the behaviour of street-bureaucrats such as police officers and medical practitioners which all point to the influence of political control, organizational control, individual characteristics and external factors. Medie (2013:380) further explains that political control is exercised by political officials and organizational control stems from implementing agents and the material conditions of the service provider. Individual characteristics refers to the norms and beliefs of individual service providers and the external pressures arise from actors and conditions that are outside of the state and its bureaucracies such as International Organisations (IOs) and interest groups such as social movements and NGO's. Some experts have argued that individual characteristics of policy implementers explains implementation behaviour, while others have concluded that social movements are critical to implementation and influence individual front- line providers (Medie,2013:380). This shows the need for, and importance of the role of social movements and NGOs in policy implementation.

2.5 Prevention and Awareness

Government's 365 Day Action Plan to End Gender-Based Violence (2007), includes a Sixteen Day Campaign related to GBV which is observed every year and focuses on awareness of GBV, gaps and challenges in the eradication of GBV and achievements (UNODC,2021:21). South Africa participates in the United Nations 16 Days of Activism for No Violence Against Women and Children Campaign every year from 25 November to 10 December. The year 2024 marked the campaign's 26th year anniversary for a period focused on creating awareness on GBV and the impact on victims/survivors, despite little measurable impact (Levendale *et.al*,2023:1 & Government Communications Brief,2024). Levendale *et.al* (2023:3) acknowledge that while there

is extensive legislation and policy in place to combat GBV, it has not brought about change. Levendale *et.al* (2023:3) suggest that laws and policies be improved through better resource allocation, having prevention programmes based on evidence, improving the quality of services for survivors and increasing the resources allocated to NGO's. Analysis of the literature and mainstream media shows that the 16 Days of Activism campaign in South Africa has been criticized and considered problematic by activists, scholars and community leaders, because the campaign is considered to be symbolic without a substantive outcome every year. The Campaign is viewed to be performative where speeches, events and media coverage are concentrated between 25 November and 10 December each year, but the campaign seems to lack long-term outcomes. This is perhaps also problematic, because GBV is a persistent occurrence in the daily lives of South African's, but strong focus is placed on this phenomenon only once a year which is inadequate to address the real extent of the problem. Other criticism relates to feelings of fatigue and desensitization as the same message is repeated each year, but again without substantial results which somehow normalizes the campaign, and thus could normalize violence. The country also seems to experience many cases of GBV during this period each year. Mkwanazi and Nthane-Taulela (2024:4) also criticized the government's interventions as being overly focused on awareness and neglecting other aspects needed to deal with GBV, thereby keeping many in a cycle of violence. Mkwanazi and Nthane-Taulela (2024:4) highlight the importance of the community as policing forum patrollers and as a community-led intervention given the lack of resources at shelters which are unable to accommodate survivors beyond 2-3 months.

There is also a lack of government accountability, as following the campaign, there is no reflection on policy implementation, what has worked and what has not, to lead to improved implementation and thus, no policy changes or increased funding, which demonstrates why the campaign is viewed to be symbolic. This aligns with Roberts (2024) study on the NSP on GBVF and its implementation. Roberts (2024:32) found that there was a lack of accountability in implementation, making it difficult to monitor and evaluate progress and determine who should be held accountable. It is also problematic, because victims/survivors of GBV continue to deal with a justice system that does not serve them given instances of poor response by SAPS, mishandling of evidence, secondary victimization, poor conviction rates and how shelters are severely lacking, including the barriers to access. Thus, the survivors of GBV are not front and center of these campaigns where they are able to share their experiences to influence planning and implementation to become more effective and beneficial to the survivor. This also reinforces a top-down approach to tackling GBV.

Calvino and Matadi (2023) advocate for a bottom-up approach to tackling GBV. They indicate that attempts to understand GBV have constantly excluded local communities, GBV Activists and important stakeholders. Mkwanazi & Nthane-Taulela (2024:2) make reference to the role of Activists in movements such as #Am I Next? One in Nine Campaign and the national Silent Protest in response to women's concerns for their safety and wellbeing, and the ability of activists and community groups to help inform an understanding of GBV and influence laws and policies. Mkwanazi & Nthane-Taulela's (2024) study findings indicate 3 main forms of GBV interventions in South Africa versus government campaigns which took place during the 16 Days of Activism for the Prevention of Violence Against Women and Children, community campaigns as a response to GBVF cases reported in the media and NGO initiatives to provide support to GBV survivors. Despite these initiatives, the study found that there were still barriers to the effectiveness of these efforts to eliminate GBV (Mkwanazi & Nthane-Taulela,2024:1). These interventions were challenged by cultural and social ideas which went against reporting GBV, a lack of sustainability of programmes, ineffective organization and management and a lack of funding. Additionally, there is a lack of sustainable community programmes and interventions which could change social norms which perpetuate GBV. Mkwanazi & Nthane-Taulela (2024) recommend GBV implementation initiatives that are not solely focused on creating GBV awareness, but encourage partnerships between government and NGOs which have the potential to change social norms.

Preventive interventions in South Africa include the National Strategic Plan on GBV and Femicide (NSP on GBVF, 2020–2030) and initiatives such as the 16 Days of Activism for No Violence Against Women and Children. These campaigns aim to raise awareness, shift societal norms, and encourage reporting of GBV incidents (UNODC, 2021:21; Levendale et al., 2023:1–3). They reflect the recognition that legislative and procedural measures alone cannot eliminate GBV; cultural transformation is necessary to challenge patriarchal attitudes and reduce tolerance for abuse. Nonetheless, the efficacy of awareness campaigns is contested. Critics argue that such interventions are often symbolic and time-bound, with limited engagement beyond initial publicity. Public desensitization can occur when campaigns are repetitive, underfunded, or disconnected from meaningful systemic change (Mkwanazi & Nthane-Taulela, 2024:4; Roberts, 2024:32). Community-based programs led by NGOs or activist movements, including initiatives such as #Am I Next? and One in Nine, have attempted to bridge these gaps. They offer grassroots mobilization, survivor support, and advocacy for policy reform. However, these programs often face sustainability challenges, limited funding, and organizational capacity constraints, which curtail their long-term impact (Mkwanazi & Nthane-Taulela, 2024:1–2). The thematic focus on prevention

highlights that awareness initiatives alone are insufficient to effect substantive reductions in GBV. They must be integrated with structural reforms, education, and continuous community engagement to address underlying causes such as social norms, inequality, and gendered power dynamics.

Naidoo and Wielenga's (2022:16) study considered the awareness and perceptions of South Africa's policy framework and found that there was a lack of awareness about GBV services. Their study also shows that policy implementers such as the SAPS were not aware of policy frameworks for GBV, even though they were familiar with TCC guidelines, showing how GBV programmes are implemented with a lack of awareness by important role-players. Furthermore, women experienced a lack of empathy and noticed a lack of appropriate equipment when seeking support. There were staff shortages and similar challenges were also reported when seeking legal and judicial support (Naidoo and Wielenga,2022:20).

2.6 Implementation of TCC Protocol

South Africa has adopted international, regional and local policies and developed local legislative framework to eliminate GBV, such as the Framework of the Sustainable Development Goals (Naidoo &Wielenga,2022:2). Thuthuzela Care Centre's (TCCs) are also a measure introduced by government that involves state structures such as the National Prosecuting Authority, the Department of Justice and Constitutional Development, the Department of Health, Social Development and the South African Police Service, working together.

Complementing legislation, South Africa has sought to implement multi-sectoral service delivery models, most notably through the Thuthuzela Care Centres (TCCs) and Khuseleka Care Centres. These centres are designed to provide survivors with coordinated access to medical, psychological, and legal services while minimizing secondary victimization (Nortje & Hull, 2024:300; Western Cape Government, 2015). In principle, the TCC model embodies a victim-centered, collaborative approach linking the South African Police Service (SAPS), National Prosecuting Authority (NPA), Department of Justice, Department of Health, and Social Development. This approach theoretically ensures that survivors can navigate a complex system without being repeatedly traumatized by fragmented services. However, practical implementation reveals numerous challenges. Variability in staffing, training, and resource allocation across TCCs results in uneven service delivery. For example, some centres operate with limited social workers or forensic staff, reducing their capacity to conduct timely investigations or provide ongoing support (Naidoo & Wielenga, 2022:16–20).

Survivors often encounter long delays in accessing protection orders, attending court proceedings, or obtaining counseling services, which undermines trust in both service providers and the criminal justice system.

The limitations of standardized protocols are particularly apparent when dealing with survivors from marginalized groups, such as minors, persons with disabilities, or those living in unsafe home environments. The need for flexibility in implementing services, combined with insufficient guidance and support, creates gaps that may leave the most vulnerable survivors without adequate protection (Medie, 2013:377). This thematic area underscores the importance of examining not only the existence of multi-sectoral models but also the operational challenges that affect their capacity to provide meaningful support.

2.7 Operational Challenges: Frontline Service Providers

Analysis of the TCC protocol, shows that it aims to provide a victim-centred approach and emphasizes a collaborative and multi-sectoral approach and while this protocol is comprehensive and appears to be structured implementation varies based on resources, availability of police vehicles, the amount of staff, availability of police officers and detectives trained to deal with victims of GBV may not always be available in underserved communities, and this includes the amount of Doctors stationed at TCC's as is shown in key informant interviews in Chapter 4 of the dissertation. Due to these factors, service delivery in relation to the TCC Model may not be the same across all TCCs. The protocol is also vague in relation to the victim's safety and the procedures to follow when it is unsafe for them to go home and in the case of them not meeting the criteria for a shelter. The protocol also does not provide any clear indication of how minor survivors of sexual assault are dealt with indicating a more generalized protocol. This could be problematic, because protocol must indicate how to refer minors or in the case of a child with a disability to prevent inappropriate service and re-victimization. A key informant also mentioned a lack of awareness on feedback mechanisms and the process to be followed as this process is vital to ensuring proper service delivery and victim-centred support and care.

The SOA protects witnesses and victims of sexual offences as well as victims who are minors. The Act also prevents the complainant's sexual history from being used as evidence or proof of consent to make the complainant appear less trustworthy (WLC,2013:97,98). The Act makes provision for the complainant to be listened to with respect during criminal proceedings, plea agreements,

sentencing and parole hearings.

Despite progressive laws, GBV in South Africa persists as a result of poor implementation of policies and legislation. One of the challenges experienced by victims of GBV in South Africa, is access to the criminal justice system. Despite the DVA and SOA indicating clear procedures on how the SAPS should deal with cases of GBV, there is still a lack of urgency by the SAPS when addressing GBV. Victims of GBV are often sent back home to resolve the issue with the perpetrators. The negative responses by the SAPS to victims of GBV discourages victims from reporting rape cases and decreases the victims and the public's trust in the criminal justice system to hold perpetrators to account. It was also found that SAPS has a lack in training on provisions provided for in legislation such as the Victim Empowerment Programme, or police officers interpret this in their own way (Thobane *et.al*.,2020:84,85). A key informant in Thobane *et.al*'s (2020:85) study revealed that police in specialized units on domestic violence only received one week of training which was concerning. Another factor contributing to implementation failures of GBV legislation is the shortage of specially trained staff to address sexual offences (Thobane *et.al*.,2020:85). Areas without sexual offences courts experience challenges in handling sexual offence cases, because Prosecutors tend to be overworked with heavy case-loads in other areas of criminal law and are likely to invest less time on sexual offences cases, which was also expressed in one of the key informant interviews. Victims of GBV experience difficulties accessing the courts and understanding the court system as they are not properly informed by staff on court processes. Applications for protection orders are often delayed due to insufficient resources and a shortage of staff in courts. The Courts have also showed leniency towards perpetrators of GBV when granting bail and in sentencing proceedings, with perpetrators receiving minimum sentences in serious GBV cases. Key informants of the research felt that the legislation failed survivors in this way. These are factors that could potentially affect a victim's confidence in the criminal justice system.

One of the most significant challenges in the effective implementation of the DVA stems from when the Act was developed and the fact that it was not costed. Additionally, the Act acknowledges that GBV must be addressed with a multi-disciplinary approach and does not oblige the DSD, the Department of Health or the NPA to be responsible for the provision of care and support services (Mpani & Nsibande, 2015:35). Mpani and Nsibande (2015:35) refer to a 2012 Tshwaranang Study which reviewed the implementation of the DVA and found that the SAPS were largely unaware of the provisions of the DVA and their responsibilities in this regard and not much has changed since then. Furthermore, the study reported a lack of capacity and funding played a role in the ineffective

implementation of the Act, as was also reported by the Department of Community Safety in the Western Cape (Interview WCDCS,2023) Most of the SAPS officers also viewed domestic violence as being a family matter and not a crime, which exacerbates the implementation issues of the DVA and other GBV legislation.

The Criminal Law, Sexual Offences and Related Matters Act No 32 of 2007 presents challenges in its implementation as there is a limited understanding of its provisions among key implementers and while this law has a broad definition of rape, there is a major gap between community perceptions of what represents rape and what is provided for in the law. This Act defines rape broadly, moving beyond the traditional common-law definition that focused solely on penile-vaginal penetration. Section 3 of the Act states that rape includes "any person … who unlawfully and intentionally commits an act of sexual penetration … without the consent" of the complainant (South Africa, SOA, 2007, s. 3). Sexual penetration is further defined to include any bodily part or object, making the law gender-neutral and inclusive of a wide range of non-consensual acts (South Africa, SOA, 2007, s. 1; Wits Gender Programme, 2017:13). Despite this, research shows that many community members continue to associate rape narrowly with forced penile-vaginal intercourse, and do not recognise other forms of non-consensual sexual acts as rape (Wits Gender Programme, 2017:15). This gap between legal definition and public perception affects reporting and the way cases are handled, as survivors and even some law enforcement officials may not interpret certain acts as criminal under the law.

The Act also focuses on consent, defined as a "voluntary or uncoerced agreement" (South Africa, SOA, 2007, s. 1(2)), which places the burden on the prosecution to prove absence of consent rather than just physical force. In practice, this creates challenges for complainants, particularly in cases where coercion is subtle or where social norms complicate the interpretation of consent (De Rebus, 2019:22). Consequently, while the law is progressive on paper, these perception gaps and evidentiary burdens contribute to difficulties in effective implementation.

The gaps in implementation can also be seen in the police and medico-legal service as well as a lack of coordination in the duties of staff which contributes to implementation failures (Mpani & Nsibande, 2015:34). An example of this is a shortage of specialized staff to deal with sexual offences or when Prosecutors who are overworked might spend little time on preparations for rape cases when there are no specialized sexual offences courts in the vicinity (Burger,2015:52). The fact that there is no incentive for police officers to become specialized in dealing with sexual

offences matters or becoming Investigators is also a contributing factor in shortages of personnel (Interview WCDCS,2023). According to a report on Parliament's Detective Dialogue, the detective service at the SAPS was neglected in terms of resources and did not receive much attention from Station Commissioners (Burger,2015:52). The detective environment also did not have a proper retention strategy.

According to a CGE Briefing on progress in the implementation of the NSP on GBVF, the CGE findings show that out of 81 targets across the five focus areas, only 17 targets were achieved within the ERAP six-month timeframe while 12 targets were only partially achieved (PMG,2021). The majority of 51 targets were not achieved. The CGE then enquired about the reasons for the non-achievement of targets and of the 22 departments and entities responsible for the implementation of the NSP, only 8 responded (PMG,2021). It is important to note here that a key role-player, the Department of Social Development had not accounted for their implementation of ERAP, showing a lack of implementation and accountability. The CGE also reported that to date the multi-sectoral body on GBVF was not established. Before being dissolved, the Interim Steering Committee (ISC) also did not establish the National Council on GBVF within a six-month timeframe as set out when the summit declaration was signed. In a 2023 report from the CGE, it considered the implementation of the NSP on GBVF by the government and government-funded entities and in analysing implementation of the 6 pillars found that of 11 of the 144 indicators, targeted for achievement within 2020 and 2022 were achieved. 5 of the indicators the were not achieved by the end of 2022. There were also 75 targets with a five-year roll-out period between 2020 and 2024 which only made some progress and 15 indicators that had no progress in the NSP implementation. Some information on performance could not be obtained for 38 of the 144 indicators (CGE Missing Pieces of the Puzzle,2023:72).

2.8 Attrition in the Criminal Justice Sector

Each year, a significant number of rape cases are reported to the police, but a very low number of offenders are convicted due to attrition, which is the arrests of perpetrators that result in no conviction (Vetten *et.al.*,2008:57). Attrition considers the number of rape cases reported to SAPS in comparison to the amount of cases that go to trial, resulting in a conviction. Some attrition of rape cases were, because a perpetrator could not be identified, which could not result in an arrest, or a case is evaluated based on merit and whether it could feasibly result in an arrest. The Rape Adjudication and Prosecution Study in South Africa Report (2017) indicates that the most attrition

occurs during the police investigation phase and that most cases never reach the trial phase. High attrition also occurs during prosecution, before the trial or due to a victim withdrawing charges. High Attrition rates are also due to victim-blaming, a lack of support for survivors, poor police training for dealing with rape cases, availability of forensic evidence and attitudes in society toward rape and sexual assault (Machisa *et.al*,2023:588-589). Statistics on attrition in the criminal justice system show that 100% of cases were examined, an arrest was made in 57% of the cases, 65% of cases were referred for prosecution,34,40% of cases were accepted by Prosecutors and 18,50% of trials began with only 8,60% of cases finalized (RAPSSA Report, 2017).

These statistics show a significant difference between when a case is reported and when the case is finalized, as less than 20% of cases reach the trial phase and only 8,6% of cases result in a conviction, causing victims to lack trust in the criminal justice system. The criminal justice system has a vital role in bringing about justice for rape victims which is currently not a reality requiring more in-depth investigation and better supervision over Investigating Officers (RAPSSA Report,2017:15). Between April 2022 and March 2023, SAPS recorded 43 037 rape cases, but only 519 perpetrators were sentenced (Ditshego,2023).This means that attitudes within the SAPS needs to be addressed, including resource allocation, tools of trade, the availability of vehicles, circulars on procedures and information on TCC's, shelters and the available resources for victims. Given this reality, we need to interrogate whether the legislative framework on rape and other sexual offences are effective. The RAPSSA Report (2017:15) suggests that Prosecutors should receive incentives to work on more complex cases and ensure that victims are identified to assist the court in trials, and their own work environment which would prioritize time to successfully prosecute rape. Investigation and prosecution decisions need to be based on evidence of what works including the training of GBV service providers, which must remain ongoing.A significant factor contributing to legislative ineffectiveness is the prevailing dismissive attitudes of the SAPS toward sexual assault victims and a lack of legislative enforcement. Based on a 2017 study, 37,5% of rape victims reported that police did not collect evidence and showed no empathy; 54,2% reported that witnesses were not interviewed and 62,5% felt there was no need to report to police in future. This suggests that secondary victimization is a deterrent to help-seeking by survivors. This is also reported to occur during cross examination and victim- blaming based on clothing choices or behaviour believing the perpetrator to be justified (Oppenheim, 2019). This demonstrates that without a "grassroots enforcement" of GBV legislation, the top-down government action will be ineffective. George (2020) states that South African GBV policies and legislation are ineffective due to a lack of implementation and that the majority of policies and legislation focus on post-rape care and services

for when victims have already experienced GBV as opposed to violence prevention strategies. Little emphasis is placed on prevention which means resource allocation is inadequate to broaden interventions, ensure effective practices and develop multi-dimensional best practice approaches across government (George, 2020). Dr Valerie Hudson, Gender Studies Researcher and Author, notes that sometimes top-down and bottom-up approaches must be used together to create sustainable change in combatting GBV as opposed to affirming that one approach is more effective than the other (George, 2020). In medie's (2013:384,385) examination of the role women's movements have in the implementation of GBV and other women's rights policies, he shows the positive impact that bottom-up and joined up partnerships between NGOs and the police can have in effectively enforcing rape laws.

2.9 Social and Cultural Barriers

Informally resolving matters are preferred by victims for various reasons as some view the courts as being divisive where it places emphasis on punishing perpetrators as opposed to a focus on reconciliation. The criminal justice system is also viewed as being corrupt, the length of trials and the impact this has on the lives of victims as well as their fear of retaliation, victimization and stigmatization or being told that they are lying in the case of rape are all contributing factors to non-reporting (Medie,2013:386). Public attitudes toward GBV have been negative and victims fear being shamed as victims tend to be blamed, as is shown by 69% of respondents in Medie's research who believed that women contributed to being raped by flirting with men and 61,9% of respondents felt that women contributed to rape by being alone with a male (Medie,2013:386). Some also thought restorative measures should be considered for "less egregious" forms of rape, further demonstrating the largely negative attitudes toward rape and other forms of GBV thereby ultimately making it even more challenging for women to seek justice with the prosecution of perpetrators (Medie,2013:386). In Kwa-Zulu Natal in South Africa, the Centre for Community Justice and Development (CCJD) explains that through a network of community-based paralegals, justice and long-term solutions to GBV can be found (Social Justice Initiative). Sometimes it may be daunting and complex for victims to take action on abuse and violence within a family unit as many may not know how to navigate the legal system. The CCJD helps women to seek justice through a dual legal system by first looking to the traditional chief to see if the matter can be resolved in this way (Social Justice Initiative). Medie (2013) also referred to instances where traditional courts often adjudicated on matters of rape and sexual violence and perpetrators provide compensation to families in the form of livestock, but leaned more towards this being ineffective, while the Social Justice Initiative offers

a different perspective. The Initiative has the view that a perpetrator could be given a sentence which involves paying damages in the form of a goat or cow (Social Justice Initiative). The Initiative views this type of resolution as having the potential to provide more emotional healing than a court, but may need to be accompanied by a protection order from a court to ensure the perpetrator is kept away from the Victim. The Initiative points out that sometimes domestic violence cases cannot be disconnected from the societal pressure's women may be faced with, particularly taking into account where an individual comes from, their background and those who are from poor families. For the victim such a choice could be about survival, access to food and other resources or having dependents or a situation of illness. The idea behind this is that sometimes women want justice, but do not want the perpetrators to lose their job or go to prison, particularly if the perpetrator is within the family unit.

2.10 Accountability and Monitoring

Accountability is central to understanding why legal and policy frameworks often fail to translate into meaningful outcomes. Monitoring and evaluation of GBV interventions reveal significant gaps. For instance, the Commission for Gender Equality's assessment of the Emergency Response Action Plan (ERAP) and subsequent NSP on GBVF indicates that many departmental targets were partially achieved or unmet, with minimal explanation provided for implementation failures (PMG, 2021; CGE Missing Pieces of the Puzzle, 2023:72).

Weaknesses in accountability intersect with systemic issues within the criminal justice system. High attrition rates in sexual offenses, delays in court proceedings, and dismissive attitudes among law enforcement officers exacerbate survivors' experiences of secondary victimization (RAPSSA Report, 2017; Ditshego, 2023). Inadequate coordination between departments, insufficient training, and limited resources further compromise the ability to enforce existing laws effectively. These challenges underscore that legal and policy instruments alone cannot address GBV without robust monitoring, resourcing, and political commitment (George, 2020; Medie, 2013:382–383).The thematic analysis of legislative protections, service delivery models, preventive campaigns, and accountability mechanisms highlights a recurring pattern: South Africa possesses a comprehensive policy environment addressing GBV, but systemic, structural, and cultural factors impede effective implementation. Persistent barriers including resource limitations, inconsistent application of protocols, societal attitudes, and gaps in survivor-centered approaches demonstrate that progress cannot be measured solely by the existence of legislation or campaigns. Evaluating the effectiveness of GBV responses requires considering both policy design and operational realities. Laws and

programs can only fulfill their protective and preventive functions if they are adequately resourced, implemented with fidelity, and informed by the lived experiences of survivors (Nortje & Hull, 2024:300; Medie, 2013:383). This thematic foundation provides a lens for understanding how South Africa's GBV interventions are situated within a broader social, political, and institutional context, setting the stage for deeper analysis of implementation challenges in subsequent chapters.

Chapter 3: Institutional Arrangements for implementing policies and legislation targeting GBV

3.1 Mandated Government Departments, Programmes and Campaigns

The states response to GBV and its responsibilities are spread over several government departments such as the Department of Social Development, the Department of Health, Justice, Education, Correctional Services, the SAPS and others, which operate in both national and provincial spheres. The Department of Social Development is mandated to prevent violence against women and children and to respond to violence by monitoring the prevalence of GBV and offering continued support to survivors as well as supporting their re-integration into society (Mpani & Nsibande, 2015:37). There are some policies which offer guidance to the DSD in its policy responses such as the Department of Social Development, Policy on Funding Non- Governmental Organisations for the provision of Welfare and Community Development Services (2013); the Integrated Social Crime Prevention Policy (2011), the White Paper on Families in South Africa (2012), Social Development Guidelines on Services for Victims of Domestic Violence (2010); the Guidelines on Services for Victims of Sexual Offences (2010); the Strategy for the Engagement of Men and Boys in Prevention of Gender-Based Violence (2009); the National Policy Guidelines for Victim Empowerment (2009) and the National Action Plan on addressing GBV (Vetten,2014: 51; Mpani & Nsibande, 2015:37).

The DSD employs the above listed campaigns to combat GBV in coordination with the Justice and Crime Prevention Strategy (JCPS) which guides the development of implementation plans on Domestic Violence and Sexual Offences. The programmes under this include the availability of shelters, providing psycho-social support, establishing TCCs, victim support models as well as the Green Door Programme where in some communities, certain houses are identified as places of safety for survivors of GBV (Mpani & Nsibande, 2015:37). The Inter- ministerial Committee on the root causes of Violence Against Women (VAW) and Children was created to understand the prevalence of GBV, its root causes and develop a National Action Plan to address GBV which would support the DSD and other government departments on tackling the scourge by 2015 (Mpani & Nsibande, 2015:38).

The Department of Women which was established in 2009 is tasked with coordination,

promotion, facilitation and monitoring the socio-economic rights and empowerment of women. The Department of Women must align its efforts with all government departments to ensure that gender, disability and children are considered in all government programmes. The Department also has an oversight role in matters related to gender mainstreaming in government. The Department of Women, Children and persons with disabilities (DWCPD) established the National Council on Gender-Based Violence which brought stakeholders together to tackle GBV, but with a change in government administration in 2014, the President announced that the DWCPD no longer had the mandate relating to children and persons with disabilities which was assigned to the DSD and the NCGBVs work was placed on hold (Roberts,2020). This then made it unclear which Department was responsible for GBV.

The Department of Justice and Constitutional Development (DoJ & CD) is responsible for the administration of justice and the implementation of the DVA and Sexual Offences Act, the management of Courts, protection orders, criminal prosecutions of domestic and sexual violence and managing TCCs (Mpani & Nsibande, 2015:40). It should be noted that the Department of Health has no legal obligations in terms of the DVA, but has implementation responsibilities relating to the SOA such as providing medico-legal services. The Department of Health must therefore, provide care to survivors of GBV by attending to the victim, collecting forensic evidence, administering PEP, preventing pregnancy and providing HIV testing as well as developing training courses on the SOA (Mpani & Nsibande, 2015:40).

The SAPS has a mandate to implement both the DVA and SOA, gathering evidence and ensuring the protection of survivors and witnesses. Partnerships also involve the community in the fight against GBV through Community Policing Forum's, communication, education and awareness programs. Family Violence and Child Protection Units (FCS) in 176 police stations in 2010 was re-introduced for the specialized training of First Responders to Sexual Offences to deal with victims, record sexual offences and manage crime scenes (Mpani & Nsibande, 2015:42).

In assessing the mandates of the above Departments, issues in the functioning of the departments can be identified. Issues relate to the duplication of mandates and confusion of roles and responsibilities and overlapping functions. There are also insufficient human and financial resources for the implementation of legislation as the DVA was not costed when it was

signed into law and staff tend to lack training and skills to properly assist victims of GBV (Mpani & Nsibande, 2015:44). A 2005 study found that the financial allocations were for single projects for training and publicity and most of the funding was allocated by international donors. The Criminal Justice system is weak and conviction rates remain low. The public lacks awareness on the relevant laws and a continuous failure by the government to address implementation challenges negatively affects its progressive legislation. Civil society also remains fragmented due to funding shortages making networking and advocating issues challenging. Some stakeholders take the position that prevention programmes should target men and boys on GBV, but this has divided the sector and contributed to the weakening of women's rights programmes (Mpani & Nsibande, 2015:44). The reprioritization of GBV programmes is weakening the sector which has seen a shift in responses by investing in prevention interventions and creating the challenge in incorporating the prevention programs due to funding challenges (Mpani & Nsibande, 2015:45). There is also a lack of coordinated efforts to address GBV, particularly with engaging civil society organisations.

3.2 WC GBV Implementation Plan

The Western Cape Government (WCG) GBV Implementation Plan which was led by the DSD presents six pillars of the NSP. The Ministry of Social Development also played a fundamental secretariat role in the WCG GBV implementation plan which was developed from the first extended Cabinet on Gender-Based Violence meeting held on 25 August 2020. The Western Cape GBV implementation Plan focuses on 6 pillars:

Pillar 1: Accountability, Coordination and Leadership Outcomes: The focus is on the involvement of the government, the private sector, education, CSOs and cultural institutions to contribute to and be held accountable in the fight against GBV. Pillar 1's activities involve convening a monthly transversal working group to report back on GBV, receive progress reports, training teachers for reporting sexual offences against children, capacitating and raising awareness, addressing faith-based partnerships, monthly discussions on GBV programmes, interventions and exchanging knowledge on GBV issues and working on multi-sectoral coordination to implement the NSP.

Pillar 2: Prevention and Restoration of Social Fabric Outcomes: South Africa has made noteworthy progress in creating social awareness where GBVF is increasingly viewed as

being unacceptable. Pillar 2's activities include integrated law enforcement and violence prevention initiatives to support GBV reduction, ensuring that there are safe schools officers at a district level, ensuring that department's have sexual harassment policies and contact officers in place and implementing the Western Cape Drug Master Plan, implementing the gender mainstreaming policies and creating awareness and empowerment on GBV targeting specific sectors including community healthcare workers.

Pillar 3: Protection, Safety and Justice Outcomes: The criminal justice system must offer protection, safety, and justice for victims of GBVF and ensure accountability by perpetrators. The activities include monitoring domestic violence and the role of SAPS, registering criminal cases and investigations, reporting on systemic failures which lead to cases being struck off court roles, monitoring the function of victim support services such as victim-friendly rooms, providing referrals to TCC's and court preparation, engaging in sensitization sessions.

Pillar 4: Response, Care Support and Healing Outcomes: The aim is to have victim-centred services that are accessible and of exceptional quality. Pillar 4 focuses on communication campaigns on services for victims of GBV, school based support programs, providing healthcare for survivors, providing rehabilitation for perpetrators of GBV, providing supervision and mentoring for effective service delivery to victims of GBV, expanding beds in shelters, and providing specialized training for staff on managing LGBTQI+ and GBV victims.

Pillar 5: Economic Empowerment Outcomes: Women, children and LGBTQIA+ persons should not be discriminated against in all spheres of life and should have access to resources that enable healthy choices. Pillar 5 involves strengthening support to existing interventions such as women empowerment.

Pillar 6: Research and Information Systems Outcomes: This encourages Multi-disciplinary, research and integrated information systems for a coordinated response by GBV implementers. Pillar 6 activities involve identification of GBV hotspots, research to help develop the GBV strategy and continually monitoring the GBV implementation plans for evidence-based programmes and interventions.

Considering the Western Cape Governments Gender-Based Violence Implementation Plan, The Western Cape DSD in April 2022 briefed the Committee on the Western Cape government's gender-based violence policy, the progress with its implementation, and the DSD's GBV and sexual harassment policies. The Committee expressed concern over counselling support

to victims and given the prevalence of GBV in the province, Members questioned whether there was sufficient funding for victim empowerment. Other issues raised included how victims often felt the criminal justice system had failed them, the challenges in obtaining convictions by the NPA, the level of engagement between DSD and SAPS, and the vacancies available for Social Workers to effectively combat the scourge of GBV.

3.3 National Policies and guidelines for Police

National instructions for Police on sexual offences:

The instructions were issued to ensure that victims of sexual violence receive professional services when seeking police assistance and relating to investigations. These instructions aim to guide the SAPS in handling victims reporting sexual offences, when accessing the scene of an offence, investigating offences and assisting and advising victims during court proceedings.

The instructions state that:

1. The SAPS must have a list of local organizations which offer counselling and support services to victims. However, this has been shown to be outdated at police stations.

2. When a victim reports a sexual offence, they must be escorted to a private area; the Officer must reassure the victim of their safety and handle the case professionally and sensitively; make arrangements for medical attention; offer the option to have another person present during the reporting process; Record the victims account without interruption or judgement; respond to all reports seriously regardless of when or where it took place; open a case docket or skeleton docket if the victim is unable to make a clear and logical statement at the time of reporting where a person accompanying the victim can make a statement and the victim at a later stage (WLC,2013:77).
3. After reporting, the victim must be given a case number, the investigating officers' details and be advised on the processes that will follow. Victims are also entitled to regular updates on the progress of the investigation (WLC,2013:77).

3.4 National Policy Guidelines for Healthcare providers:

Healthcare professionals must assume that the rape survivor is honest about the offence alleged and treat the survivor with dignity and respect. They must ensure that the victim does not endure secondary victimization, again showing the important of the Victim Support Services Bill. A medical examination must be conducted as soon as possible where information is obtained on the sexual offence and the survivor's medical history in a private space. The healthcare provider must also explain the procedure for this. The healthcare provider must then refer the victim for emergency medical treatment, sexually transmitted infections, pregnancy, HIV testing and counselling, however this can be prioritized over the medical examination when necessary (WLC,2013:91).

The medical evidence must then be submitted to the court by the National Prosecuting Authority with the application of the Criminal Procedure Act 51 of 1977 (Criminal and Related Matters Amendment Act) in relation to survivors of sexual offences.

When a rape survivor is assisted at a TCC, the medical evidence is submitted to the court via the NPA Office located within the TCC.

Considering the role of healthcare providers at TCC's it's important to note that successful prosecution in rape cases rely on J88 forms which are completed by a Doctor or Forensic Nurse to detail a victim's injuries. However, these healthcare professionals were only trained for clinical management, but not on how to fill these forms out to be used as evidence (Randa et.al 2023). This document comes from the Department of Justice and are considered to be inaccurate and thus weaken a case for prosecution.

3.5 Thuthuzela Care Centre protocol:

The Thuthuzela Care Centres are usually located in communities where rape incidences are most prevalent and have links to sexual offences courts. The sexual offences courts have staff which include Prosecutors, Social Workers, Magistrates, NGOs and the SAPS. The staff are managed by a team made up from various departments such as the Department of Justice, Health, Education, the National Treasury, Correctional Services, SAPS and Social evelopment as well as civil society Organizations (NPA,2019:3). Upon arrival at a TCC, the victim should then be taken to a private space where the site manager will attend to them and arrange for a doctor to conduct a medical

examination. The doctor must explain the medical procedures that will be performed and the victim must provide written consent for the medical examination and blood specimens to be collected (NPA,2019:3). If the medical examination takes place within 72 hours of the rape, DNA must be collected and Post-exposure Prophylaxis medication must be given to the victim to prevent HIV infection. The victim should then be offered the space to take a shower and change into clean clothing (NPA,2019:3).

3.5.1 There are 5 steps to receive assistance at a TCC (NPA,2019:2). A rape case can be reported directly to a TCC which is based at a community clinic or hospital or the survivor can report to their nearest police station.

3.5.2 TCC staff will direct the survivor to receive medical assistance at the TCC.

3.5.3 The TCC staff will then arrange counselling services for the survivor at the Centre from a Nurse or Social Worker. The victim must also receive the necessary medication and an appointment must be made for follow-up medical care and Counselling services.

3.5.4 TCC staff will also assist the survivor to open a criminal case immediately or this can be done at a later stage. The victim's statement is taken by the investigating officer on call at the TCC and police or the investigating officer should escort the victim home. If it is unsafe for the victim to go home, arrangements must be made for the victim to go to a place of safety.

3.5.5 TCC staff should then organize long-term counselling and prepare the victim for court appearances should the case proceed to trial. This service should involve consultation with a specialist prosecutor before the case goes to court, preparation of the victim by a victim assistant officer and an explanation of the outcome and updates on the trial process by the assigned case manager.

3.6 Shelters for victims of GBV

Violence shelters for victims of GBV is another important aspect in the response to GBV and includes the National Shelter Movement of South Africa (NSMSA), which represents

South Africa's GBV shelters. Similar to TCCs, research implies that there are insufficient shelters in the country with staff being overburdened as they play multiple roles and rely extensively on volunteers (Human Rights Watch,2021). Sherwood et.al. (2020:3) states that many shelters were forced to reduce their program provision as their expenditure was above the funding amount offered by the Department of Social Development. Additionally, there are other factors which influence how a GBV survivor is assisted beyond limited capacity issues and the needs of some survivors may not be met as there are various criteria which must be met before a victim can be accommodated in a shelter. For example, there are shelters unable to accommodate women with children or older male children, individuals with mental health conditions and some may be unable to accommodate men. Some shelters could only accept women who were referred by the Department of Social Development. These are only some of the barriers to access which may extend to a lack of transport, financial barriers, citizenship requirements which also points to barriers which can potentially exclude survivors from being taken in by shelters, even if space is available. These criteria also draw attention to individuals with physical disabilities or communication challenges being accommodated at shelters and in accessing GBV services (Sherwood et.al.,2020:3). Thobane et.al. (2020:60,61) points out that these shelters may have a lack of funding and not have the capacity and resources to accommodate survivors of same-sex intimate partner violence.

Data Collectors called all GBV shelters that were publicly listed in the NSMSA shelter directory which amounted to a total of 86 as well as all TCCs listed by the NPA which amounted to 55. More shelters were added to the list with the total shelters amounting to 93 (Sherwood et.al.,2020:3,4). The results of Sherwood et.al's (2020:4) assessment show that 63% of TCCs and shelters could be reached, but only after 3 calls. Only 25 shelters had space for victims (Sherwood et.al.,2020:4,5). TCCs are located in each province varying between four, five and eight TCC's in each province. Sherwood et. al.'s (2020:5) data collection process showed that only two TCC's of the 55 were decommissioned and of the remaining 53 TCCs, the majority which was 40, were reachable by telephone. 13 of the TCCs could not be reached and 22 answered the first call while 18 TCCs were reached after multiple calls. Sherwood et.al (2020:5) reports that it took just over 2 calls to a facility to get assistance. It was also found that TCC staff were friendly and knowledgeable, but many TCCs did not have direct lines and calls were directed through hospitals and sometimes hospital staff seemed to be unsure about the existence of the TCC. Of the TCCs that could be reached, 26 stated that they were open 24 hours a day, but all services offered would not be available at certain times.

Fifty-three Shelters were reached by phone and only 35 answered on the first call while 18 shelters were reached after multiple calls. Only 25 shelters indicated that they had the capacity to accept new clients (Sherwood et.al., 2020:7). Data Collectors had to call the shelters an average of 4 times to reach someone. Sherwood et.al. (2020:6) highlights that very few shelter staff members were able to indicate whether they could accommodate new clients and then referred data collectors to Social Workers who could provide the information which was also found to be the case in key informant interviews.

3.7 The South African Police Service

From 2013/14 the number of households satisfied with police services dropped from 63,9% to 54,2% in 2017/18 while the number of households that expressed satisfaction with the courts in 2013/14 dropped from 63,9% in 2013/14 to 41,1% in 2017/18 (Stats SA). The police or doctors insist that victims first make a statement before receiving medical attention or counselling which compromises on the quality-of-service provision and care, thereby failing clients (Shukumisa Report,2017:37,38). This is essentially secondary-victimization and police must take into account the needs of different victims of crime when assisting them as a victim of GBV may need immediate medical attention or psycho-social services first (Tlou,2023:120,124). The SAPS must also assist the victim in a private and victim friendly environment.

When reflecting on policy gaps and harmonisation, it can be noted that the services of TCCs are based on what is prescribed in the SOA and DVA. These Acts also complement various policies and guidelines such as the VEP. NGOs have said that some policies or their implementation was unclear. Sometimes there was a lack of understanding of policies and ambiguity such as whether TCCs should be assisting victims of GBV who were not raped given that the policy guidelines refer to victims in general (Shukumisa Report,2017:39). Despite this, some TCCs only attended to victims of sexual assault and required a criminal case to be opened before assisting victims. Police are still reported to turn GBV victims away if the perpetrator is a partner or husband despite IPV provisions in the DVA. This could be based on the police's misinterpretation of the law or the need to reduce the number of violent crimes reported which impacts on the SAPS performance. This highlights the need for frontline providers to be trained at a site level to guide their perceptions and decisions. It also shows a disparity between what is communicated to staff by the DoH and the provisions

of the SOA as an adult is not required to open a case (Shukumisa Report,2017:39). Thus, a number of policy implementation gaps can be identified such as certain inefficiencies in the DVA and SOA. This has been compounded by the lack of accountability when legislation is enforced ranging from police turning victims away, to a lack in the coordination of various government departmental policies that relate to GBV (Shukumisa Report,2017:6).

SAPS should be aware that the TCC Model represents a multi-disciplinary approach and team work. As in the case presented above and the lack of care with victims, there are reporting and

oversight mechanisms in place to ensure that SAPS complies with a victim-centered approach. The National Commissioner of the SAPS is required to submit a report to Parliament every 6 months on complaints against the SAPS, disciplinary proceedings, and the corrective action taken which is recommended by the Civilian Secretariat for Police. In addition to this, the SAPS must report to Parliament's Select Committee on Security and Justice on the management of the Domestic Violence Program (Tlou,2023:120,124). SAPS members must be trained to respond to GBV victims appropriately and should receive the relevant training on laws and protocols to be followed.

According to a Commission for Gender Equality Report from February 2022, "Counting Achievements in One Hand", which addresses current responses and interventions to combat GBVF in South Africa, the CGE visited SAPS and TCCs across the country to conduct oversight and monitoring and to determine the levels of compliance in delivering victim- centred services for survivors of GBV. The oversight visits were conducted in 9 provinces and four police stations were visited monthly in each province (GCE,2022). The report's findings show that across the provinces, GBV was rising in all provinces despite interventions. The findings also showed high withdrawal rates of rape cases by victims, high levels of poverty and proximity to police stations and courts as factors which prevented victims from accessing the justice system. There was also a lack of skills development by the SAPS in handling GBV cases as well as on the time it took to finalise DNA evidence demonstrating a lack of efficiency and effectiveness in coordinating GBV responses. When the CGE evaluated the implementation of the Victims' Charter, it found that services to victims were below the expected standard and this was due to the limited human and physical resources (CGE,2022). It was observed in all provinces that some victim-friendly rooms were poorly structured, lacked adequate resources and compromised the safety of victims, or victims were unable to access these rooms as the official with the keys would be absent. When probed as to why the

victim friendly rooms were locked, the explanation was that staff members misused the rooms (CGE,2022). Some police stations across the country did not have D1 to D7 evidence collection kits which are DNA reference sample collection kits which are essential in investigating and prosecuting sexual violence cases. The CGE also highlighted the importance and lack of psychological debriefing for police officers. The importance of debriefing has been emphasised in academic literature and should be compulsory for all GBV policy implementers to promote psychological healing and prevent trauma, however this remains a challenge for SAPS (CGE,2022). This ultimately shows a lack of standard procedure in effecting policies across the provinces in relation to training and staffing processes again highlighting the need for evidence-based approaches in addressing gaps in GBV policy implementation.

3.8 FCS Units challenges

Looking at FCS units, the weaknesses which have been identified from victim perspectives largely indicate slow service delivery due to the long travel distances for already few FCS Unit members to reach victims. There was also a shortage of vehicles to reach and transport victims. SAPS also felt that there were low numbers of trained staff, resulting in heavy workloads for detectives from large geographic areas, which also required longer hours of travelling. There was also insufficient capacity based on the number of specialised detectives available to assist victims and the standby details of detectives were not readily available. Deployment of SAPS officers also meant that there was no continuity of services for victims. If specially trained officers were deployed or fell sick, untrained officers would take their place. Deployment also resulted in dockets moving with investigating officers instead of staying in the region/station where incidents occurred, compromising confidentiality. The reconfiguration of FCS Units has resulted in the unfair distribution of resources as victims were often sent to another station to find a specialized FCS officer. Investigating Officers also constantly changed. The reality was that some police stations had resources but no skills while other stations had skills but lacked the necessary resources. Lost dockets also resulted in delayed cases that were eventually set aside preventing justice for victims (Frank et.al.,2009:71-74).

3.9 Healthcare

Rees et.al (2014:4) states that GBV interventions have shown that system-wide approaches work best as these interventions are complex and require more than training for healthcare providers to ensure that programmes are well functioning. Rees et.al (2014:4) refers to a realist perspective which considers certain tools to understand how and why programs could be successful. This perspective suggests that frontline providers can be increasingly capacitated by 4 elements in programmes such as institutional support, effective protocols, on-going training and speedy access to support services.

South Africa's health sector responded to GBV and HIV with Vezimfilho which was implemented in four districts and upon evaluation of the implementation of the programme, it was found that a system response with political commitment was needed (Rees et.al,2014:4). In addition, policies, protocols and efficient referrals systems were crucial. Furthermore, capacity building should include a focus on attitudes and values toward GBV and gender norms and interpersonal skills in healthcare providers. To ensure the sustainability of programmes, support from managers within the healthcare system and strong relationships between the various stakeholders is essential. System barriers to implementation were found to be due to a lack of staff, a lack of confidence in managers and the attitudes and perceptions on gender which all negatively affected implementation (Rees et.al,2014:4).

Considering the protection of victims, the Womens Legal Centre's (2013:42) study showed that there could be conflicts between the medical and forensic requirements when assisting victims of sexual assault. The study noted that TCC's worked well, but findings suggest that forensic examiners did not always complete the J88 form which is required to collect evidence from a victim. Similarly, Forensic Examiners would sometimes not collect blood samples from the perpetrator which meant the suspect and victims blood samples could not be compared (WLC,2013:42). Evidence was also not always sent to laboratories for analysis and there was a shortage of forensic nurses. PEP was reported to be unavailable sometimes and cases involving children were prioritized over others (WLC,2013:18). Rape survivors reported experiencing more issues with accessing healthcare than they did with the police or the courts as a considerable amount of rape survivors were not taken to a healthcare facility for examination. Medical staff were reported to sometimes be rude and insensitive, did not explain medical procedures to the victim, did not explain the choices the victim had in their case and provided no information on PEP and did not provide the necessary medication.

Doctors are required to inform the victim that they have the option to get the perpetrator tested for HIV and must provide information on additional referral and follow-up services for a victim of sexual violence (WLC,2013:42). Multi- step and indirect referral routes were also cited by victims as hindering their access to care (Johnson et.al.,2017:11)

Despite policies and legislation to combat GBV, research, studies and reports show that weaknesses remain in GBV service provision. The 2013/14 Shukumisa report highlighted an unfriendly demeanor, inefficiency and a lack of professionalism amongst the various service providers as the main reasons for dissatisfaction amongst victims who report rape to the police (Johnson et.al.,2017:8). The Shukumisa report also referred to the lack of knowledge on important policy documents and guidelines or forms not being available to reporting officers (Johnson et.al.,2017:8). There is also insufficient access to specialized staff from Family Violence, Child Protection and Sexual Offences Investigations Units, particularly staff such as Advocates, magistrates or volunteers who are trained in dealing with victims of sexual violence. Moreover, there is a lack of space available that is clean and well equipped to allow victims privacy (Johnson et.al.,2017:8). Johnson et.al. (2017:8) reports that a study showed victims reported that police officers discouraged them from reporting incidents of sexual violence and that they experienced demeaning and traumatizing cross-examination in court. Police also threatened to charge victims if they were found to be lying.

3.10 Funding for NGOs

The withdrawal of Global Fund Grant funding which is an independent, multilateral financing entity for governments, NGOs and other entities which reflect donor-defined priorities, at TCCs may result in decreased NGO services. NGOs, however, did not show detailed proposals for grants and many organisations were dependent on a combination of donor and government funding, but this was still insufficient to bridge the funding gap. While the government must provide psychosocial services to survivors, its ability to provide the same quality and standards of NGOs poses a challenge as well as government dictating services offered when providing funding. Even if government, through the Department of Social Development, funds the services provided by NGOs, the financing would most likely be insufficient for meeting the full cost of the service affecting the ability to retain experienced staff thereby negatively affecting the quality of services (GBV Process Evaluation,2018:15). South Africa's public health system comprises of primary, secondary and tertiary healthcare

and each structure must provide mental health services according to the level of care that they offer, however there are resource constraints such as a constrained budget, and the uneven distribution of resources across provinces and only 5% of the national healthcare budget is allocated to mental healthcare, placing the burden of providing accessible healthcare with NGOs (National Planning Commission,2024:7,8). There are also shortages of mental health professionals such as in rural areas and NGOs help fill this gap and assist with the workloads of mental health professionals in the public sector (Mkhize & Kometsi,2008:7). Despite South Africa's high levels of GBV, NGOs and community-based organisations (CBOs) are experiencing financial difficulty. This is largely due to the lack of responsibility government departments show in providing funding to NGOs, as well as the numerous issues associated with NGOs reliance on foreign funding. Such issues include competition for resources, limited grants and conflicting agendas with donor priorities. This is exacerbated by declining funding for GBV programmes in South Africa in particular, as private donors, such as the corporate sector, have provided very little for rape and domestic violence initiatives (GBV Process Evaluation,2018:15). It was found that where funding is awarded to organisations addressing GBV, grants are primarily for treatment, care and support services and tertiary prevention strategies. This is despite evidence suggesting that a shift is needed towards GBV at a primary prevention level. This may also be because large funders such as the Global Fund, UNAIDS, PEPFAR, and UNFPA mainly focus on HIV/AIDS and it appears that the main focus for donors is addressing GBV through an intersectional HIV/AIDS perspective. Considering the reality of decreased and insufficient funding to effectively address GBV, there is huge concern that the current funding for psychosocial services at TCCs are largely insufficient.

3.11 Data, resource allocation and training

Having updated data is critical for implementing agents whether at high level strategic and policy levels or at operational and local levels as it affects the way policy decisions are made. The data should be located at one central place where various role-players are able to access the data to see the key trends and challenges and will allow for the identification of individual offenders, repeat offenders, the analysis of court cases, length of investigations and selection of cases for prosecution. It will also be helpful in decision-making on resource allocation. Such data may ultimately enable continual learning on how to improve the victim-focused

approach to services which would include the criminal justice system (UNODC,2021:38; Resistire',2021:10) None of the OECD states had any mechanisms to coordinate the way they collected data on GBV. The importance of such data will also show which interventions, policy or guidance documents work or do not work and may be helpful in monitoring the effectiveness of interventions.

The OECD (2021:4) Suggests 3 Pillars, Systems, Culture and Access to Justice and Accountability as a whole-of-state framework that is victim-focused for the prevention and response to GBV. This encourages developing holistic policies and legislation which clearly set out the roles and responsibilities of state actors and all other role-players to establish internal as well as external accountability mechanisms and information sharing through cross sector collaboration and constant engagement with those affected by GBV as well as GBV service providers (Lilleslatten,2019; OECD,2021:5,7). Key to improving policy implementation is also the allocation of sufficient resources and political will. There should be a governance and service culture which focuses on the needs of victims and then assessing and increasing the capacity of service providers; committing to GBV identification and prevention; funding essential services; engaging men and boys and challenging harmful gender norms (Lilleslatten,2019). The OECD places emphasis on decentralizing the top-down approach to becoming a horizontal and collaborative approach which engages all the important implementers in addressing GBV. In practice, this means shifting from a rigid, centrally driven GBV response toward a networked, multilevel governance model. The OECD envisions **horizontal integration**, where different state actors (such as health, justice, and social services) collaborate through shared planning, referrals, and co-locating services, and **vertical coordination**, where decision-making, resources, and accountability flow down to subnational and local levels (OECD, 2021:102). This structure promotes a **survivor-centred approach** by enabling integrated service pathways, shared data systems for tracking trends and repeat offenders, and inclusive forums for stakeholder engagement (OECD, 2023:102–103). In the South African context, this could translate into strengthening multilevel coordination bodies (national, provincial, municipal), establishing integrated service hubs in high-burden areas, developing a shared GBV data repository, and building cross-sector capacity among frontline providers. Such a decentralized and collaborative framework would improve responsiveness, accountability, and the quality of care for survivors.

According to a 2009 World Health Organization study, adapting service innovations to

changing socio-cultural, economic and institutional contexts is important to improve success rates rand this means adapting programs to expand their impact, effectiveness, efficiency, sustainability, equity and to increase their geographic coverage to include more beneficiaries (USAID,2015:11). The success of policy implementation plans and strategies depend on the context, but three types of methodologies are suggested such as expansion of scope, replication, and expansion of geographic coverage. Expansion of scope involves increasing the size of an intervention, adding resources and increasing the number of beneficiaries to allow for more services on a ground level (USAID,2015:11). Scaling up through replication means reaching more beneficiaries geographically which is locally and nationally by making certain changes in an intervention (USAID,2015:12). The process of ascertaining an intervention's potential for scaling up involves identifying and incorporating best practices in the design of programs which will show whether the environment is favourable and will mitigate against potential barriers such as a weak program or policy design, weak institutional capacity, weak resource or financial constraints and lack of political commitment (USAID,2015:13).

Considering the GBV policy interventions in the OECD countries we can see that efforts to curb GBV is undermined when there are no data systems in place which can be accessed by all role- players in GBV service provision. The data must be up to date and accessible to all the relevant role-players to inform decision-making and to regularly assess what interventions work and what interventions may be ineffective. The GBV service providers emotional and psychological well- being must also be prioritised to ensure that victims receive the best quality of post-rape services. Training and capacity building efforts often ignore the fact that frontline providers have been socialised in communities alongside victims and perpetrators and may have certain prejudices, stereotypes and patriarchal worldviews, thus training programmes must aim to alter these mindsets and this must take place amongst all service providers and not only those who are a first point of contact for survivors such as the police (UNODC,2021:42).

Lessons from the UNODC (2021:36) report show the importance of coordination at the national, sub-national and regional level. The report indicates that improved coordination at a local level between the various GBV service providers can ensure an effective progression of the victim in accessing post rape care and navigating through the criminal justice process. This will prevent secondary victimization and will build more trust in the justice system. The importance of coordination at a sub-national and national level is also emphasized to

have cohesive multi- sectoral approaches that prevent and respond to GBV. Evidence has shown that spaces must be created for dialogues that are inclusive, built on trust and must be evidence- based (UNODC,2021:36). The UNODC (2021:36) refers to a dialogue forum created in South Africa in 2015 which saw a small group of stakeholders from government and non-government stakeholders meeting on a regular basis to discuss available data to find explanations for trends and then brainstorm to find responses to the challenges identified. The group also reflected on what has worked and what has not worked and why this may be the case. Also helpful in combatting GBV is prevention work which is often not part of the main mandate of criminal justice systems in the OECD Member States, which the group reported contribute to public awareness and public education programs such as outreach programmes at schools and with religious groups (UNODC,2021:37).

Policy responses to sexual offences has been fragmented across government departments and policies addressing rape have been developed by departments who operate outside of the criminal justice system, such as Provincial and Local Government, as can be seen in the case of the Western Cape Provincial Government which is discussed later. This is also noted by the 2007 Sexual Offences Act which notes that the implementation of laws relating to sexual offences is not consistently seen across government departments (Vetten,2011:176). In 2004, the Victim's Charter aimed to address secondary victimisation and ensure a victim-centred approach. There are also several other documents to support the Victim's Charter, such as on the minimum standards of services for victims of crime, but these standards are more likely what victims may expect from the system and no actual commitment to broaden and improve the existing services. The main issues in policy implementation are related to policing, prosecutions of rape, the criminal justice system and its administration relating to resources and management and the discriminatory treatment against victims of sexual violence (Vetten,2011:180,181). The NPA and DOH stances on policy are conflicting and often determine responses to rape which are based on the interests and concern of the prosecution services and for example placing the preservation

of evidence above therapeutic services to victims which is not a victim-centred approach to policy as is claimed. Ultimately, there is no consistent understanding of and specialised implementation of policies on sexual violence across government departments.

Chapter 4: Findings

GBV remains one of South Africa's most important social challenges, despite all the laws and policies in place to address it. This chapter considers the gaps and barriers to GBV, by considering the gaps in implementation that undermine the effectiveness of support for victims. The chapter highlights the policies and plans in place by the Western Cape government to protect the rights of women and how policies have failed in practice due to disjointed implementation by frontline providers and under- resourcing. There are three key themes that emerged from key informant interviews: Secondary Victimization and Systemic Failures in Service Provision; a lack of coordination and accountability between GBV service providers and resource constraints and inadequate support for service providers. The key informant interviews revealed that secondary victimization due to a lack of sensitivity and procedural issues by frontline providers worsened the trauma experienced by victims and thereby undermines their access to justice. The findings also highlight a huge lack in coordination and accountability amongst implementers which has caused fragmented and inadequate GBV support interventions. This discretionary adaptation is not ad hoc but can become institutionalised. Over time, frontline workers internalise this "coping mode," creating a culture where short-cuts, triaging, and informal routines become standard. As Gilson (2015: 5) argues, street-level bureaucrats develop mental models of their role that reduce tension between policy ideals and resource realities, which shapes how they prioritise and operationalise victim-centred care. A lack in resources, such as staff shortages and financial constraints have hugely impacted the kind of care provided to survivors, showing the frontline services providers work under stressful conditions with limited resources to support them. These themes show the barriers to implementation of GBV laws and policies in a victim-focused way.

Street-level discretion is deeply implicated in how these resource constraints translate into uneven implementation. Frontline agents (police, medical staff, TCC Social Workers) often operate under high caseloads and limited guidance, forcing them to interpret and adapt policies in real time. This reflects the classic model of "street-level bureaucrats" who make policy practical in their day-to-day interactions (Gilson, 2015: 3–4).

4.1 Implementing measures to combat GBV: Western Cape Provincial Case

The Western Cape Government crime statistics report for 2022-2023 indicated that there

were 7 310 sexual offences in the Western Cape which increased by 2,1% while rape increased by 4%, sexual assault increased by 3,2% and attempted sexual offences increased by 4,1% (Crime Statistics Report,2022-23:6). Eight of the top 10 police stations where sexual assault was reported is in the Western Cape at police stations in Mitchells Plain, Delft, Manenberg, Mfuleni, Cape Town Central, Kleinvlei, Bishop Lavis and Gugulethu (PMG,2022). Researcher for the Parliamentary Committee on Police, Nicolette Van Zyl-Gous noted in a presentation to the Committee on the quarterly crime trends across the financial year, that in 2022/23, 43 037 rapes were recorded in comparison to 41 695 recorded in the previous financial year which showed an increase of 3,22% of rapes nationally (PMG,2023).

Premier of the Western Cape, Alan Winde delivered the annual State of the Province Address in February 2022 and announced that the Provincial Cabinet had adopted the GBV implementation plan (Lukas,2022). Democratic Alliance Spokesperson on Community Safety in the Western Cape, Reagan Allen confirmed that the SAPS was under-resourced, under- trained, under-staffed and were facing increasing challenges around the processing of DNA which was only at 15% capacity. To monitor police stations, the Department of Police Oversight and Community Safety would adopt a two-pronged approach to violence prevention and law enforcement as well as oversight mechanisms (Byron,2022). The Western Cape government introduced its Western Cape Integrated Violence Prevention Framework 2013, to prevent and reduce violence and its impact, and the Violence Prevention through Urban Upgrading in partnership with networks such as the Western Cape Network on Violence Against Women which coordinates interventions to address GBV at local levels (Violence Prevention Cabinet Policy,2013:2). The Western Cape Network on Violence Against Women was established in the late 1980s to assist organizations working to combat GBV and facilitate more open communication and information sharing. Although the Network does not provide service delivery, it supports organizations who do, as well as those responsible for advocacy, research and public education delivery.

The Western Cape Integrated Violence Prevention Framework 2013, is a provincial policy framework based on the 5th Milestones Meeting "Joining forces, empowering prevention" where almost 300 experts from more than 60 countries met to discuss the World Health Organization's Global Campaign for Violence Prevention (Integrated Provincial Violence Prevention Policy Framework,2013:7,29). The framework recommends the adoption of an inter-sectoral approach to combatting violence and uses short-term evidence-based

interventions to create long-term change to the social and societal norms that perpetuate violence. The strategies to achieve this involve Provincial Strategic Objective 5: Increasing Safety though a "whole of society" approach which does not only focus on law enforcement, and involves developing safe and nurturing relationships between children and care-givers, developing life skills such as social behavioural competencies and promoting gender equality to prevent GBV (Integrated Provincial Violence Prevention Policy Framework,2013:7). The Violence Prevention through Urban Upgrading aims to improve safety and the living and social conditions of communities through urban improvements and social interventions (Saferspaces,2023).

4.2 Secondary victimization by the SAPS and other GBV implementing agents

Interviews were conducted with representatives from a GBV service provider, a First Responder at a TCC, the Western Cape Department of Community Safety and the Western Cape Police Ombudsman.

One of the most pronounced challenges in GBV service provision and its implementation inferred from respondents relate to the perpetuation of secondary victimization by GBV implementing agents which negatively impacted on victims. Secondary victimization was a theme that came up amongst all the respondents in the challenges and barriers to effective GBV service provision and sometimes occurred as an unintended consequence of a lack of knowledge, training of service providers and SAPS, the negative attitudes, values and beliefs of service providers, a lack of coordination and cooperation amongst implementers and a lack of accountability. Sometimes the criminal justice system itself was a hindrance to effective post-rape care, where policies and laws aimed to assist victims of GBV and sexual assault in fact made it more challenging for them to get help, causing more trauma in the process (TCC Respondent 1).[1]

Literature on GBV and sexual violence suggests that in accessing post-rape care, victims of sexual violence are often exposed to further trauma and secondary victimization. Victims are exposed to secondary victimization through distrust, insensitive and discouraging

[1] Cape Town 25 January 2023

> treatment and failure by the government to provide privacy for victims in accessing post-rape care. Secondary victimization is also seen in the collection of evidence and its management by forensic doctors as well as the updating of victims on trial and inappropriate and incorrect handing of cases by the investigating officers assigned to the case.

Respondents confirmed that secondary victimization often occurred as GBV implementers such as police or first responders often engage in victim-blaming and emphasized that there should be no responsibility on rape survivors to prevent rape and that they should not have to be told not to dress in a certain way to prevent this (NGO Respondent).[2]

This suggests a lack of sensitivity and specialised training amongst GBV implementers and this could perhaps be resolved through collaborative training partnerships between NGOs and frontline providers as Medie's (2013) work suggests.

Statistics show that 50% of women are sexually assaulted by someone known to them and respondents confirmed that it often did not occur to survivors that they were at risk of sexual violence, because it occurred in spaces which they were familiar with (NGO Respondent; Life Healthcare, 2022). The literature shows that NGOs generally perceived the quality of services in TCCs to be good, but it could be inferred from all respondents that service providers did in fact have different interpretations of protocols and their roles and responsibilities due to a lack of training. Less than 10% of SAPS members elected to be trained for the National Victim Empowerment Training Programme were sent for such training (Asma,2020). Respondents experienced cases where victims were intoxicated at the time of their assault and were seen by SAPS to lack credibility (NGO & TCC Respondents). Thus, GBV policies sometimes hindered the responses of service providers when it had certain requirements, as with the criminal justice system and the evidence needed to prosecute perpetrators of rape.

> *If there was hard core forensic evidence and a DNA match then you have to arrest the person, but prosecutors will withdraw cases or put it on hold because a child cannot testify, do you understand like at 3 or 4, so the legislation fails the child. Out of the mouth of the child, there will be the truth. Sometimes people say I don't remember, I was drunk, but I woke up naked next to the person. She didn't see him penetrating her, but when there is evidence of a witness then the police or NPA must take the case* (TCC Respondent).[2]

[2] Cape Town 25 January 2023

While the respondent perceives that the legislation "fails the child," this reflects broader systemic and procedural challenges rather than an inherent flaw in the law itself. Procedural requirements—such as the necessity for direct testimony, combined with institutional cultures, including patriarchal biases and scepticism toward victims, can seriously hamper the effective use of legal protections (Grocott's Mail, 2022). Importantly, legislation does provide protective measures for vulnerable victims, such as intermediaries for child witnesses, in-camera testimony, and broader definitions of rape under South African sexual-offences legislation (South African Medical Research Council, 2022: 50–52). However, due to limited training and inconsistent implementation of these protections, they do not always function in practice, contributing to procedural barriers for justice and further victimisation (Mutizira, 2025).

In the cases of young children or victims who were drunk when being raped and could not remember what happened, prosecutors were reported to fail in their duties if victims were unable to testify. In this sense, the legislation failed the victim, despite forensic evidence proving the victim was in fact raped. The feedback highlights a critical gap in the South African criminal justice response to sexual violence, particularly in cases involving vulnerable victims such as young children or intoxicated adults. While forensic evidence may clearly establish that a sexual offence occurred, the legislative and procedural framework often hinges on the victim's ability to testify. This reliance places an unrealistic burden on individuals who are either too young to articulate their experience or whose memory of the assault is impaired due to intoxication. In effect, the law and its application fail to prioritise the victim's rights and protection, instead indirectly privileging procedural technicalities over justice (Sibanda, 2021, p. 45).

In the South African context, this reflects a broader systemic challenge within the criminal justice system, where prosecutors may withdraw or postpone cases despite conclusive forensic evidence, because the victim cannot provide testimony (TCC Respondent, 2023).[3] Such procedural barriers illustrate a disconnect between legislation and the realities of GBV, particularly for highly vulnerable populations. This also underscores the need for legislative reform that allows corroborative evidence, such as DNA results, eyewitness accounts, or expert testimony, to support prosecution in the absence of direct victim testimony. By doing so, the system would shift towards a more victim-centred approach, reducing the secondary victimisation caused by procedural constraints and acknowledging that trauma, age, or intoxication should not undermine the pursuit of justice (Ditshego, Daily Maverick, 2023:12).

[3] Cape Town 3 February 2023

The meaning of rape in South Africa's legislation such as with the Criminal Law, Sexual Offences and Related Matters Amendment Act presents procedural issues in proving rape and sexual offences. This allows perpetrators to provide a defence based on the belief that there was consent, regardless of whether what the belief was based on, was reasonable or not. The also means that this could be used as a defence without any further evidence, and as such, the state needs to prove that there was no consent, placing the courts focus on the victim as opposed to the perpetrator, to prove that they were sexually violated (Ditshego, Daily Maverick,2023). There are also rape myths, which perpetuate stereotypes on what rape is or how a victim is meant to respond to rape which contributes to the high rates of attrition the country. Legislation should be amended to be more victim-centred where the pressure is not on the victim to prove that they were violated and limit cases in which a perpetrator having a mistaken belief of consent, can be applied. For example, this could apply in cases where a victim was intoxicated.

Under South African law, the defence of mistaken belief in consent is not purely subjective; it is evaluated against a standard of reasonableness. The courts require that any claimed belief in consent must be reasonable given the circumstances, rather than merely asserted by the accused (Van der Merwe, 2018:5). This ensures that the focus remains on protecting the autonomy and dignity of the complainant, rather than privileging the perpetrator's perception.

Research on child witnesses further illustrates the challenges of consent and credibility in sexual offence cases. Intermediary services in South African courts, designed to assist child witnesses, demonstrate the legal system's recognition that vulnerable victims require support to communicate effectively and safely during testimony (Olivier, 2018:8). These mechanisms indirectly affect the assessment of consent, as courts are more likely to ensure that evidence from children is fairly interpreted, reducing the risk that unreasonable claims of belief in consent might succeed.

The theoretical implications of this legal standard reinforce a victim-centred approach. By requiring that any belief in consent be reasonable, the law shifts the burden away from the victim to disprove consent, aligning with trauma-informed principles and protecting survivors from secondary victimisation (Van der Merwe, 2018, p. 7; Olivier, 2018, p. 10). Nevertheless, as empirical findings show, prosecutorial discretion and resource limitations can still undermine this framework. High caseloads, evidentiary challenges, and limited access to specially trained staff may lead prosecutors to withdraw cases when they anticipate difficulties in disproving a claimed belief, thereby perpetuating systemic barriers and indirectly placing

pressure back on the victim (Olivier, 2018:12). In practice, ensuring that mistaken belief in consent is assessed objectively, especially in cases involving children or incapacitated victims, is critical. The law's requirement of reasonableness supports a more just and victim-focused response, but only if accompanied by sufficient procedural support, specialized training, and inter-agency coordination as highlighted in broader findings on GBV service delivery.

Smilar to other literature on GBV, the NGO respondent reported that the Khayelitsha Magistrates Court did not have a private space for victims to wait in and they often had to share the space with their perpetrators when appearing in Court (NGO respondent). The Department of Justice then intervened and provided a container for victims to wait in. Responses again suggested that sensitivity training was always necessary, particularly for government officials as such issues were often picked up on during counselling sessions with clients. There was a general view amongst key informants that the GBV policies sometimes hindered the response of service providers in assisting victims because of its requirements and guidelines, systems and structure which was described as being oppressive, as sometimes victims could not be assisted in such cases to receive the required care. Given the NGOs in South Africa receive limited financial assistance from the government and rely heavily on volunteer or para-professional staff to offer psychosocial support and this is often unpaid (Dimant,2022:20).

Lay counselling was reported to be underappreciated, because lay counsellors do not have formal professional or para-professional qualifications or professional regulatory body affiliations, but receive basic counselling training from the NGOs. There was also a view that short volunteer training programmes for lay counsellors were not efficient in comparison to the training provided to Psychologists and Social Workers, despite their role being important for delegation of tasks and assisting with the workloads of Psychologists and Social Workers (Dimant,2022:22). Thus, lay counselling was underappreciated due to various factors such as a lack of training, limited resources and a certain stigma that disregarded Lay Counsellors in favour of formal health professionals, such as Psychologists, despite Lay Counsellors being first responders who provide initial support and guidance to victims. Lay Counsellors also bridge an important gap in assisting with the workload of mental health professionals, and cover the gap for this service given the financial and resource constraints that are faced. Policies aimed to address GBV hindered service providers in how government was funding organisations and being rigid and prescriptive about this in dictating what services were provided and how they should be provided. This meant organisations had to balance their methodology or approach with

what was being dictated by the government. Implementation and accountability were also a challenge.

> *There's also no after care for clients after they've been through that legal system. There's no compensation for people. I don't recall that they (the government) give any kind of compensation. We don't always get to see where that funds go for Criminal Assets fund* (NGO Respondent).[4]

Policies also did not make provision for after care of victims once court processes are concluded. The NGO service provider representative also pointed out that they did not see where funds from the Criminal Assets Recovery Account was directed to and suggested that this could be directed to survivor support as a form of compensation. A media statement by the Chairperson of the South African Law Reform Commission (SALRC), Yvonne Mokgoro in 2011, stated that the SALRC approved a report on recommendations and proposed draft bill on a compensation fund for victims of crime, which was submitted to the Minister of Justice and Constitutional Development (SALRC,2011:1). This would allow victims of violent crime such as rape to claim from the state. The statement went on to say that the fund was not viable given the economic climate, and instead recommended the establishment of the VEP, but noted that the current VEP still did not deal effectively with victims of crime (Wessels,2018:35).

The WCPO received a complaint from Philisa Abafazi Bethu, a GBV organisation based in the Cape Flats, relating to the Victim Empowerment Programme not being properly implemented by SAPS (WCPO Respondent). It was reported that provincial training needs were severely lacking, and insufficiency in SAPS was due to a lack of funding. Police were reported to turn victims away citing that the FCS detectives were not available to assist them and instructing the victim not to take a shower and return the following day. This was essentially re- victimization. There were cases where ordinary police officials would take a victim's statement as opposed to FCS detectives who would be better equipped, as the ordinary officer may be negligent by not taking the victim for evidence collection by a forensic doctor, which meant a conviction could not be secured without evidence (WCDCS Respondent).

> *Sometimes FCS detectives did not come out to attend to victims and they are told*

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> *SAPS will come back to you. The victim empowerment room is also not being utilised the way it's supposed to. We actually have pictures where it was a storeroom and referral lists is outdated so victims can't reach anyone. This was found to be an issue all over the Western Cape. Other issues are when the detective doesn't come back to the victim and don't arrest and interview the suspect* (WCPO Respondent).[4]

Victim friendly rooms were sometimes not used as intended and became storage rooms and volunteers were often overburdened as only 2 of them worked on a shift and not all volunteers were trained in dealing with victims of GBV. SAPS was found to generally have a low level of compliance and the majority of victims were neither informed of their right to protection or to be treated with fairness and respect. Secondary victimization was a major issue with SAPS and detectives often did not report back to victims on the progress of their cases. Sometimes witness statements were not taken and suspects not interviewed or arrested.

> *In one case, SAPS did not register a rape docket in the case of an older person being the victim. The victim couldn't remember what had happened to her and was not sent for a medical exam, because she was just told that she won't be able to testify, but the officer failed to even open a docket (WCPO Respondent).*[5]

After investigation by the WCPO, the suspect was arrested and there was a guilty finding, again demonstrating secondary victimization, failure to follow procedure and negligence in evidence collection. Victims were not always interviewed in a victim friendly or private room. Respondents all believed that SAPS failed to properly implement GBV laws and policies, because they viewed assisting victims to be a tedious process and sometimes SAPS officials were lazy. This highlights that there is a definite deficit and lack of capacity in SAPS relating to insufficient resources, poor investigations, a lack of proper monitoring and evaluation, poor relationships between SAPS, TCCs, NGO's and oversight bodies as well as a lack of dedicated VEP Coordinators.

4.3 Lack of co-ordination and co-operation undermines compassionate responsiveness to victims

Survivors are also at risk of facing secondary victimization due to institutional arrangements

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which sometimes act as a barrier in accessing post-rape care for survivors. This proved to be true for rape survivors as one respondent highlighted that survivors experienced several issues when trying to access shelters (NGO Respondent). It was also true that sometimes shelters would not accept victims without referral from the Department of Social Development. After directly calling a shelter for victims of GBV located in Woodstock, Cape Town, a staff member at the shelter indicated that another call should be made to the shelter after the weekend to speak to a Social Worker, showing a lack of knowledge, awareness and training on the proper care and procedures to follow when dealing with victims. No further advice on what steps could be taken or any help-seeking measures were offered, given that the call was made over a weekend suggesting that there were barriers to accessing GBV services after hours or on weekends. Some NGOs felt that their relationships with stakeholders was a barrier to better patient referral systems and improved patient care (Shukumisa Report,2017:36). TCC staff viewed themselves as being independent from one another given that they carried out services from different departments such as medical, legal and counselling services (Shukumisa Report,2017:36). This showed the lack of coordination and cooperation amongst them and suggested that attitudes, beliefs and values of GBV implementers was crucial and needed to be addressed through more training initiatives across the various departments involved in the post-rape care of survivors.

The WCPO believed there was an implementation crisis and that a lack of trust between GBV implementing agents contributed to the barriers which prevented effectively joining up responses to GBV and sexual violence (WCPO Respondent). The WCPO indicated that it could sometimes not effectively carry out its mandate as the Provincial Commissioner's Office was often reluctant to share information or implement recommendations on SAPS misconduct to improve service provision (WCPO Respondent). This infringed on the mandate of the WCPO nd left complaints unresolved, perpetuating a culture of impunity amongst implementers like the SAPS. The government and service providers are also held accountable in this way to track issues in service provision. The importance of keeping up-to-date data was emphasised in the UNODC (2021) report to be accessible to all role players in GBV service provision to formulate an effective response to GBV. The implementation crisis was exacerbated by the fact that there was not sufficient interaction between SAPS and the Department of Justice in record keeping such as with protection orders. Respondents pointed out that Protection orders were not properly upheld as sometimes SAPS had no record of this, but the victim did, and this was due to a lack of coordination between SAPS and the NPA. This was usually a

function to be carried out by the NPA but was left to SAPS to uphold which negatively affected victims by not affording them protection from their perpetrator's.

Sometimes staff such as police did not coordinate well in these cases and became desensitized when dealing with victims which is how mistakes were sometimes made and protocol not followed. Police and TCC staff dealt with so many cases and their inefficiency could be attributed to their heavy workload and a lack of compassion to assist survivors perhaps due to vicarious trauma (WCDCS Respondent). Staff could also become preoccupied with this in their own lives. Respondents indicated that all staff from the different units at the TCC such as the medical staff, the NPA and the police received training together, to better coordinate their roles and ensure seamless post-rape care processes for victims, but GBV reporting cases were still not taken seriously by SAPS (WCDCS Respondent).[6]

Another significant trend amongst respondents showed that while entities such as the Western Cape Department of Community Safety and the Western Cape Police Ombudsman played oversight roles over SAPS and dealt with complaints against the SAPS seeking to enhance the effectiveness and efficiency of police services to improve relations between the police and communities, they had very little influence in ensuring accountability. The capacity for discretion is moderated by supervisory structures: studies show that frontline bureaucrats' willingness to apply discretion, and how they apply it, is significantly influenced by the support (or lack thereof) from supervisors (Hassan, Ariffin, Mansor & Al Halbusi, 2021: 4). In contexts where supervision is weak or inconsistent, discretionary decisions may go unchecked, perpetuating uneven implementation of GBV policies across different agencies.

All the respondents indicated that these entities merely had investigative powers and could make recommendations to the Provincial Commissioner for Police on complaints of misconduct and made recommendations to hold GBV service providers accountable, but there is no direct remedial oversight body to ensure that SAPS in particular takes corrective action. Responses suggest that the WCPO was merely a reactive unit and Counsellors working with NGO service providers at TCCs had the authority to hold other key role-players accountable such as FCS Unit detectives, Forensic Doctors or Nurses and Prosecutors when victims reported issues in how services were presented to them, but there remained a lack of accountability.

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> *TCCs have implementation meetings to submit complaints from clients on service provision and we sent this to the Advocacy Unit and it's recorded on a data base and then we discuss it at round table discussions with SAPS* (NGO Respondent).

Another challenge most pronounced amongst the various responders was that there appeared to be an absence of a collaborative culture amongst professionals working at TCCs. Research showed that nurses had a lack of respect for social workers and could get them to perform tasks that were not their responsibility such as collecting urine samples from clients (Shukumisa Report,2017:36; WLC,2013:44). This indicates a hierarchical culture within TCCs which places doctors and nurses at the top with all other stakeholders left to perform their services around their convenience.

> *Depending on the time someone gets to the TCC, because doctors were on call and either don't come to assist the victim or they come hours later. Victims keep coming to ask why the doctor is not coming, where is the doctor and when we call the doctor's, they don't answer the phone or they will ask you is it "a proper case", is it a "fresh case" and the victim can hear all this, because the phones are on loudspeaker* (TCC Respondent).[7]

This negatively affected the relationship between staff at the TCC and often caused hostility. The TCC respondent revealed something equally disturbing, that the healthcare providers bias and perspectives on what may constitute serious cases of sexual assault could be heard by victims and perpetuated secondary victimization. This also suggested a lack of accountability as the various professions operating within the TCCs viewed themselves as being independent from each other. This is in fact incorrect and indicates an approach to working in silo's as well as a lack of coordination and cooperation amongst stakeholders across the various departments involved in the post-rape care of survivors.

Another trend could be inferred that clearly indicated strained relationships between implementing agents who attempted to hold each other accountable. All the respondents indicated that there were mechanisms in place to hold non-compliant staff accountable such as doctors who were on call at TCCs as incident reports could be written up in cases where they failed to follow proper procedures in attending to victims, but respondents reported that this negatively affected the relationships and morale between staff and GBV implementing agents.

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> *Definitely, there is a way to report issues, but sometimes you just feel it keeps happening and it's the same doctor doing the same thing, now it impacts the relationship and the doctor's going to think oh, you reported me* (TCC Respondent)[8].

The same was true for the relationship between the WCPO and the Provincial Commissioners Office.

> *Let me be honest, in the time that I have been here, and this is my seventh year, they've changed Provincial Commissioners three times. So initially when we started here, I think the relationship was strained, because they (Provincial Commissioner's Complaints Unit) felt like who are you to tell us, but there is legislation in place basically obliging them to implement recommendations* (WCPO Respondent).

This again, indicated perceived hierarchical ideas amongst implementing agents and showed a strained relationship between the WCPO and the Provincial Commissioner's Office which was a crucial relationship in ensuring accountability and effectiveness of GBV and post-rape service provision. Respondents believed that another contributing factor to the general feeling of hostility between the WCPO and the Commissioner's Office was that Commissioners often changed and the Office was reluctant to implement any recommendations by the WCPO, perhaps due to a lack of trust. The respondents felt that each time there was a new Commissioner, the WCPO had to go back to the drawing board in establishing trust between its Office and the Commissioner's. Sometimes Commissioner's had different ideas and were not always comfortable meeting with WCPO staff and sharing information, which infringed on the WCPOs mandate. SAPS was also reported to have a mentality in which they refused to be advised by the WCPO.

The WCDCS also reported issues with SAPS and policy implementation processes to the Western Cape Provincial Commissioner and would make recommendations to improve services. In addition is used a questionnaire and contacted victims to rate their service experience with SAPS, but often dealt with victims who refused to give feedback making it difficult to take into account victim-centred approaches to services.

Responses suggest that a number of themes have created barriers to the implementation of GBV policies and poor quality of service provision by frontline providers. This includes a lack of proper resource allocation; poor management of budgets and its expenditure; a lack of accountability by government officials and service providers mandated by the

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government; a lack of collaboration between departments and service providers and a lack of access to information and education for citizens and victims.

4.4 Lack of Capacity and Resources

A lack of funding for NGOs who collaborate with TCCs and government Departments in assisting survivors of sexual violence was highlighted to have negative consequences for rape survivors as they were often shaped by an incident of sexual violence and tended to adopt certain negative beliefs about themselves and engage in destructive behaviours. This demonstrates some of the negative psychological effects that sexual violence can have on a victim and further highlights the need for long-term counselling services to be provided by the government. A recurring point of agreement observed amongst respondents related to survivors' perceptions on the psychosocial support they received as well as the counselling and debriefing for GBV service providers being unsatisfactory. GBV service providers and survivors alike indicated dissatisfaction with follow-up support and long-term counselling for survivors of sexual violence (GBV Process Evaluation,2018:26). First responders who offered trauma counselling at TCCs were often changing as they were Volunteers employed by an NGO who worked in partnership with the government's TCC facility. This meant that the lack of consistency of volunteers or counsellors negatively affected victims as they would be speaking to a different person in each session offered, which ultimately affected the continuity of sessions. Similarly, another pattern observed amongst respondents was that they shared the same views on counselling and debriefing for staff. For example, First Responders of an NGO service provider agreed that they received internal and external supervision, but this was not sufficient.

> *In terms of being taken care of we have many policies like counselling and debriefings, for volunteers, but this is not sufficient because this is done by the Co-ordinator of the volunteer so it's like the person who must be punitive with you is offering the counselling.*

That's not a good relationship. We should offer them something more, because they are volunteers. These spaces cost money as well to have the counselling (NGO Respondent)[9].

A particularly significant observation was that debriefings did not happen often enough as the lack of funding for NGOs providing the service posed a challenge to this. Counselling and debriefings were important for volunteers as they delivered direct services to victims and were often the first responder to the victim, thus they required more support than is currently offered. The need for more resources and counselling support was clearly shown in that some respondents indicated how their own managers who were also exposed to the same type of work and challenging situations in dealing with victims were facilitating their counselling. This

resulted in a strained relationship as the manager would also have the role of overseeing the work of the volunteer and holding them accountable which thereby affected the quality of services provided to victims in post-rape care. A noticeable trend from literature and respondents such as the NGO service provider related to resources and funding, revealed that while government provided funding for projects, it did not prioritize such funding for counselling of staff as supervision was implemented, but the staff felt like this was not enough (GBV Summit Report,2018:34). The government funded training and development initiatives or awareness workshops and TCCs, but did not make enough investment in counselling for staff dealing with victims of sexual violence, again highlighting the negative impact this may have on high quality and professional service provision to victims.

The Department of Community Safety aims to increase safety for all in the Western Cape by improving safety through effective oversight of policing and optimising security risk management and the Departments work is underpinned by the Western Cape Community Safety Act 3 of 2013. Considering Compliance Monitoring of the Domestic Violence Act with SAPS, respondents reported that the Department only began monitoring FCS units in 2022. Challenges experienced by FCS staff were also related to insufficient resources.

We are so little and that's exactly the reason why we only started monitoring FCS last year, but the mandate has been there since it started in the early 2000s. We are

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like eight officials to do monitoring of the police (WCDCS Respondent)[10].

Respondents expressed that there were too many case dockets to deal with and FCS detectives were overburdened. The detectives dealt with mentally challenging work and reportedly also did not receive sufficient counselling and debriefing and sometimes when this was made available, the detective may not have been able to attend due to attending court proceedings. While FCS detectives received specialised training, they were not immune to making mistakes and could fail to follow proper procedures as they were desensitized and did not receive sufficient remuneration discouraging them from properly processing cases up to the level of securing convictions.

FCS detectives will also take a much better and detailed statement than the other police officers who don't specialise, because certain things are highly important to them to build a case and the others wouldn't know about this (WCDCS Respondent).

This also posed a challenge in encouraging ordinary police officials to become detectives as there was a lack of incentive amongst officials which could be seen in how they handled cases.

There are issues with incomplete investigations and dockets not at court, negligence from the detective and it can also be that the detective is overburdened so they can simply not deal with that case load, because we are all human-beings, and we have our limitations. If you look at FCS detectives, for many years, they are fighting for an allowance to recognize their specialised investigative skills and for ten years they've never recognised this in police management. So, you have these limitations. The detectives get less money than your visible policing general officers, so how do you convince them to become specialised FCS detectives. It is a major issue. The overtime funding is so small (WCDCS Respondent).

The detectives were also not compensated for working overtime. Convictions were often not secured due to outstanding forensic lab reports and backlogs which resulted in prosecutors withdrawing cases as well incomplete investigations, dockets not at court, and negligence in evidence collection as staff are overburdened. The clerk of the court was also overburdened in such cases. Empirical research from other low- and middle-income contexts demonstrates how discretion can skew policy outcomes: for example, a study of Kenyan traffic police showed that officers prioritise certain offences for enforcement that do not always align with

[10] Cape Town 25 January 2023

the most serious or high-risk categories, undermining the intended goals of road-safety policy (Sidha, Magutu & Shivachi, 2024:8–9). By analogy, similar patterns in GBV service provision may skew the kinds of cases that receive full investigative or medico-legal support, depending on how frontline actors "pick and choose" under pressure.

South Africa has good policies and legislative frameworks in place to combat GBV, but there are barriers to implementation which largely affect their effectiveness. GBV survivors are exposed to secondary victimization by the SAPS and other frontline service providers, negligence and lack of follow-up support. These issues are exacerbated by a lack of resources, training and inadequate psychosocial support for victims and service providers. The findings highlight the need for better coordination amongst GBV implementers and more investment in human and financial resources to help encourage a victim-centred approach to tackling South Africa's GBV crisis.

Chapter 5: Conclusion

This dissertation examined the implementation of Gender-based Violence and Femicide policies in South Africa, also with a specific focus on the Western Cape. The research aimed to understand the barriers and gaps in policy implementation, the experiences of survivors, and the effectiveness of frontline service providers in delivering victim-centred care. This chapter synthesizes the key findings, demonstrates how they answer the key research objectives and discusses practical recommendations, including the application of a bottom-up approach to policy implementation.

The South African government has made progressive efforts to strengthen policies and legislation to combat gender-based violence. However, the combined efforts of state institutions and non-governmental bodies to support victims of sexual violence in particular, continue to lag behind these progressive aims. Challenges exist in the operation of structures and their lack of integration and funding, poor co-ordination amongst policy implementers and poor monitoring and evaluation systems. Other issues include the inadequacy, ineffectiveness and inconsistency of some structures such as the TCCs. The Gender-based Violence and Femicide National Strategic Plan aims to provide a coordinated national response to the GBVF crisis by the government of South Africa, but the government has not shown political will, accountability or committed to proper costing and budgeting of GBV interventions, and funds have not been utilised as intended.

Literature on GBV and sexual violence indicates that the South African government has shown a commitment to addressing GBV through the various policies and legislation enacted as well as the establishment of the Ministry for Women, Children and Persons with Disability, but violence remains rife. Mogale *et.al* (2012) emphasizes that addressing the barriers to combatting GBV cannot be done in isolation, but that the government, legal system, police, service providers and the general public must work in collaboration to create a plan and must all assist in its implementation. The stakeholders involved should include the public, women in particular, the various government departments which are responsible for justice, health, social support, education and community development, the police, the legal system and community health and social service providers. This essentially means that additional resources must be allocated or resources must be redirected toward governance and administrative implementation and monitoring of the acts. An accurate base of statistics and records of GBV cases could be created to allow for a planned, coordinated response and particularly for research to be supported by the correct budget allocations (GBV

Summit Report,2018:35).

The findings indicate that GBV remains a critical social challenge in South Africa, despite the progressive legal and policy frameworks developed to address it (Crime Statistics Report, 2022-23:6; PMG, 2023). The research revealed three interrelated themes undermining the effectiveness of GBVF interventions:

Secondary victimization and systemic failures: Survivors often experienced secondary victimization at the hands of the SAPS and other GBV service providers. Procedural delays, insensitive treatment, inadequate private spaces, victim-blaming attitudes, and failure to follow protocols exacerbated trauma (TCC Respondent; NGO Respondent; WCPO Respondent). Interviews with respondents from the Western Cape Police Ombudsman and the Western Cape Department of Community Safety revealed that, although these bodies provide oversight and can make recommendations regarding police conduct, they lack the authority to enforce corrective measures or ensure remedial action is taken in cases of police misconduct.These findings align with literature emphasizing that ineffective service provision and poorly coordinated post-rape care increase harm to survivors (Medie, 2013:382; Asma, 2020). Legislative frameworks such as the Criminal Law (Sexual Offences and Related Matters Amendment Act 13 of 2021) provide for survivor rights and protections; however, gaps in implementation, particularly regarding evidence collection and prosecutorial processes, perpetuate further trauma (Ditshego, Daily Maverick, 2023).

Lack of Coordination and Accountability Among Implementers: Respondents highlighted fragmented service provision, insufficient inter-agency collaboration, and strained relationships among government departments, NGOs, TCC staff, and the WCPO. This lack of cohesion undermines survivor-centered care, impairs referral mechanisms, and allows for continued impunity among perpetrators (WCPO Respondent; WCDCS Respondent; Shukumisa Report, 2017:36). Literature similarly emphasizes that policy implementation requires both top-down support and bottom-up engagement to be effective (Medie, 2013:383).

Resource constraints and limited capacity: Both survivors and service providers experienced gaps in psychosocial support, counselling, and debriefing services. Volunteers and first responders were often overburdened, with inconsistent training and limited supervision, negatively affecting service quality (GBV Process Evaluation, 2018:26; Dimant, 2022:20-22). FCS detectives faced high caseloads, limited incentives, insufficient overtime remuneration, and backlogs in forensic

processing, which hindered effective prosecution (WCDCS Respondent). These findings corroborate literature indicating that laws and policies alone cannot guarantee survivor protection without adequate funding, human resources, and oversight (Burris, 2022:36; NPA Annual Report, 2024:117). Collectively, these findings indicate that while South Africa has advanced legal instruments such as the Criminal and Related Matters Amendment Act 12 of 2021, the Domestic Violence Amendment Act 14 of 2021, and the Victim Support Services Bill 2019, their effectiveness is compromised by systemic weaknesses in implementation.

The research objectives focused on understanding barriers to GBVF policy implementation, the experiences of survivors, and how service provision could be improved. The findings indicate that there are barriers to implementation. This means that procedural failures, under-resources frontline services, poor inter-agency coordination, and inadequate oversight impede survivor-centred care (WCPO Respondent; WCDCS Respondent). Survivor experiences have demonstrated that secondary victimization is prevalent, highlighting the gap between policy intent and practical service delivery (TCC Respondent; NGO Respondent). Enhancing accountability, coordination, training, and resourcing are essential to improve outcomes for survivors (NGO Respondent; Dimant, 2022:20). These outcomes confirm that top-down legislation, while necessary is insufficient without complementary bottom-up strategies that actively engage survivors and community-based organizations. The findings of this dissertation closely align with the literature reviewed.

Secondary victimization: Literature underscores that insensitive treatment, victim-blaming and procedural delays in post-rape care increase trauma (Medie, 2013; Life Healthcare, 2022). The research findings mirror this, with survivors reporting re-traumatization due to SAPS and TCC protocols. Coordination and Accountability: The literature identifies a persistent gap between policy adoption and practical implementation (Burris, 2022:36; Shukumisa Report, 2017:36). The research demonstrates that fragmented service provision and siloed approaches within TCCs and government departments contribute to this problem.

Resource Constraints: Studies on the Victim Empowerment Programme and Khuseleka Care Centres show that inadequate funding and human resources limit long-term survivor support (Dimant, 2022:20; GBV Summit Report, 2018:34). The findings highlight how volunteer and FCS staff limitations exacerbate service challenges.

The findings suggest that applying a bottom-up approach can address many of the challenges in GBVF service provision: Community and survivor-led initiatives will Empower survivors and community organizations to lead awareness campaigns, peer counselling, and local monitoring of GBV services. This aligns with the success of NGOs in lobbying for the 1998 Domestic Violence Act, as noted by Medie (2013:382). Decentralized decision-making will allow frontline services providers at TCCs and shelters to contribute to decision-making, ensuring survivor needs are prioritized and reducing procedural bottlenecks. Collaborative training is important as cross-training between NGOs, SAPS, TCC staff, and health professionals can create a shared understanding of survivor-centered care and limit secondary victimization. Participatory Monitoring and Feedback would be helpful to Implement survivor feedback mechanisms and community oversight committees to monitor service quality and accountability, complementing formal structures like the WCPO. Resource allocation is important as direct funding to community-led initiatives, survivor counselling, and capacity-building for volunteers and first responders, creating a sustainable model for psychosocial support.

The bottom-up approach, when integrated with top-down legislation, can foster a more responsive, accountable, and survivor-focused GBVF response in South Africa. In conclusion, while South Africa has made significant progress in establishing legislative and policy frameworks to combat GBVF, systemic failures, resource constraints, and coordination gaps undermine their effectiveness. The research highlights that survivors continue to experience secondary victimization, and frontline service providers operate under severe constraints. Addressing GBVF requires not only robust legislation but also a comprehensive, multi-sectoral, and bottom-up approach that incorporates survivor and community perspectives, strengthens inter-agency collaboration, and ensures adequate resources for service provision. By combining top-down policy frameworks with practical bottom-up initiatives, South Africa can enhance the implementation of GBVF policies, improve post-rape care, and create a more effective, survivor-centred response to the GBV crisis.

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Appendix A - List of Respondents

- An Official at the Western Cape Department of Community Safety responsible for SAPS oversight. *(The Department of Community Safety aims to increase safety for all in the Western Cape by improving safety through effective oversight of policing and optimising security risk management and the Departments work is underpinned by the Western Cape Community Safety Act 3 of 2013).*

- A Manager at a Cape Town-based NGO that provides services to survivors of rape and sexual violence. *(The NGO provides direct services to survivors of rape and sexual violence and engages in popular education and awareness raising which includes community workshops and mobilisation as well as legal advocacy and lobbying for legislative change for adequate survivor support services*).

- A first Responder at a Cape Town-based Thuthuzela Care Centre. *(Thuthuzela Care Centres (TCCs) are one-stop facilities forming part of South Africa's anti-rape strategy to reduce secondary victimization and increase the number of successful prosecutions).*

- An Official at the Western Cape Police Ombudsman. *(The Western Cape Police Ombudsman seeks to enhance the effectiveness and efficiency of police services to improve relations between the police and communities by investigating complaints of police inefficiency and or a breakdown in relations between the police and communities).*

Appendix B – Interview Schedule

General Information & GBV Basics

- What are the demographics of sexual offences by age and sex or in other words what do survivor profiles look like? Do survivor profiles include mothers of children born as a result of sexual violence and what is the prevalence of this in the Cape Metro?
- What are the types of GBV seen and dealt with?
- What are the risk factors for different types of GBV?
- What are the perpetrator profiles?

Disclosure, Help Seeking and Referral

- What is the primary means through which victims of GBV seek assistance from service providers?
- What process must be followed by the various service providers in assisting victims of sexual violence?
- How do service providers such as the TCC and the FCS Unit ensure confidentiality and how is information sharing handled?
- What are the issues/challenges/barriers surrounding assistance to victims that service providers themselves have indicated they are experiencing?
- Do service providers engage in community outreach as a means to facilitate reporting of GBV cases, and particularly in relation to cases of sexual violence? If so, how is this done?

Survivor support services

- What barriers or challenges does your organisation experience in providing services to victims of GBV?
- Could you list the support services offered by your organisation?
- What role does your organisation play in GBV service provision, given that the

organization is meant to enhance the effectiveness and efficiency of police services to improve relations between the police and communities, by investigating complaints of police efficiency and the breakdown of relations between police and communities? (WCPO)

- What corrective action is taken to improve to improve police services to victims of GBV when wrongdoing is found?
- How is the implementation of the corrective measures monitored for SAPS to be held accountable?
- How does your organisation work with other GBV service providers to ensure victims get the required assistance as set out by the policies and interventions?
- Are service providers/staff/ volunteers/SAPS provided with adequate training and knowledge related to sensitivity, awareness and their attitudes in dealing with victims of GBV and sexual violence in particular?
- How is secondary victimization addressed with GBV implementers to avoid this?
- How is it ensured that staff are familiar with legislative protocols governing victim support?
- Is there community involvement in supporting survivors and their reintegration into the community?
- What is being done to encourage this and how is reintegration done?
- Are there any challenges related to the reintegration of victims of GBV and sexual violence into communities?
- Are resources provided for the reintegration of victims and where does this come from?
- What barriers impact the victim from disclosing sexual violence?
- Do you think government policy and or legislation to combat the prevalence of GBV helps or hinders the ability of service providers to support victims?
- (follow-up question) – How does this help or hinder the response of service providers/your organisation?
- What are the impediments to service providers when dealing with victims which

prevents policies from being carried out as intended? Does the service provider think there is anything which the policy does not make provision for based on their own experience? Considering a bottom-up approach. (E.g. operational capacity challenges in effecting policy and legislative interventions to assist victims of GBV?)

- Is adequate training provided to staff stationed in FCS Units at police stations on the process of handling victims and cases and how do they avoid the contamination of evidence of a victim of sexual violence?
- Do good relationships exist between your organization and other GBV policy implementers or is the collaboration weak and relationships conflictual?
- Are the relevant Departments tasked with implementing GBV legislation working in silos?
- What are the key support needs and preferences sought by victims of GBV and does legislation adequately allow you to provide this?
- How do service providers ensure that their staff are familiar with legislative protocols governing victim support?
- Are the experiences of victims/survivors factored into efforts to improve the operational response of Service providers?

Appendix C – Ethics Approval Letter

UNIVERSITY OF CAPE TOWN

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14th December 2022

To: Haanim Davids

From: A/Prof Vinothan Naidoo

Subject: Ethics Clearance

Research: The identification of gaps and barriers in the implementation of Gender-Based Violence (GBV) service provision by frontline providers in South Africa: NGO and GBV Service providers perspectives on policy responses to victims of Sexual Violence

Date: 14th December 2022

This letter confirms that the ethics application for the student researcher, Ms Haanim Davids, referred to above, has been approved by the Department of Political Studies Ethics Committee on the 14th of December 2022.

Yours sincerely

Signed by candidate

A/Prof Vinothan Naidoo

For the Department of Political Studies Research Ethics Committee (members: A/Prof Vinothan Naidoo, A/Prof Zwelethu Jolobe, A/Prof John Akokpari Department of Political Studies)

"OUR MISSION is to be an outstanding teaching and research university, educating for life and addressing the challenges facing our society."