

POST-RAPE CARE AND JUSTICE IN SOUTH AFRICA:
IMPROVING SUPPORT SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE

by

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THESIS ABSTRACT

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Title: Post-Rape Care and Justice in South Africa: Improving Support Services for Survivors of Sexual Violence.

The purpose of this study is to explore and describe the current experience of sexual violence survivors in Sexual Offences Courts and Thuthuzela Care Centres in South Africa. While these two models were developed as a way to alleviate rates of sexual violence and encourage reporting, they have strayed from their original purpose, creating additional stressors for survivors wishing to access support services. Literature on this topic from the perspective of survivors is still scarce. This study aims at giving a voice to a community of women-identifying survivors of sexual violence who have accessed these services, in order to determine how they operate and to identify ways to improve service delivery. I posit that the current obstacles to a smoother service provision for SOCs and TCCs are multi-layered, ranging from their spatial implementation to poor training of specialized personnel, to post-apartheid deeper-rooted societal issues creating racial, gender and economic divides.

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CHAPTER I

INTRODUCTION

While sexual and gender-based violence affects millions globally, rates of violence are particularly high in South Africa and especially the Western Cape region. Socio-economic conditions and systemic forms of oppression inherited from apartheid have caused the perennation of a climate of sexual and gender-based violence that was widespread during the conflict (Mosavel, Ahmed and Simon, 2012). Moffet (2006) explains that South Africa has some of the highest rates of sexual and gender-based violence for a country not at war – a statement supported by Britton (2006), who describes South Africa as ranking at the top, internationally, for the greatest incidence of reported rape.

Over two decades after the democratization of the country, apartheid's destructive legacy and current political dynamics raise challenges for governmental institutions and organizations trying to address these issues. Exact numbers are difficult to quantify, but the scale of the problem is clearly significant. It is estimated that 40% of South African men have hit their partner, according to the South African Medical Research Council (2017). Rape Crisis Cape Town Trust statistics (2018) indicate that 27 people are assaulted every day in the Western Cape; these numbers are indicative of a much larger crisis taking place at a national level. Although South Africa is not the only country grappling with these concerns, they are compounded by a number of other deep-rooted

social issues including poverty and racism, prompting organizations to work together to address the root of the problem at the community level.

Despite many post-apartheid challenges, the South African Government has implemented what could be considered to be innovative institutions to combat sexual violence, in the form of specialized Sexual Offences Courts (SOCs) and integrated rape management clinics known as Thuthuzela Care Centres (TCCs).

The first Sexual Offences Court was implemented in Wynberg Magistrate's Court in the southern suburbs of Cape Town in 1993, following pressure from women's organizations on the Government to address the burgeoning rates of sexual violence. The Sexual Offences Courts (SOCs) model was then rolled out throughout the country with the intention to improve the experience and treatment of rape survivors within the criminal justice system (Walker & Louw, 2003). SOC's deal exclusively with cases of sexual violence perpetrated against women and children and aim to eliminate secondary trauma (also referred to as secondary victimization) for survivors and increase conviction rates by encouraging survivors to report sexual violence to the authorities (MATTSO Report, 2013).

The Department of Justice & Constitutional Development (DoJ & CD) indicates that in July 2018 there were 74 Sexual Offences Courts in operation in all of South Africa. These statistics, however, include both *hybrid* and *pure* courts. The DoJ & CD describes the former as regional courts that are "*established to give priority to sexual offences cases, whilst permitted to deal with other cases*" (2018). In order to be considered *pure* Courts, SOC's must meet certain material requirements – they should all

possess a CCTV-equipped court room, separate waiting rooms for adult witnesses and survivors, as well as waiting rooms for child witnesses and survivors, and they should offer victim support services as well as specialized interpreters trained in child development and mental disabilities (MATTSO Report, 2013). In theory, specialized Sexual Offences Courts should improve women's experience with the criminal justice system, and thus encourage them as well as other survivors to come forward and officially report rape or sexual assault. However, since 2013 the South African Government has not rolled out SOC's as it promised (RSJC, 2018).

In existence for over 25 years, SOC's remain relatively unexplored in scholarly literature. Non-profit organizations such as Rape Crisis that work directly with survivors have raised concerns about the way these Courts are currently being run, and about their unequal spatial implementation. It appears that scholars have tended to focus on the larger issue of systemic sexual violence in South Africa, analyzing the factors that have led to violence, but they have rarely examined or given a voice to survivors themselves regarding their perception of the specialized courts. This results in the general idea that SOC's operate adequately, but it is not clear how survivors experience the SOC's.

This assumption is also true for Thuthuzela Care Centres. They were implemented shortly after SOC's, as part of a similar national anti-rape dynamic aiming at reducing secondary trauma, reducing the time for finalization of cases and overall improving user experience for survivors of sexual violence (NPA, 2009). They are best defined as one-stop, comprehensive rape management medical facilities that operate as separate units

within public hospitals, generally located close to communities with high rates of rape, and they usually work conjointly with SOCs and their officers.

In this thesis I explore both the promise and the reality of Sexual Offences Courts and Thuthuzela Care Centres from the perspective of survivors who utilized these services, as well as non-governmental organization and law enforcement personnel who work within and with these systems. I argue that including survivor-centered narratives tells a more complicated story about these services, and the information and perspective provided in their accounts forms an important resource for improving the process and the outcomes for survivors of sexual and gender-based violence in South Africa.

Purpose and Context of Study

I have witnessed firsthand and, to a certain extent, taken part in some of the growing efforts to tackle the issue of sexual violence in South Africa. From September 2017 to June 2018, I interned at Rape Crisis Cape Town Trust and volunteered at Sisters, Inc., a shelter for survivors of domestic abuse. The stories I heard and the women I met while in South Africa have shaped my decision to dedicate my career to addressing sexual and gender-based violence. I seek to better understand the experience of survivors through the legal and medical systems in South Africa and identify ways to improve holistic service delivery. Understanding and acknowledging the needs of survivors of sexual violence is key to the improvement of service delivery. These changes have the potential to lead to substantial outcomes triggering a ripple effect of positive change in South African society. Improved services would lead to the alleviation of secondary

victimization in service provision, strengthening survivors' trust of the systems, potentially leading to higher reporting rates and better justice. This chain of events could eventually lead to deterrence for potential perpetrators of SGBV, improving the country's general perception of gender roles. Although these are but suppositions and speculations, they are intended to show the importance of this study in the larger context of the feminist field in South Africa.

This study is an analysis of the experience of sexual assault survivors within various support systems operating in South Africa, with a particular focus on the SOC and TCC models currently in place. While these models are laudable in theory, they largely do not operate to their full potential or in accordance with the baseline project. Through a survivor-centered approach, my research thus focuses on the following questions:

1. How do survivors perceive their experience of support services, from Sexual Offences Courts and Thuthuzela Care Centres to nonprofits?
 - a. What currently works and what are some of the shortcomings of the systems?
 - b. Are SOCs and TCCs providing adequate services?
 - c. Do support services currently available in the Western Cape and in KwaZulu-Natal cater to all survivors equally?
2. How do support services currently in place operate, based on interviews with staff members?

3. How do government-implemented institutions compare with community-based initiatives or NGOs?
4. What do survivors need and how can service delivery be improved holistically in order to better fulfill these specific needs?

Contemporary South Africa is divided into 9 provinces that are governed on a national, provincial and local level. TCCs and SOCs, are national initiatives and thus operate under the same rules and guidelines throughout the country. NGOs vary from one another, and although there are many in bigger cities, rural areas remain in need for more non-governmental support. My research focuses on the Western Cape province, particularly its capital, Cape Town, as well as the KwaZulu-Natal province (Durban and surroundings, especially). This geographic preference comes from my familiarity with both regions, especially the Western Cape. While I would have loved for this project to take place on a larger – perhaps national – scale, this was not possible given the timeframe of my research, which is why I chose to focus on areas where I knew my research would yield results relatively quickly and efficiently. Further, these geographic limits are particularly relevant in that the Western Cape and KZN are home to the two most populated cities in South Africa (Cape Town and Durban, respectively) which might impact service provision and survivors' perceived experience of support systems in these areas.

The main languages spoken in the Cape Town area are Afrikaans, English and Xhosa. In Durban, English and Zulu are the most commonly spoken languages. The

majority of the South African population is proficient enough in English to feel comfortable conversing during such interviews. For the purpose of this study, I conducted interviews in English, but had various options for translators (in Afrikaans and Xhosa) should the need have arisen.

Literature Review and Theoretical Framework

Many scholars have written about the issue of sexual and gender-based violence especially as it pertains to South Africa. Artz and Smythe (2007) and Thomas et al. (2013) all correlate the scale of the problem with the country's democratic and political transition and the reinforcement of the patriarchal order that stems from pre-transition conflicts. Thomas et al. describe violence within patriarchal societies as a continuum and argue that political transition does not cause or amplify sexual and gender-based violence, but rather that the latter is an inherent part of the country's history of violence, which has deeply impacted power relations and gendered identities and is perceived as a way to regulate social interactions. Helen Moffett (2006:132) posits that SGBV against women in South Africa is often rooted in apartheid discourses and is understood by many as "performing a necessary work of social stabilization," similarly to the way whites in power used various methods to regulate blacks and affirm their subordinate status under apartheid. She describes the effects of both in-conflict and post-transition violence as traumatic and long-lasting. Artz and Smythe discuss the general focus on the advancement of women's rights in South Africa and on using the law as an instrument to address high rates of sexual violence that came with the democratic transition. They draw

an interesting parallel between the utilization of legislation to enforce some of apartheid's most violent laws (the Group Areas Act of 1950 for instance) and the country's focus, during and after the transition process, on the law as a regulator. They further explain (2007:8) that, "Recourse to the law is both necessary and unavoidable in an emerging democracy, where emerging rights are embodied through various forms of legislations."

Feminist scholars in South Africa have heavily criticized the legislation surrounding rape, especially regarding evidentiary issues, such as previous sexual history, the disclosure of medical records, and the cautionary rule (which requires caution when evaluating a rape survivor's testimony, implying that rape is an accusation easily made) (Artz and Smythe, 2007). In South Africa, the crime of rape is defined by the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. However, this definition is very broad and states that (p.10): "any person ('A') who unlawfully and intentionally commits an act of sexual penetration with a complainant ('B'), without the consent of B, is guilty of the offence of rape."

This definition and the aforementioned evidentiary issues demonstrate how the criminal justice system often solidifies sexist stereotypes and assumptions about women and other survivors of sexual assault. Some global as well as South African feminists have described the law as a "fundamentally patriarchal institution" (Freeman, 1979:55) and have expressed doubts regarding the use of legislation to achieve transformative change (Snider, 1998). Artz and Smythe however, argue that the post-apartheid transitional democracy is an opportunity to advocate for critical legislative reforms in

order to ensure that human rights are entrenched in a way that advances women's rights. Matsuda (1989) and Henderson (1991) describe staggeringly high levels of reported – and unreported – rape in South Africa, and make the argument that women who do choose to report and navigate the criminal justice system should benefit from a system that works adequately and serves their best interest, as survivors of sexual violence. Artz and Smythe, drawing on this statement, argue for a way to use the law to give sexual violence and rape a social meaning, moving beyond the simple definitions in legal terms. Due to the profound physical and psychological consequences of rape, they further argue for a holistic, “comprehensive medical management of rape survivors” (Artz and Smythe, 2007:14) and support the South African Law Reform Commission (SARLC)'s 1998 paper, *The Legal Aspects of Rape* in explaining that rape is considerably and inherently different from other forms of violent offences and thus requires victim-centered legislation and care. This statement is echoed by Louise Du Toit, who proposes a framework for understanding post-conflict sexual violence in South Africa.

Sexual violence in South Africa has indeed been the subject of many research papers and analyses over the years; however, very few authors have used clearly articulated frameworks for understanding and interpreting the extent of this societal issue. Du Toit (2014) presents four widely used frameworks and argues that three of them fail to capture the nature and impact of rape on South African women. The first frame, called the past-perpetrator trauma approach, locates rape within the perpetrator and posits the idea that men rape because of the country's colonial and segregated past, infused with violence and racial divide (Du Toit, 2014). Under apartheid, black men were

subordinated, dehumanized, and stripped of their individuality, identity, and culture through the racial policies of the regime (Cock, 1991). This frame uses this argument of emasculation to explain sexual violence against women, it implies that men use rape to reassert the power that was taken away from them and to reaffirm their masculinity after having been rendered powerless by the regime and the people in power (Moffett, 2006). The limitations of the past-perpetrator trauma theory revolve around its tendency to not only otherize but also racialize perpetrators. This approach seems to focus solely on one demographic, alluding that impoverished black men are always the perpetrators of rape. Furthermore, Du Toit argues that this frame places men at the center of the argument, dismissing the struggles of women or the harm inflicted upon them.

The second approach is the current socioeconomic exclusion frame. It shares some similar ideas with the past-perpetrator trauma theory but bestows it a more contemporary aspect by analyzing the economic struggles that plague the country and using these to justify hypermasculinity amongst boys from poor areas. It considers that the flawed transition from apartheid to democracy resulted in burgeoning poverty rates and high social expectations, which fostered a climate in which masculinities are challenged, compelling young men to turn to violence to assert power. Hamber (2007:13) mentions the “social expectations of manhood” that generate feelings of inadequacy and marginalization amongst impoverished young men when they are unable to reach these expectations. Du Toit (2014) confirms the existence of a correlation between poverty and violence but suggests that this argument fails to address the intersection of violence with gendered politics or power relations at a larger societal and more systemic level.

The third framework introduced by Du Toit is that of patriarchal politics, which revolves around gender politics. This theory claims that as a result of the democratization of the country and the gradual emancipation of women, the power balance began shifting in men's disfavor, causing them to feel threatened and generating a desire to assert power the only way they could, by raping. Financial independence and sexual autonomy, which many women began accessing post-democratization, are perceived by men as a menace and as an attack against their masculinity. Rape is thus used to perpetuate patriarchal systems and maintain the subordination and otherization of women (Moffett, 2006). Whilst this frame progresses from the previous ones in that it draws a larger picture of rape and analyzes it as not simply something that is perpetrated by one demographic of men, Du Toit argues that it is best to have a "political understanding of rape" rather than a psychological one as this leads to holding the perpetrator accountable instead of finding justifications. Psychological approaches, she adds, create sympathy and induces victim-blaming behaviors, but also place women at the periphery of sexual violence when they are in fact at the heart of it and are the ones directly suffering from this violence.

To better explain post-conflict violence in South Africa, Du Toit introduces a fourth framework of ontological violence, which draws a clear distinction between sexual violence and other, more general and normalized forms of violence. This approach rests on the idea that men perform their masculinity through sexual violence and thus integrate it as a central aspect of their identity. The ontological violence frame brings a new angle to the literature in that it recognizes the profoundly intimate and violating nature of rape, that causes survivors to feel dehumanized and stripped of parts of their identity, reduced

to the status of ‘victim’. This theory, which relies on previous findings by Steven Pinker (2011), postulates that men are aware of the devastating consequences of rape and use it as a tool to serve their own interest and gain respect from male peers. Du Toit acknowledges the vast complacency adopted by society, as well as the general mistrust that society and especially black women display towards police officers or judicial institutions – due to the complicated legacy of apartheid, under which blacks were brutalized and neglected by SAPS and whites in power, which facilitate these behaviors amongst men. Of course, black women’s distrust of government institutions and law enforcement, specifically, must be understood historically and analyzed with attention to black women’s social locations within systems of power.

The concept and theoretical approach of intersectionality (Crenshaw, 1989) helps advance our understanding of how our multiple social locations shape our experiences within relationships and institutions. Intersectionality is an approach that recognizes the interconnected nature of various forms of oppression such as race, class or gender, used together to create overlapping or interdependent systems of discrimination and disadvantage. Civil rights activist and legal scholar Kimberlé Crenshaw, who coined the concept and approach, argues that historically mainstream feminist ideas and policies in the US exclude women of color and in particular black women, by not acknowledging the overlapping discrimination that is unique to them (1991). Her paper introduces different angles of intersectionality such as structural intersectionality or political intersectionality. When addressing the latter, she explains “the concept of political intersectionality

highlights the fact that women of color are situated within at least two subordinated groups that frequently pursue conflicting political agendas.”

The conflicting political agendas she refers to are racism and sexism. Crenshaw indeed posits that the political fights to end racism or sexism do not acknowledge each other and therefore exclude women of color from both struggles, as they do not experience racism in the same way men of color do, nor sexism or patriarchy in the same ways white women do. This creates a narrative of exclusion where women of color are placed at the periphery of these struggles when they, in fact, experience both of these oppressions in even more depth. Intersectionality is a framework that has been applied to understanding social issues outside the U.S. as well (Braun, 2015), given how it always demands consideration and contextualization of social locations within larger systems of power and histories.

With this in mind, intersectionality is a key concept when it comes to examining issues of sexual violence in a country like South Africa, shaped by intense systemic violence and racial tensions (Braun and Dreiling, 2018). Black women in South Africa were, under apartheid and to a certain extent still today, marginalized based on their gender, race, or socioeconomic status. A United Nations report (1980:108) even describes impoverished black women under apartheid as the “oppressed of the oppressed.” This complexity emphasizes the need for a framework that takes into consideration these various levels of oppression and experience faced by women within the cultural, social, political, and economic realities of their lives (Braun, 2011).

Methodology

This study was conducted using a mixed methods approach, including semi-structured interviews, Likert scale questions, surveys, and participant observation conducted at various support services sites as well as one TCC. I believe this approach was the most adequate for this specific project as it enabled me, as a researcher, to capture the needs of the focus population, through the collection and combination of quantitative data and personal narratives. Giving survivors a voice remains one of the most important aspect of this research; therefore, maintaining a survivor-centered approach was a crucial aspect of the project's design.

The majority of the data collected is qualitative, although some quantitative data such as general demographics were gathered through surveys. Seven (7) semi-structured interviews were conducted, with self-identified women bound by a common experience of sexual violence and who had accessed support services from either NGOs or Sexual Offences Courts and Thuthuzela Care Centres. To diversify the range of experiences and perspectives, I also conducted three interviews with organization staff members.

The surveys were administered remotely using the University of Oregon's Qualtrics platform and were communicated to participants through various tracks, using online support groups, other relevant online platforms as well as word of mouth. Full anonymity was ensured as I disabled all functions that could collect identifiable information such as IP or email addresses. Survey results are not as prominent in my findings as interview results, as they elicited less 'clear' trends due to the small number of people surveyed (7). I would have liked to be able to analyze some of the results in

more depth but having set up this survey to be completely anonymous, it was impossible to gain more insight on certain answers, rendering it challenging to draw any strict or clear conclusions. For this reason, some of the data is presented visually in an appendix, but I felt unable to speak to these findings with as much accuracy as I have for interviews, and thus chose to mainly limit my analysis to interviews.

A word about the language used throughout this thesis: although sexual and gender-based violence is something that affects everyone, including transgender individuals who are already battling a complex, often misperceived identity, for the purpose of this paper the focus will mostly be on violence against women and girls. I include femme-identifying transgender folks and people who identify as both female and transgender in this category. I want to make clear that sexual violence against men and boys is a real issue that also takes place in South Africa, which presents its own complexities and taboos. I would have loved to gather more much needed information on this critical topic, but for the sake of time and organization, I focus on women and girls in this research.

Interviewees were recruited using purposive sampling with multiple snowball starts through networks I gained from my prior professional experiences in Cape Town, as well as various organizations in Durban. In order to diversify the pool of participants and to reach data saturation, and in an attempt to create diversity amongst a somewhat homogenous group, my recruitment process had multiple starts. Flyers were prepared containing information about my research project and myself, and participants were invited to contact me directly through my local phone number. Some flyers were posted

at the University of Cape Town's medical campus, and others were emailed to staff at various organizations such as the three Rape Crisis offices (the central office in Observatory, and the two regional offices in Khayelitsha and Athlone). More flyers were made available at Sisters, Inc., a shelter in the southern suburbs of Cape Town. This geographic diversity was an opportunity to reach different demographics, and while age was not an important factor in this project (although the participants recruited were all over the age of 18), South Africans are not a monolith, and these multiple snowball starts allowed for ethnic, linguistic and cultural diversity amongst my sample, allowing this project to reflect a broad range of experiences.

I was always aware that the topic of my research is sensitive, and I have and continue to do my best to ensure that survivors were not revictimized through the interview process. I ensured they had complete control over how interviews were conducted, and how their data was being used. My goal with these interviews was in no way to ask participants about their assault, or about their mental or physical health. My questions were not directed at these issues and I did not ask about them unless first mentioned by the interviewee. When survivors shifted the conversation to their assault or their difficulty coping, I listened, but never probed about such topics as my priority was to protect their wellbeing. The purpose of my research is to paint an accurate picture of the way service delivery is currently operating and to question participants about their experience of these services – my interview questions therefore solely focused on their experience navigating the systems, not on what brought them to seek these services. When stories were shared with me, I ensured through various means that survivors

consented to how their stories would be used. One survivor in particular was very open to sharing her story and told me about her assault and the consequences of it in great detail, hoping I could help shed light on the abuse she underwent in the system.

For the purpose of this thesis, I chose to present data from my interviews in narrative form in order to capture the richness and depth of interviewees' experiences (Braun 2008). I particularly focus on two especially poignant testimonies that, I believe, provide a representative depiction of both the shortcomings and the strengths of TCCs and SOC's that emerged in my interviews. I have chosen to use pseudonyms for all of my interviewees.

Positionality

Employing an intersectional approach in this research, it is important for me to also recognize the social locations that I hold and my positionality in relation to South Africa and this research. As a non-South African woman able to travel in and out of South Africa when convenient, I step into this research with a considerable amount of privilege, both racial and socio-economic. While I deeply love South Africa, and I have spent significant time there outside of the duration of this research doing similar work on gender-based violence, I cannot pretend to know what it is like to live under the constant threat of SGBV that my friends and colleagues in South Africa have described. Of course, this type of violence happens everywhere to alarming degrees. But the recent climate of fear and the heightened violent attacks, rapes, and murders perpetrated against

women, girls and other vulnerable populations have truly shaken the country and made many of my connections there very afraid for their everyday wellbeing.

I moved to South Africa in 2017, where I worked with the non-governmental organization, Rape Crisis Cape Town Trust, who provide advocacy and counseling for rape survivors, and Sisters, Inc., a shelter for domestic violence survivors. Although Rape Crisis was not associated with this research in any way, I maintained many connections in the Western Cape and in KZN, and I navigated the usual anxieties associated with new research and especially about such a sensitive topic with relative comfort. I was fortunate to benefit from gatekeepers who vouched for me and connected me with many great survivors, and without whom I would have certainly had to work harder than I did to gain informants' trust. I made every effort to get testimonies as 'truthful' and unbiased as possible, without ever encouraging people to tell me about their assault (unless they mentioned it openly) or to take one perspective over another on the SOCs or TCCs. I am aware that due to the privilege of being associated with a collegial institution in the United States, power dynamics might have formed themselves unbeknownst to me and the stories I heard might have been biased by what people thought they 'ought' to say due to my perceived 'authority.' I trust that I have been able to minimize such issues to the extent possible.

Organization of Thesis

Most literature on the topic of sexual and gender-based violence in South Africa focuses on the gravity of the problem and explores South Africa's past in relation to the

widespread ‘epidemic’ of sexual violence we see happening today. Some organizations have also assembled statistical reports on strategies for alleviating SGBV and supporting survivors. My thesis aspires to combine these approaches while looking at SGBV responses through a survivor-centered lens and providing insight from survivors themselves. The first part of this paper provides historical information about South Africa, looking at its past from the mid-17th Century up to the country’s democratization post-apartheid in 1994. It will then situate SGBV in the new legislature before diving into some landmark cases that helped shape the national legal framework and shift the national discourse about sexual violence, and finally, discussing the creation of Sexual Offences Courts and Thuthuzela Care Centres. Chapter III contains data analysis developed through the introduction of some key informants. The chapter takes a detailed look at two particular stories that, through the power of narratives, provide close and accurate insight into the experience of survivors in various support systems. Finally, Chapter IV provides recommendations for how to best serve survivors in response to the findings in Chapter III, before exploring the future of SGBV in South Africa since this research was conducted.

CHAPTER II

SEXUAL AND GENDER-BASED VIOLENCE IN SOUTH AFRICA:

BACKGROUND AND LEGAL FRAMEWORK

History of sexual and gender-based violence in South Africa

This chapter is one of the densest parts of this thesis: it contains important historical information on South Africa's past, crucial for situating the country's "problem" with sexual and gender-based violence, and an in-depth analysis of the legal framework and pivotal cases that shaped South Africa's current approach vis-à-vis SGBV.

South Africa as it is known today was first claimed by the Dutch East India Company in 1652. Colonization began with the establishment of *Kaapstad* – now known as Cape Town – as a supply station for the Dutch Empire; but there were interestingly no initial plans to colonize the surrounding areas. However, as the outpost grew and labor demands began to increase, Jan Van Riebeeck, who administrated the colony, turned to slave labor and expanded company rule into the interior of present-day South Africa. Some thought was given to enslaving KhoiKhoi men – the first native Southern African people to come into contact with Dutch settlers – but the idea was rejected on the grounds that such a policy would be costly and dangerous. Colonizers feared that Khoikhoi people, if enslaved, could easily escape into the local community (Byrnes, 1997). To this end, slaves were brought in from India, Ceylon, the Indonesian archipelago, and West Africa. An important aspect of slavery in this specific context is that, unlike in the United

States, Dutch communities in South Africa did not implement anti-miscegenation laws. The offspring born from the interracial relationships that ensued were known as *Cape Coloreds* and *Cape Malays* (Heese and Robertson, 2011). This contributed to shaping a perception of race and ethnicity that revolves around four discrete categories of White, Black, Colored, and Indian, and is still extremely prevalent in contemporary South Africa. For the purpose of this thesis, race shall be defined as a social construct referring to a group of people who share distinct and similar physical characteristics (Nengwekhulu, 1986), although it should be noted that the very concept of human races is biologically and semantically inaccurate, if still socially very powerful (Gallagher, 2012).

In 1948, a policy of apartheid was adopted when the National Party took power. The Government introduced numerous legislations based on, and supporting, racial classification, such as the *Population Registration Act No. 30* of 1950. This Act formally divided the population into the main recognized racial groups: Whites, Natives (Blacks), and Coloreds or Indians. Race became a social determinant of health, access to civil rights, mobility, and it was used as a political, social and economic tool by the government. White nationals bore the right to vote, had access to State security and relative professional stability and benefitted from representation in the National Assembly (Lever, 1982). In 1983, a vast majority – approximately 85% – of the 31 million individuals populating South Africa were black. White people represented only 15% of the population but, whilst they were a clear minority, they nonetheless remained a powerful and privileged one. One of the main aspects of the apartheid regime was the

blatant exclusion of the black South African majority from central government participation. White South Africans were not only in power in every sphere of society, they also had physical and geographical dominance over Black South Africans as they owned 87% of the country's land (Bernstein, 1985). They inhabited most of this land and, in an attempt to enforce territorial segregation, created subordinate, poverty-ridden structures called Homelands or *bantustans*, where they relocated Black South Africans after having displaced them from their original home. A major element through which this territorial segregation was implemented and maintained in place, were the Pass Laws, which required Black and all other non-white South Africans to carry a pass with them at all times in order to move outside of the homelands. This pass was colloquially referred to as the "*dompas*" (of which the literal translation means "the dumb pass"), and while it was initially targeting Black South African men and their movements, it started controlling women's influx in 1952, impacting their daily life considerably. They could no longer visit relatives on their own, and while this may seem insignificant, it increased women's likelihood of being at home during the week, which put them at greater risk of being subjected to the police's invasive and violent raids. To this day, these raids remain a very traumatic memory in many South African women's minds (Lee, 2009). In colonial South African society, one's condition and life roles were determined at birth; they rested first, on skin color, and secondly, on sex and economic class. Black women, in the apartheid context, were therefore labeled as the oppressed from the second they were born. One of the ways in which this oppression is expressed and experienced is through sexual and gender-based violence.

According to Jacklyn Cock, it is estimated that in 1980 in the US only 1 in 10 cases of rape were reported. That same year in South Africa, approximately 1 in 20 cases were reported to the police, with numbers reaching 1 out of 30 cases in certain regions of extreme poverty. Rape had, at the time, the lowest conviction rate of any violent crime in the country (Cock, 1980; Bernstein, 1985). These disturbing numbers have evolved since then, but rape and other forms of sexual violence still hold the lowest number of convictions amongst all of the South African provinces (NPA, 2017). An investigation on Violence Against Women in South Africa, conducted by the Human Rights Watch in 1995 confirmed the lack of reliable statistics on the number of violent attacks against women in the country. It explains that although the reported figures are staggeringly high, they only show the tip of the iceberg.

Accurate figures are extremely difficult to obtain, now and even more so in the apartheid era, as only a small percentage of rapes are and were officially reported. We do know that during the conflict, the highest percentage of rapes involved black women as victims, and were often perpetrated in terrible, aggravating conditions – usually in urban townships where families lived in extreme poverty, and where law enforcement forces had little interest in cases involving women, especially if they were black (Bernstein, 1985).

Bernstein (1985:55) writes about Soweto, the infamous Johannesburg township, and describes young men going out in groups, raping women for what she describes as “entertainment.” This phenomenon, which she calls “*jackrolling*” is now often referred to as *streamlining*. In her piece ‘*Contextualizing Group Rape in Post-Apartheid South*

Africa, Wood (2005) explains high levels of sexual violence in the country as a result of “patriarchal gender ideologies” and a “crisis of masculinity.” These explanations fall within the theory of the ‘past perpetrator trauma,’ a popular set of beliefs used to analyze the prevalence of sexual and gender-based violence in post-apartheid South Africa. As noted in Chapter I, Louise du Toit (2014) provides an acute critique of the past perpetrator trauma framework when it comes to considering gender-based violence and offers a new lens of ‘ontological violence’ in lieu of the formerly used theories.

Whilst a variety of terms exist to describe this phenomenon of group rape perpetrated by young men upon one or several young women (streamlining, jackrolling, “the train” etc.), the terminology of gang rape is not often employed by the perpetrators themselves, but rather, by outsiders (Wood, 2005). This is, according to Wood, likely due to the fact that young men involved in these group rapes do not often perceive their actions as unjustifiably violent, but rather, invoke arguments pertaining to the “*tactics*” used to downplay this violence. While they acknowledge the verbal refusal of the victims involved, they will often legitimize their actions on the basis that they (the victims) “deserved it.” Wood further explains that in Xhosa communities, sexual relations begin relatively early and are a way for young people to gain a reputation and establish a sense of self-worth. They play a substantial role in the transition to adulthood, which leads young boys to experience more pressure to have intercourse. A 2014 study about forced sex conducted by DeVries et al. in KwaZulu-Natal found that most South African adolescent girls’ first sexual intercourse is shaped, in some way or form, by gender-based violence and sexual coercion. If children do not experience it themselves, many witness it

in their home, in the form of intimate partner violence (IPV). The study found that boys held more positive views of forced sex than girls, as they reported associating it with love and financial dependence or submission of girls to them. Interestingly, findings from the study also revealed that a higher prevalence of experiencing forced sex was found amongst young men. This is tentatively explained by De Vries et al., by the fact that young men reported being considerably more experienced sexually, which led them to having intercourse more often than their female peers, increasing their odds of experiencing forced sex. Another possible explanation for these findings is that in the context of this study – a high school – girls having experienced forced sex may drop out of school at a much higher rate than boys. This is likely due to unexpected pregnancies and/or HIV transmission, which are two significant concerns for young girls when discussing the topic of forced sex (De Vries et al., 2014).

The 1995 report by the Human Rights Watch also addresses jackrollers and explains that in heavily (racially and economically) segregated townships, population density and tensions within family units under the stress of apartheid policies and unemployment led to increased levels of violence, especially directed against young women by armed youth gangs.

Official reports and numbers on sexual violence vary greatly according to the source and the year, but here are some pertinent examples: Roland Graser, former director of the National Institute for Crime Prevention and the Rehabilitation of Offenders (NICRO), argues that as many as 292,000 rapes occurred in 1976, of which 2,920 led to rape-related abortions. However, official statistics for this year only show

539 legal abortions, of which 74% were performed on white women (Cock, 1991). The disparities in medical treatment based on racial factors is evident. One could assume that black women were either denied access to legal abortions, not informed that it was within their rights to get one, or that they might have simply been too intimidated by racist and patriarchal medical, judicial and political institutions that systematically favor white women, to go through with the termination of unwanted pregnancies. At the time of apartheid, both black and white women alike experienced discrimination with regards to their reproductive rights (Cock, 1991). In 1974, State-sponsored family planning programs were implemented, meaning that, in theory, contraception was available at no cost to all women (Kaufman, 2000). However, the reality of things was largely different – women, and especially black women living in rural areas had no access to these services. In 1989, 80% of them declared having been given Depo Provera as a birth control method, despite its proven inefficiency and the clear health risks involved (Cock, 1991). A direct consequence of this inadequate contraceptive utilization was abortion. As mentioned earlier, although women were allowed to seek abortions in cases of rape, incest, fetal abnormality or threats to the mother’s mental or physical health, a disproportionate number of these legal abortions was performed on white women. Black South African women largely resorted to illegal abortions, which led to severe gynecological complications and infections. An informant interviewed by Cock in 1991 revealed that the reason a staggering majority of legal abortions were done on white women is because they “knew how to work the system” (Cock, 1991:38).

Cock's findings (1980: 285) show that in 1977, 14,953 rapes were reported, of which 95% were perpetrated on "non-whites, by non-whites." The following year, the South African Police Services (SAPS) reported 14,600 cases per annum, which averages 40 cases a day. NICRO argued that in 1980, around 400 women were raped every single day, with only 20 cases out of these being reported. Cock (1983) nearly doubled this figure and argued that the number was along the lines of 777 daily rapes. In other words, statistics pertaining to sexual violence were and still are confusing because they lack accuracy and largely vary according to the sources and the interests at stake. One could argue that SAPS, for instance, present lower estimates than nongovernmental organizations do, as they wish to instill a perception of safety within the community. Rape Crisis Cape Town Trust, in a 1981 report, revealed that over a four-year period, 41,341 men were prosecuted for rape on victims aged from 3 to 70. Only 22,408 of these men – which sits barely above the 50% mark – were convicted, and 19 of them were sentenced to death (Bernstein, 1985). On the other hand, interestingly, the rape of a white woman by a black man at the time, under apartheid, was almost perceived as the ultimate crime and could result in the death penalty; but rape against black women, whether involving a white or black perpetrator, remained treated as a minor offense. In fact, the police themselves were regularly involved in sexual assault cases (Bernstein, 1985).

The Violence Against Women in South Africa report (1995) reveals that one of the legacies of apartheid in contemporary South Africa is the substantial lack of police officers and staff members, despite the high levels of violence experienced in the country. Under the regime, police forces were largely required to protect whites and their interests,

often by eliminating political activism amongst the black population. At the time of the democratization of the country, the national ratio of police officers per 1,000 citizens was 2.75 and 74% of the country's police stations were located in areas formerly reserved for 'whites only' (Department of Safety and Security, 1998). In "troubled areas," with high crime rates and important socio-economic disparities, these numbers fell to 0.75 per 1,000 (DSS, 1998). Lisa Vetten (2011) writes that following the democratization, the African National Congress (ANC) inherited a wide set of challenges bequeathed by the National Party, including policing. The new government was tasked with the burden of transforming a highly militarized force whose goal had been the enforcement of racist policies into a service that could be trusted by the same communities it had spent 46 years maltreating and brutalizing. Post-apartheid policing also implied reintegrating 11 distinct police forces into one united service and ensuring the equitable redistribution of policing resources (Vetten, 2011). The redistribution of resources was further amplified by the country's high levels of crime; in 2004, ten years after the democratization, South Africa spent 3.1% of its gross domestic product (GDP) on its criminal justice system (CJS) (Altbeker, 2005). However, these expenditures did not equate to an increase in human resources and person power was still lacking in the CJS. Altbeker (2005) blames this imbalance on the government paying criminal justice personnel more than their equivalents in other countries, relative to GDP per capita. Furthermore, according to Cock (1998), post-apartheid police forces and judicial personnel were inadequately trained and aimed for convictions rather than thorough investigative processes.

Sexual and Gender-based Violence in a Post-apartheid Legal Context

Throughout this paper, sexual violence and rape are often used interchangeably – although the terms are defined differently – on the grounds that most, if not all of the sexual violence referred to in this analysis consists of rape. In the South African context, rape was used as a weapon of conflict under apartheid and continues, to this day, to be widely perpetrated against women in an attempt to subordinate them and annihilate their identity (Du Toit, 2014).

As mentioned earlier in this paper, the current definition of rape in South African legislative remains deeply flawed. A more appropriate definition, although not yet complete, is that provided by the World Health Organization (2002:149) which defines rape as physically or otherwise coerced penetration, “even if slight,” of the “vulva or anus,” using not only a penis but also other body parts of objects. This definition, by focusing on genital organs, fails to address forced oral penetration, which is a form of rape.

After a difficult transition to democracy, the strong human rights framework adopted by South Africa in its new Constitution gave hope to many formerly oppressed South Africans. In 1993, the Interim Constitution guaranteed a right to freedom and security of the person to all South African citizens, however, the definitions and limits of this protection were unclear and thus left to the discretion of judicial interpretation (Combrinck, 1998).

At a time where concerns about women’s rights and gender-based violence were being enshrined in legislation worldwide, South Africa drew from international

instruments in its own politics. In 1995, the United Nations held its Fourth World Conference on Women in Beijing, China, which South Africa attended in an attempt to “achieve the non-sexist South Africa” (Department of Welfare, 1995:10). As a result of this conference, the Government ratified the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), described by Kathree (1995:426) as the “definitive international legal instrument requiring respect for and observance of the human rights of women.” This ratification implies that South Africa, in terms of international law, is bound by the obligations this text creates, and ought to sanction all forms of gender-based discriminations. The CEDAW employs very straightforward definitions and recommendations and states that violence against women constitutes a violation of human rights regardless of whether the perpetrators are state officials or private agents (Combrinck, 1998). Combrinck further argues that South Africa, despite having ratified documents and modified its own Constitution in order to achieve the protection of women from violence, is still deficient in its duty to punish violations.

A number of Sub-Saharan African regional tools for the eradication of violence were also adopted by South Africa, such as the Southern African Development Community’s (SADC) *Protocol on Gender and Development* which S.A. ratified in 1997, along with the *Addendum on Prevention and Eradication of Violence against Women and Children*, ratified in 2008 (Artz, Meer & Aschman, 2018). The former commits States to changing “social practices” and all relevant laws subjecting women to violence and/or discrimination, while the latter requires States to not only take steps towards reducing rising levels of violence against women, but also acknowledge, protect and support the

“human, reproductive, and sexual rights” of women and girls (Artz, Meer & Aschman, 2018:2). Women’s reproductive rights, their protection and their promotion, are explicitly laid out in the *Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa* (2003) also known as the Maputo Protocol. The protocol addresses violence against women and girls through three rights: the right to dignity (Article 3), the right to life, integrity and security of the person (Article 4, which also addresses State responsibilities to respond to violence against women by taking “effective measures”), and the right to peace (Article 10). Articles 22, 23 and 24 of the Maputo Protocol also highlight the need for special protection for, respectively, elderly women, women with disabilities, and women in distress; and call on States to ensure their freedom from violence, including sexual violence (Articles 22(b) and 23(b)). Articles 25 and 26, finally, require the signatories to “provide for appropriate remedies to any woman whose rights or freedoms, as herein recognized, have been violated” (Art. 25(a)), to ensure the Protocol be implemented nationally (Art. 26(1)), and to adopt “all necessary measures” including providing “budgetary and other resources for the full and effective implementation” of the rights recognized (Art. 26(2)).

Locally, policies such as the 1996 *National Crime Prevention Strategy* and *South Africa’s National Policy Framework for Women’s Empowerment and Gender Equality* (Office of the Status of Women, 2000) both analyze violence against women through the lens of discrimination and find that all forms of gender-based violence correlate with gender inequality. In 1996, following promises made at the 1995 UN World Conference on Women, the DoJ&CD launched a public prevention campaign combatting violence

against women (an initiative carried by the Minister of Justice, Dr. Omar and the Deputy Minister of Justice, Dr. Tshabalala-Msimang) that led to the 1998 National Policy Guidelines for Victims of Sexual Offences. The campaign included two components: public awareness and strategy planning with relevant State actors and Government branches. The DoJ gathered various “relevant role players” (DoJ, 1998) to articulate practical plans for improving “the treatment of women within the legal system” (DoJ, 1998). Interestingly, according to a DoJ report signed by Deputy Minister of Justice Dr. Tshabalala-Msimang (1998:5) these relevant actors included:

“magistrates, judges, prosecutors, members of the South African Law Commission (SALC) and other personnel from within the Department [of Justice], as well as parliamentarians and staff working with the Departments of Welfare and Safety and Security, the South African Police Service (SAPS) and relevant NGOs.”

It appears that a majority of the key actors consulted were Government members or judicial and law enforcement personnel, with only little attention given to non-State actors such as NGOs. Furthermore, the report does not appear to mention the presence or consultation of actual survivors of gender-based violence, whom, one can assume, could have significantly informed the decision-making process by sharing relevant personal experiences or testimonies. Following a series of meetings with these key actors, emerged a recommendation: the establishment of a “high level” intersectoral task team that would

help develop “uniform national guidelines for all role-players handling rape and other sexual offence cases” (DoJ, 1998:1). The DoJ assembled a task force comprising of SAPS personnel, the Department of Health, Welfare and Correctional Services, representatives from different aspects of justice (such as “prosecutors, magistrates and appellate courts” and “*an* [emphasis added] NGO representative from the National Network on Violence Against Women” (DoJ, 1998:2). Again, whilst the analytical part of the process will come later in this paper, it appears relevant to point out that a single non-State actor in the form of one NGO representative was selected to be part of the national task force. The task team’s goal was to articulate a set of guidelines that would enable the development of an “integrated and holistic” approach common to both the government and NGO sector in dealing with sexual offences (DoJ, 2018:2). It is important to note that the report was written after the task force was set up but right before it could take concrete actions; therefore, being unable to verify that each of these promises was kept, I will use conditional language for the following section. The guidelines developed by the task force were to be sent to “central offices” (a term the report fails to clarify) and relevant Government Departments in the country’s nine provinces, where they were to be made accessible to those working in the field of sexual violence prevention. Each department would have received relevant guidelines – SAPS stations would receive police-related guidelines, healthcare practitioners (HCPs) would receive health guidelines, etc. According to the report, information brochures for victims were to be made available and although there was no mention of location, it was indicated that these brochures would contain simple language and explain the basic steps

of the legal process. Further, Dr. Tshabalala-Msimang (1998:4) writes that, “it is anticipated that victims will obtain additional information on the process and the resources available to them in their area, from material prepared locally” but she does not give any guidelines or indications concerning whose resources will fund the material or which institutions are expected to distribute the material. This lack of information is concerning as it implies that “victims” or survivors are not the focus of the new guidelines and task force.

The National Policy Guidelines for Victims of Sexual Offences represented the South African government’s first attempt at developing unique, dedicated policy for sexual offences. Since then, guidelines issued by the National Prosecuting Authority (NPA) have largely replaced those developed by the DoJ (Vetten, 2011).

To better understand the post-apartheid legal and constitutional landscape, it is critical to analyze not only international, regional and local policy changes but also the South African Constitution and how it contextualizes human rights issues pertaining to SGBV.

Section 9 of the South African Constitution guarantees equality before the law for all citizens as well as freedom from discrimination, rendering the South African Government required to enact legislation barring discrimination. A transitional clause requested this legislation be enacted no later than three years following the adoption of the new Constitution (which although signed in 1996, came into effect in 1997). As such,

the Government implemented, in 2000, the Promotion of Equality and Prevention of Unfair Discrimination Act (also referred to as *the Equality Act*), which outlaws “unfair” discrimination by the Government as well as private organizations or individuals against the following “prohibited grounds” for discrimination: race, gender, sex, pregnancy, marital status, ethnic or social origin, color, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth. Interestingly, HIV/AIDS status, whilst not mentioned in the list of “prohibited grounds,” is cited in the Act as a protected category upon the basis of which discrimination is prohibited. In addition to recognizing these protected grounds, the Equality Act also requires the State to achieve and promote equality (Vetten, 2011).

The South African Constitution has, on paper, established a rather progressive legislative framework when it comes to tackling sexual and gender-based violence (Deane, 2018). The Interim Constitution and the new democratic constitutional order of 1994 recognized all women as equal citizens, legitimizing their role in society; and the 1996 Constitution, through the Bill of Rights, defines a significant number of rights pertaining to the eradication of gender-based violence. Section 12(1)I states that “every person has the right to freedom from all forms of violence from either public or private sources.” Smythe et al. (2008) emphasize the importance of the latter part of the rule in a society where the belief that domestic violence or rape are “predominantly committed in contexts, spaces, and relationships that are traditionally viewed as private” (175-6) is highly prevalent. Section 9 – the equality clause, Section 12 – which recognizes that everyone possesses an inherent dignity that must be protected and respected, and Section

14 – the right to privacy – are other key rules relevant to legislation around SGBV.

Furthermore, Chapter 14, Section 232 recognizes that “customary international law is law in the republic unless it is inconsistent with the Constitution or an Act of Parliament.”

Artz, Meer & Aschman (2018) explain that whilst international norms signed or ratified by South Africa are regularly used in key South African human rights legislative developments, resulting in a change in policy; this has not yet led to concrete and dependable implementations in the health sector and CJS.

It is vital to note that the aforementioned Constitutional rules should be read in conjunction with Section 7(2) of the Constitution, which renders the State obligated to “respect, protect, promote, and fulfill” all rights contained in the Bill of Rights. Through a number of positive duties, the State is therefore responsible for the fulfillment of its citizens’ rights. The State not only has a responsibility to take “proactive steps” (Kruger, 2013) in the prevention of gender-based violence, it also has a duty to respond (Thorpe, 2013).

After analyzing Government-led legislative changes pertaining to sexual and gender-based violence, it is important to contextualize changes facilitated by judicial actors through relevant landmark court cases which are highlighted below.

Landmark Cases Regarding Sexual and Gender-Based Violence in South Africa

The legal context is an important dimension in understanding the promise and limits of addressing sexual and gender-based violence in South Africa. In this section I

discuss eight landmark cases that have significance for creating this South African legal context over time.

a. State v. Makwanyane (1995) and Jan Oompie Kolea v. the State (2012)

In 1995, T. Makwanyane and M. Mchunu, the accused, were convicted in the Witwatersrand Local Division of the South African Supreme Court on 4 counts of murder, one count of attempted murder and one count of robbery with aggravating circumstances. Initially sentenced to the death penalty on each of the murder counts and to long terms of imprisonment on the other counts, they appealed to the Appellate Division of the Supreme Court against both the convictions and sentencing. After their appeal was dismissed, the case was taken to the Constitutional Court of South Africa – the highest court on constitutional matters. Counsel for the accused argued that the Criminal Procedure Act 51 of 1997, Section 277(1)(a) which prescribes the death penalty as a “competent sentence” for murder, conflicted with Section 9 (the right of life) and Section 11(2) (the right against cruel, inhuman and degrading treatment or punishment) of the Interim Constitution. It is relevant to note that this case took place prior to the adoption of the final Constitution, and as such, it was tried under principles of the Interim Constitution. The accused’s counsel argued that the death penalty fell under the procedures described under Section 11(2) and qualified as ‘cruel, inhuman and degrading punishment’. After deliberations, a relatively young court system struggling to move past this transitional period in South African history, found the death penalty to be unconstitutional and contrary to Sections 9 and 11(2) of the Interim Constitution. This

focus on human rights was rather unprecedented in a relatively new judicial system and set an incredibly important precedent. In his decision, Arthur Chaskalson, then President of the Constitutional Court of South Africa, declared that:

“the greatest deterrent to crime is the likelihood that offenders will be apprehended, convicted and punished. It is that which is presently lacking in our criminal justice system; and it is at this level and through addressing the causes of crime that the State must seek to combat lawlessness.” (§122)

More than 15 years later, in *Jan Oompie Kolea v. the State* (2012), another crucial precedent was set, giving hopes of a real deterrent to rape and other sexual offences to the South African population. Kolea, the appellant, was convicted by the Kroonstad magistrate court, in the Free State, of one count of rape, after repeatedly raping a woman with another man. The case was shortly after referred to the Free State High Court in Bloemfontein, where the conviction was confirmed, and a sentence of 15 years’ imprisonment was given. The sentence was given under Section 51(2) of the Criminal Law Amendment Act 105 of 1997. When the appellant appealed the ruling and the sentencing, the Court found that his conviction should have in fact been read under Section 51(1) of the Act, which imposes a minimum sentence of life in prison when a victim was raped multiple times by more than one individual. Kolea was then sentenced to life in prison, and his appeal was denied.

Jan Oompie Kolea v. the State became a landmark case for breaking a longstanding trend of judges reluctant to impose life sentences under Section 51(1), choosing instead to impose lighter sentences. In a country where rape is so prevalent, the concrete threat of life imprisonment sets a crucial precedent. Sigsworth (2009) writes that when a country's criminal justice response to sexual violence is poor, a societal culture of impunity emerges.

b. State v. Chapman (1997)

State v. Chapman was a pivotal case in the nationwide recognition that sexual violence is a violation of women's rights. In this case, the appellant was convicted on three counts of rape in the Magistrates' Court and sentenced to 14 years in prison. Chapman's appeal was denied, and the Supreme Court of Appeal (SCA) reinstated that "women in this country are entitled to the protection of [their] rights" (State v. Chapman, 1997). CJ Mahomed and Justices Van Heerden and Olivier further argued that rape was a very serious, humiliating and degrading offence that constituted a "brutal invasion of the privacy, the dignity and the person[hood] of the victim", and reminded the Court that the rights to privacy, dignity and the integrity of every person were enshrined in the Constitution.

c. Carmichele v. Minister for Safety and Security (2001)

On August 6, 1995, Carmichele ('the applicant') was viciously sexually assaulted by a man named Coetzee, in a small secluded village near Knysna, in the Western Cape.

Coetzee had been awaiting trial for the attempted rape of another woman and was convicted of attempted murder and housebreaking. In spite of the seriousness of the alleged crime and Coetzee's prior conviction, the prosecutor allowed his release pending trial. Carmichele sued the Minister for Safety and Security in the High Court, claiming that SAPS and the prosecutors had negligently failed to keep her safe by violating their legal duty to prevent Coetzee from causing the applicant harm. The High Court and the Supreme Court of Appeal both dismissed the applicant's claim, denying that SAPS and the prosecution owed her a duty of protection. The Constitutional Court dismissed the orders of the lower courts and held that the State and its organs have an obligation, per the Constitutional and per international law, to protect the dignity and security of citizens, including women. The Court noted, in addressing these constitutional obligations that "Few things can be more important to women than freedom from the threat of sexual violence." (Vetten, 2011).

d. Ms K v. Minister for Safety and Security (2005)

In this case, the Constitutional Court took the principle of the State's liability to protect acts of gender-based violence – a principle that emerged from *Carmichele v. Minister for Safety and Security* – one step further. Ms K, the applicant, sought damages from the Minister for Safety and Security on the basis that she was raped by three on-duty, uniformed policemen after accepting a lift home from them when she had found herself stranded somewhere. The Constitutional Court evaluated the common law principles of vicarious liability, which is defined by Aco (2011) as "the law that enables a court to hold

one party responsible for the actions of another,” and ruled that because of the police’s constitutional responsibility to prevent crime and protect citizens, each of the three police officers involved in the rape had failed in their duty to protect. For this reason, according to the principle of vicarious liability, the Court found the Minister for Safety and Security liable for the acts of the three officers. In this case as well as in *Carmichele v. Minister of Safety and Security*, it appears clear that the State has a positive duty to take proactive steps towards the prevention of gender-based violence (Smythe et al., 2008)

e. Masiya v. Director of Public Prosecutions (2007)

Masiya, the accused, was brought before the Sabie District Court, in the Mpumalanga province, on a charge of rape against a nine-year old girl. When the case was transferred to the Regional Court at Graskop for trial, the evidence showed that the victim had in fact been raped anally, which required a different conviction – indecent assault rather than rape. The High Court Magistrate requested that the common law definition of rape be amended to include anal penetration and to make the definition gender neutral, on the basis that holding a distinction between non-consensual penetration of the vagina or of the anus of a female or a male was “not only archaic, but irrational and amount[ed] to arbitrary discrimination with reference to which kind of sexual penetration is to be regarded as the most serious” (*Masiya v. Director of Public Prosecutions*, 2007). Masiya appealed his conviction as well as the amended definition of rape, but the Constitutional Court, in an opinion written by Justice Nkabinde, affirmed the High Court and held that the definition of rape should be extended to include non-consensual anal penetration of a

female. Chief Justice Langa and Justice Sachs, while agreeing with this opinion, dissented with Justice Nkabinde on the point that the definition of rape should also be extended to include non-consensual anal penetration of men. CJ Langa's opinion contained a very encouraging definition of rape. He wrote that:

“the historical reason why rape was criminalized was to protect the proprietary rights of men in women. However, over the years the courts have gradually focused less on the proprietary interests and more on the sexual nature of the crime. Today, rape is recognized as being less about sex and more about the expression of power through degradation and the concurrent violation of the victim's dignity, bodily integrity and privacy.” (Masiya v. Director of Public Prosecutions, 2007)

According to CJ Langa, limiting the definition of rape to female victims would not benefit women and girls not increase the protection afforded to them by the law, as it would instead reinforce harmful gendered stereotypes.

f. M v. the State (2013)

In *S. P. M. v. the State*, a pastor from Port Elizabeth, in the Eastern Cape, was convicted of raping his adopter daughter during a sexually abusive relationship that lasted several years. He was sentenced to a 15-year prison sentence. In his appeal, the accused denied his guilt and claimed that the complainant had consented to the acts in question, arguing

that he “subjectively believed that she had [consented]” (M v. State, 2013). The judge overruled these claims and qualified the appellant’s conduct as sexual grooming. Further, the Court found that “real” consent was absent and explained that the “perceived acquiescence or submission of the complainant [by the accused] was a direct result of manipulation by the appellant.” In refuting M’s claims that he strongly believed the victim had consented to these sexual acts and in acknowledging that ‘grooming’ and manipulation took place, the judge set an important and necessary precedent that consent is not the utterance of a ‘no’ but rather the absence of a clear ‘yes’, and took significant steps towards the recognition of the complex patterns and power dynamics that often take place in sexual abusive relationships.

g. Levenstein and Others v. Estate of Frankel (2018)

The applicants in this case – eight adults of different genders, accused deceased Sidney Lewis Frankel of sexually assaulting them between 1970 and 1989, at which time they were aged between 6 and 15 years old. The Director of Public Prosecutions initially declined to prosecute the case, citing Section 18 of the Criminal Procedure Act of 1997 that bars prosecution of a case after twenty years. The applicants questioned the constitutionality of Section 18 in the Johannesburg High Court. The Court explained that Section 18 initially established a 20-year statute of limitations for all crimes except those subject to the death penalty – a category which included rape. Following the classification of the death penalty as unconstitutional, in *State v. Makwanyane* (1995), the law was amended to exclude rape and “other serious crimes” from the limitation on

prosecution. However, the law still imposed statutes of limitations on “sexual offences.” The High Court, affirmed by the Constitutional Court, ruled that Section 18, by differentiating rape from sexual offences and by imposing statutes of limitations on non-rape sexual offences, infringed on the dignity and equality of citizens. Statutes of limitations on all sexual offences were, as a result of this case, removed.

Jacob Zuma Rape Trial

In 2006, then ANC deputy president Jacob Zuma (and South African President from 2009 to 2018) was charged with rape. The State v. Jacob Gedleyihlekisa Zuma took place at the Witwatersrand Local Division of the High Court in Johannesburg, in an atmosphere “atypical of a court environment” (Moloi, 2006). This case, showcasing the intricacies and challenges of the “traditions versus the law” dichotomy (Deane, 2018) was considered a turning point for South Africa’s sexual and gender-based violence issue (Davis, 2015). A woman, whom the Judge presiding over the case declined to name – hereafter referred to as ‘the complainant’, accused Zuma of having raped her in his Johannesburg home in November 2005. Zuma pled not guilty, and in his address, alluded to the sexual history of the complainant.

In rape cases, evidence pertaining to the character and conduct of a complainant has been the subject of many debates, especially when used by the accused in their defense (Omar, 2016). Prior to the 1989 enactment of Section 227 of the Criminal Procedure Act, no “rape shield” (Omar, 2016) law existed to prevent complainants’ sexual history from being used by the accused. Section 227 was amended in the 2007

Criminal Law (Sexual Offences and Related Matters) Amendment Act 32, in order to bring it more up to date with South Africa's "constitutional dispensation" and to prevent irrelevant information from being admitted as evidence (Omar, 2016). During Zuma's rape trial, his legal representatives applied for the permission to adduce evidence pertaining to the complainant's sexual history. Moloji (2006) writes that although the court was given an opportunity to interpret Section 227 in favor of the complainant, it did not. He explains that the significance of this decision is such: according to the legal doctrine of precedence, lower courts are bound by decisions made by higher courts. Had the Judge in the Zuma case attached an interpretation favorable to the complainant to Section 227, lower courts throughout the country would have been bound by it, which is significant as at least 90% of rape cases are tried in lower regional courts (Moloji, 2006).

Jacob Zuma was, at the time of his trial, very popular. He was considered a "man of his people" with strong traditional roots (Waetjen & Maré, 2009) which was proven by his decision to address the court in his mother tongue of isiZulu during his testimony. While doing so was within his constitutional rights – anyone accused of a crime can indeed defend themselves in any of South Africa's eleven languages – Waetjen and Maré (2009) write that this decision carried a significant weight: it emphasized his affiliation with a particular cultural group and reinforced his image as a "man of tradition" (Clarke, 2015) in a country with significant racial history. Zuma's linguistic choice contributed to a shift in focus, making the trial less about rights and power and instead, about the "politics of culture" (Waetjen & Maré, 2009 and Deane, 2018). His identity as a "Zulu man" (State v. Zuma, 2006) which he emphasized numerous times, was further

reinforced by his testimony. When asked why the intercourse had taken place without the use of a condom in spite of the risk of HIV transmission as the complainant was HIV positive, Zuma explained that he believed the complainant was in a “state of sexual arousal” (Deane, 2018) and that he was under the obligation to act upon this state. Using cultural justifications once again, he testified: “and I said to myself, I know as we grew up in the Zulu culture you don’t leave a woman in that situation (...)” (Thornton, 2008).

By invoking cultural reasons to justify his actions, Zuma – and more broadly, this case – reinforced the widespread societal belief that gender power ought to be negotiated in the private, customary sphere, as opposed to the public sphere of civil rights (De Vos, 2016). The view articulated in this case thus largely conflicts with many Constitutional articles promoting gender equality and bestowing on the State a responsibility to guarantee the safety and dignity of its citizens. Deane (2018) writes that: “Within the forum of a court of law, culture offered to Zuma a legitimate medium in which to express the normativity of gender inequality and patriarchal morality.” The now-President of South Africa indeed attempted to use this legal platform to legitimize sexual violence. He was acquitted at trial, largely, according to Moloji (2006) because the court’s decision to grant the Section 227 application influenced the verdict.

The Zuma rape trial provided South Africans with a significant opportunity to engage with gender-based violence and issues of sexual violence in a progressive manner, but instead, the trial divided the nation and exacerbated hostility, allowing the issue to “become submerged in the acrimony” (Andrews, 2007).

Government initiatives to combat sexual and gender-based violence

After diving into South Africa's past, exploring the lingering legacy of apartheid and the court cases that shaped sexual and gender-based violence legislation, in this section I explore government initiatives instigated to combat SGBV and better support survivors, with the goal of eventually reducing rates of sexual violence.

Despite many post-apartheid challenges, South Africa has implemented innovative institutions to combat sexual violence, in the form of specialized Sexual Offences Courts (SOCs) and integrated rape management clinics known as Thuthuzela Care Centres (TCCs). The first Sexual Offences Court was implemented as a branch of Wynberg Magistrate's Court in the southern suburbs of Cape Town in 1993, following pressure from women's rights organizations on the Government to address the burgeoning rates of sexual violence. This decision falls within a national effort to implement "a concerted transitional justice project" (Artz, 2017); as does the ratification of the new 1994 Constitution and the establishment of the Truth and Reconciliation Commission in 1995. The post-apartheid context provides opportunities for the South African government to both expose and seek justice for past and current human rights violations (Artz, 2017) through legal reforms, policies and reparative measures (Albertyn et al., 2000), aiming at increasing gender equality (Murray & O'Sullivan, 2005).

Following the implementation of the Wynberg Sexual Offences Court, the SOC model was then rolled out throughout the country with the intention to improve the experience and treatment of rape survivors within the criminal justice system. At the opening of the Natal Law Society in 1998, Dullah Omar, then Minister of Justice,

introduced his agenda to expand the specialized courts model (De Rubus, 1998). He insisted on the need to develop both civil and criminal specialized courts, positing that specialist judicial officers would be able to accelerate the finalization of cases, improving the public's opinion of the justice system (Walker & Louw, 2003).

SOCs deal exclusively with cases of sexual violence perpetrated against women and children and aim at eliminating secondary trauma (also referred to as secondary victimization) for survivors, and at increasing conviction rates by encouraging them to report sexual violence to the authorities (MATTSO Report, 2013).

In existence for over 25 years, SOCs remain relatively unexplored in scholarly literature. Non-profit organizations such as Rape Crisis Cape Town Trust, that work directly with survivors have raised concerns about the way these Courts are currently being run, or about their unequal spatial implementation. These same organizations run advocacy campaigns and regularly call on the Department of Justice to keep a promise it made in 2013 to roll out even more SOCs throughout the country, but as of now this promise has not been fulfilled (RSJC, 2018). The Department of Justice & Constitutional Development indicates that in July 2018, there were 74 Sexual Offences Courts in operation in all of South Africa. These statistics, however, include both *hybrid* and *pure* courts. The DoJ & CD describes the former as regional courts that are “established to give priority to sexual offences cases, whilst permitted to deal with other cases” (2018). In order to be considered pure Courts, SOCs must meet certain material requirements – they should all possess a CCTV-equipped court room, a separate waiting rooms for adult witnesses and survivors, as well as waiting room for child witnesses and survivors, and

they should offer victim support services as well as specialized interpreters trained in child development and mental disabilities (MATTSO Report, 2013). In theory, specialized Sexual Offences Courts should improve women's experience with the criminal justice system, and thus encourage them as well as other survivors to come forward and officially report rape or sexual assault; however, this remains very theoretical as in reality, the Government has not rolled out SOC's as it promised to in 2013 (RSJC, 2018).

It appears that scholars tend to focus on the bigger problem of sexual violence in South Africa, analyzing the factors that led to it; but rarely giving a voice to survivors themselves. This results in an erroneous general idea that SOC's operate adequately. Listening to survivors who have gone through the legal process of reporting and who have experienced SOC's firsthand has shown that there are many multi-layered flaws in the SOC model as it currently is.

Sexual Offences Courts, although developed in South Africa, began earning worldwide interest and recognition as an effective way to reduce trauma and to support rape victims and survivors. In 2013, the South African Department of Justice developed a new Sexual Offences Court Model presenting requirements for other future SOC's. This model sets out moral engagements that each specialized court must respect, such as diminishing trauma for survivors, speeding up cases, making better-informed court decisions through experienced, specialized, and trained personnel, and ultimately, reaching higher conviction rates for rape and other forms of sexual violence (MATTSO

Report, 2013). The DoJ maintains that the current 74 SOCs operate adequately, but organizations such as the Shukumisa Coalition and Rape Crisis Cape Town Trust, through its advocacy group the Rape Survivors' Justice Campaign, argue that many of these courts lack proper equipment, and that they do not operate nearly as effectively as promised by authorities. The current system in place is largely flawed, and in many cases, magistrates blindly driven by their desire to score high conviction rates overlook the human aspect of the case and demonstrate a severe lack of support towards victims and survivors, which can cause substantial secondary trauma and thus risks defeating the very purpose behind SOCs, however laudable it was (Heath et al. 2018). The RSJC further advocates for the planned and funded implementation of SOCs and defends the idea that they have not been spread out evenly throughout the provinces, and that some rural regions or areas with extremely high rates of rape should, logically, benefit from specialized courts. The organization uses the case study of the township of Khayelitsha, in the Western Cape, where sexual violence is both omnipresent and very extreme. In the South African context, townships refer to underdeveloped and urban living areas that were reserved for non-white citizens under apartheid. They were often set up peripherally to the main cities (Artz, et al., 2017). Khayelitsha has a Magistrates' Court that does not contain a separate Sexual Offences Court, hybrid or pure. Women and girls living in Khayelitsha are already stigmatized and placed at the periphery of the city of Cape Town due to their geographic situation, but by not implementing an SOC in the township's court, the Government is further ostracizing these women who are forced to gather the financial resources and the time to take their case to an SOC in Cape Town. The DoJ has,

in the past, promised to grant the Khayelitsha Court a specialized court, but this promise was largely informal, and the legislative branch of the Government is yet to have put into operation a law ensuring the appropriate rolling out of Sexual Offences Courts (RSJC, 2018).

Traditionally, success in the criminal justice system is based upon conviction rates and finalization rates. However, according to Heath et al. (2018), these rates cannot be used to measure the success of sexual offences cases. In South Africa, the current targeted success rate for SOCs is 70-90%; but Heath et al. explain that the pressure put upon the prosecution and the judiciary to finalize or withdraw cases has caused both parties to reject the responsibility, resulting in a lack of accountability.

The authors further support this argument through quantitative findings. The turnaround times from arrest to sentencing ranged from 1 month to 64 months, with an average of 9.1 months. Of the cases finalized within the average of 9.1 months, however, 65.2% were withdrawn or struck off. Convictions obtained within this average were cases where the accused pleaded guilty, making convictions easy to obtain. Thus, on the outside, it appears that SOCs are efficient, but one must look at what statistics are not showing in order to understand what the challenges are. The MATTSO Report (2013) identifies many systemic obstacles to the smooth running of SOCs, such as:

- The lack of a dedicated budget, which causes inadequate infrastructures and equipment, thus not meeting the material requirement for Specialized courts

- A lack of human resources, such as a shortage of prosecutors, court preparation officers, dedicated forensic doctors and nurses
- Restricted space capacity in courts that often hinder full compliance with the blueprint
- Inherent interdependence in the criminal justice system that often causes serious delays in the finalization of cases
- The lack of adequate space in court buildings to establish Sexual Offences Courts and the facilities they require
- The lack of a specialization framework for the prosecution and the adjudication of sexual offences cases, rendering victims of sexual offences unable to see their specific needs being met. Likewise, the current support services available for LGBTQIA+ individuals and people with physical or psychological disabilities are inadequate, sparse, and poor
- A lack of debriefing programs, that results in many court officials developing vicarious trauma.

Furthermore, a case study analysis of specialized Sexual Offences Courts led by Artz et al. (2017) showed evidence of many challenges faced by sexual violence survivors when navigating the criminal justice system. The main challenge revolved around managing their wellbeing, encompassing both physical and mental health while going through the judicial process. The study also revealed a critical lack of information provided to survivors in service-provision contexts. As a result, sexual assault survivors

were not adequately informed about their legal options and about the way specialized SOC's operate. They were not aware of many of their rights, such as access to protection, the right to have a nurse chaperone present in the room during the forensic exam; or of the procedures, such as the need to bring the clothes they were wearing during the assault to a forensic examination, or to request the post-exposure prophylaxis (PEP) as soon as possible to prevent the transmission of HIV.

A 2016-2017 report by the National Prosecuting Authority reveals that the conviction rate for rape is 91.8%. In contrast, the 'Rape Justice in South Africa' report conducted by the Medical Research Council on behalf of the NPA shows that only 8% of rapists brought to court are convicted. Although there are now more institutions and efforts to address and combat sexual violence against women, the situation in post-apartheid South Africa is not far from that in conflict. Reported figures are still extremely difficult to obtain, and women are still largely afraid of reporting sexual offences. The inadequate personnel responses, long turnover times and misinformation regarding the judicial processes that are mentioned by Artz et al. and Heath et al. cause indifference and hostility from service providers, causing survivors to develop a mistrust in police forces and in the criminal justice system. In addition to these obstacles, the social stigma associated with reporting sexual violence is poorly addressed by Governmental institutions and seems to fall under the operational realm of non-profit organizations. Survivors of rape are often ostracized by their families and communities when they choose to make their perpetrator(s) accountable, which SOC's fail to provide support for (MATTSO report, 2013). Therefore, when considering reporting, women and other

survivors are discouraged by their perception of the way the justice system handle cases, and they often decide to opt out, judging that the humiliation they would experience from their peers outweighs the possible chance to hold their assailant accountable. Rape, therefore, continues to be one of the most underreported and therefore unpunished crimes.

Thuthuzela Care Centres, or TCCs, were implemented shortly after SOCs – the first TCC emerged in 1999 – with the idea that the two systems would run cohesively. The South African Government developed a set of policy guidelines, norms and standards informing the functioning of TCCs. According to a 2016 compliance and audit analysis report drafted by Shukumisa – a coalition of over 60 organizations across South Africa working against sexual violence – these guidelines are described in the TCC Blueprint. TCCs were built with the intent that they would become a one-stop rape management clinic to support and care for survivors of sexual violence without exposing them to secondary victimization. The term Thuthuzela is derived from an isiXhosa word meaning ‘comfort’, highlighting the primary goal of these institutions – to provide comfort and care to an increasing number of victims of SGBV. According to the Shukumisa report (2016), the TCC Blueprint not only highlights the processes required in the management of sexual violence and explains the roles and responsibilities of key stakeholders (staff members, NGOs, Government institutions), it also explains the “ideal TCC lay-out and staffing, the minimum level of care and the norms and standards for managing victims of assault” (Shukumisa, 2016:35).

TCCs are all linked to pre-existing healthcare facilities. As such, they are bound by certain Department of Health Norms and Standards for primary healthcare facilities. These norms include (DoH, 2003):

- The monitoring of all TCCs by DoH officials monthly, in order to ensure the quality of services delivered.
- The completion of annual evaluations by the DoH to identify gaps in service delivery.
- The conduct of medico-legal examinations or investigations by appropriate, adequately trained medical staff.
- That TCCs are victim-friendly locations thus offering educational material for various ages.
- That TCC personnel follows the appropriate guidelines for the prescription of the PEP as well as other medical services.
- The existence of a functioning, multidisciplinary committee including Government and NGO stakeholders guiding the functioning of TCCs.
- The use of correct referral mechanisms for victims of sexual assault.

TCCs, although primarily located on the grounds of hospitals and other health centers – they are required to have a separate entrance – also operate at various sites. Their role is not simply to provide immediate, emergency services to recently assaulted survivors (which takes place in a dedicated separate TCC facility within a larger public

healthcare facility), it is also to assist with the medico-legal component of sexual violence, which takes place at an SOC when possible (i.e., when TCC and SOC are located within a reasonable distance from each other) (Shukumisa, 2016:37).

The TCC Blueprint contains guidance on several aspects of care, which include (Shukumisa, 2016):

- Welcoming the victim, providing accurate information, explaining services and procedures, and obtaining consent for procedures.
- Referral, follow-up, and emotional support.
- Emergency immediate psychosocial support.
- Assistance with case reporting and court preparation, should a survivor wish to proceed with an official police report.
- Emergency medical care, including but not limited to: provision of the PEP for HIV prevention, medication to prevent other STIs, and an emergency contraception method, if relevant.
- In certain cases, a medico-legal examination.
- The opportunity for survivors to shower, including the provision of a change of clothes.
- Transport home or to a safe space for the survivor to stay.

In reality, the Shukumisa report (2016) found many discrepancies between this Blueprint and actual service delivery. Amongst these, victim friendliness was named as a

“major problem,” leading to further secondary victimization for survivors. Some medical providers and SAPS staff are described as “insensitive” and some of the counseling rooms are described as “inadequate” and lacking privacy. Further, not all TCCs were found to be child friendly as required, despite a high volume of their patients being children.

While all of the TCCs audited reported providing reception services, HIV counselling and testing, not all provided case reporting services (98%) or court preparation services (92.6%). Surprisingly, although one can posit this may be due to the discrepancies in the spatial implementation of TCCs and SOCs, only 70% reported being linked to a Sexual Offences Court.

In terms of material resources, 83.3% of TCCs reported providing comfort packs, 96.3% had shower and/or bath facilities, and 83.3% provided a clean change of clothes for survivors that needed them. Further, another substantial discrepancy from the TCC Blueprint remains the issue of transportation. While transport should be guaranteed (usually through SAPS) it is often a challenge. If SAPS are sometimes able to bring people to TCC sites, due to long wait times they cannot wait for survivors to take them home or to a safe location. Additionally, the report points out that many survivors do not have access to adequate transportation to come back to a TCC for follow-up PEP or psychosocial support if required.

The various stakeholders involved in the delivery of care at TCCs in accordance with the Blueprint include a variety of State and non-State actors, such as the National

Prosecuting Authority (NPA), responsible for the general coordination of TCCs, the management of criminal cases and SOCs and the appointment of site coordinators; the DoH, in charge of providing healthcare workers and medication such as the PEP; NGOs, responsible for most of the counseling at TCCs, the provision of comfort kits to survivors, and the follow-up psychosocial support services; SAPS, responsible in certain cases for statement taking, transport and sexual assault evidence collection kits; and finally, the Department of Social Development (DoSD), in charge of some counseling services (most are outsourced through NGOs), emergency shelter services (of which they fund most of) and the appointment of social workers and counselors (Shukumisa, 2016: 41). The coalition, in its report, writes that:

“One of the greatest strengths of the TCC model is the multisectoral approach that brings all services under one umbrella, and brings all the stakeholders together (i.e. NPA, DoH, DSD, SAPS and various NGOs). This is also the model’s greatest weakness, as not all stakeholders are equally involved and there is no way to ensure accountability. This varies across and within provinces.” (p.14)

According to the Blueprint, all TCCs are required to have the following staff:

- A forensic nurse allocated to the TCC, trained to collect forensic evidence, complete relevant legal forms and allowed to appear in court to testify.
- One full-time or part-time doctor.

- Non-medical personnel such as a site coordinator, a case manager, a victim assistance officer and a counselor.

The report found that many TCCs actually lacked significant human resources and did not have site coordinators, dedicated doctors or social workers, considerably hindering service delivery. Further, while 70% of TCCs reported providing 24/7 service, the Shukumisa report explains that most health services are not in fact available within the TCC after hours, forcing survivors to either be referred to the main hospital's casualty department, or to face long wait times for a forensic nurse or doctor to reach the TCC site from casualty (p.16).

According to the Blueprint, TCCs should provide in-service training for their medical staff members. The trainings should cover:

- Multi-disciplinary training.
- Forensic medicine training.
- Termination of pregnancy (ToP) administration training.
- Victim support training.
- PEP administration training.
- Sexual assault training.
- STI training.

However, findings from the Shukumisa Compliance & Audit Report once again found discrepancies in the actual provision of trainings, especially for non-medical staff. It highlighted that “most” (p.42) and not all of TCCs comply with the provision of training for medical staff, and that significantly less training was provided to non-medical staff such as counselors, receptionists, or victim assistance officers. These trainings usually included information about importance legislation such as the Domestic Violence Act, the Child Care and Sexual Offences Act, the Victims Charter. The reported noted that: “All staff who are involved in the treatment and case management of rape survivors need to receive training on post-rape management. This must specifically include training on when PEP must be initiated.” (p. 43)

The importance of administering the Post-Exposure Prophylaxis within 72 hours of a rape or at-risk intercourse is thus central to TCC operations. In a country where more than 5 million people live with HIV (UNAIDS, 2019), access to preventive treatment matters and must be fully understood by all TCC staff members.

The Shukumisa report recognizes that “there are serious disciplinary and accountability issues that need to be addressed” (p. 14) when it comes to the operation of TCCs. Many appointed regional managers who are in charge of the functioning of their allocated TCC are not actually based in the province where the TCC is located, hindering their ability to work efficiently and ensure the smooth running of their institution. Further, the report states that “there is insufficient accountability from all stakeholders”

especially at the more micro level (at district and facility levels) – in other words, the levels that have the most direct impact on survivors.

In the following chapter, I introduce two narratives that provide a clearer understanding of the lived experiences of survivors of sexual violence in TCCs and SOCs, and the narrative of a service provider with SAPS. Many of the points raised in Chapter II about the TCC Blueprint for service delivery will be addressed in Chapter III and confronted with the reality of TCC operations. All three stories come from very different individuals with different social locations and experiences. While their experiences are not representative of the entirety of the institutions or services they discuss, I believe their stories highlight many of the themes I have encountered throughout my research, and I am confident that the three stories I chose to feature powerfully capture what it means to be a survivor, the mother of a survivor, or a police officer, dealing with trauma and healing in their own way.

CHAPTER III

SURVIVORS' NEEDS AND THEIR EXPERIENCE OF SUPPORT SERVICES

Throughout the interviews and surveys I conducted with survivors and service providers across the provinces, themes emerged regarding survivors' perception of support services. One troubling pattern that is worth mentioning is that many of the survivors I interviewed were not actually aware that they had used dedicated government institutions such as SOCs and TCCs. We eventually discovered it after I asked more questions about what the premises looked like and what the process was to access services. In addressing the points mentioned in the previous chapter about the variety of different stakeholders involved in the operating of TCCs, I posit that this richness of actors and the different levels at which they operate is likely a source of confusion for survivors. As explained below, when I first met Melissa, one of my key informants, she came up to the group I was with after a speech from a Rape Crisis representative to ask us whether 'we' (Rape Crisis) ran TCCs. The merging of actors and institutions, whether Government-led or not, certainly brings about a variety of different trainings and types of knowledge and *savoir-faire* to TCCs, but it should also be remembered that most people have difficulty navigating these complex institutional relationships from the outside.

Some of the most common themes across the stories and testimonies I gathered included concerns such as wait times, respect (in terms of whether survivors felt respected by the staff at whichever institution they sought help from – those varied drastically), comfort and discomfort (the latter often measured by indicators such as

intimidation, pain levels, lay out of the space or room, levels of cleanliness, etc.) or support and helpfulness (this usually meant whether the service they sought provided the outcome they were hoping for or not). The women's stories I am about to introduce in this chapter offer, I believe, ways to help us understand and humanize these themes. For instance: what does it mean when a survivor has to face long wait times or feels uncomfortable or intimidated by a person in charge of their case or their health? These concepts lead to outcomes, whether positive or negative, that have a direct impact on survivors' lives, and sometimes on those of their families. Through narratives, one can better understand the realities of what it means to be a survivor going through the system(s). It was important for me, in alignment with my commitment to a survivor-centered approach, to represent outcomes and lived experiences not solely through a convolution of themes or statistics, but also through powerful narratives from real individuals that represent the current landscape in South Africa.

In this chapter, I focus on three interviews in more detail which help us understand the lived experience of accessing support services and SGBV for various actors. Although each interviewee's background and identity are very different from one another, each story conveys the reality of navigating support services for many South Africans. Survivors of sexual violence are not and will never be a monolith. Their identities and social locations are sometimes complex and the systems in place although built to serve everyone regardless of their gender, sexual orientation, age, religion, race or profession, often fail to do so equitably. These interviews demonstrate the impact of these

failures and successes on survivors, on their future, and on the way their life has changed – positively or negatively – from the support services they received.

Melissa's story

I met Melissa at a Rape Crisis-sponsored event that I was attending, not in my capacity as a researcher but rather as a friend, supporting former Rape Crisis colleagues who were tasked with giving a speech about the organization's services. The event involved several nonprofits all focused on gender identity and sexual violence prevention. Only a small group of women that seemed to know each other attended.

As we were packing up the purple banners and gear we had laid out across the venue, a woman from the group made her way to us and timidly asked about the Thuthuzela Care Centres, after they were mentioned in the speech. The woman, whom I will call Melissa, was curious to know how exactly Rape Crisis was affiliated with TCCs and she was eager to report a very negative experience she had had at one of the clinics. We listened to her and it seemed impossible not to include her story in this research as it is not only pertinent but also, based on the interviews I conducted, painfully representative of the experiences of many other survivors. I took Melissa aside, introduced myself and explained the topic of my research, and we exchanged numbers, deciding to meet up for tea in town so we

could discuss things more comfortably. Melissa was very open to discussing her experience, hopeful that the publication of my thesis could shine a light on the treatment she received. She assured me several times that “getting this off [her] chest” was very a very helpful process for her.

Melissa is a coloured transgender sex worker originally from Durban now living in the streets of Cape Town. When she was 7 years old, her father began sexually abusing her.

While, she says, he did not penetrate her, he regularly subjected her to forced oral sex until she was 13. One morning in January 2017, she was selling stickers, as many homeless people needing an extra source of income do, on Bree St, one of downtown Cape Town’s liveliest areas, when she was approached by two men. Fearful that they might assume she had cash on her from the sticker sale, she put them away as she saw them walking towards her. One of the men asked her which direction “the bar” was in. She pointed them to a nearby bar (one of many on Bree St.) and noticed the harsh tone that one of the men was speaking in. She had only moved to Cape Town a year and a half prior and she could not understand Afrikaans, which the two men were speaking. The other man, whom she describes as “softer” and “kind,” said he had to use the toilet. The more menacing man then took out a knife and directed Melissa towards a bathroom located in a nearby public carpark. The man was “swearing in Afrikaans” while the other one was

talking “decently.” Threatening her with the knife, the men took her inside the bathroom and took turns raping her while the other watched on the other side of the door. The “kind” man, at one point, began using a condom that his friend proceeded to then remove. When Melissa asked: “Why are you doing this?” she was not given an answer but her instincts to fight were subdued by the presence of the knife. She thinks that “the whole idea was to rob.” After they were done, the men walked away and the one that she persistently describes as “kind” threw her a roll of toilet paper after noticing that she was bleeding profusely. He asked her why she was bleeding so much, puzzled: “But you’re gay, I thought you were used to it.” Melissa told the men the same story she told me: that this was her first time receiving anal sex. She came out of the parking lot shocked and confused, unable to comprehend what was happening. Having remarkably sound instincts, she walked down the street to Triangle Project, an NGO she had worked with in the past, that provides psycho-social and health services to LGBTI+ people, to ask for help. Someone offered to drive her to a Thuthuzela Care Centre.

Heideveld TCC:

Melissa and the woman drove to Heideveld Community Health Clinic – where the TCC is located – approximately 9.5 miles away from Triangle Project (which averages a 20-minute drive). Melissa could hardly sit because of the pain or stand because of the bleeding. Upon their arrival at the TCC, they noticed it was near empty. The nurses told them there was no doctor on site at the moment and that

they should go to Mitchells Plain Day Hospital instead. They drove to Mitchells Plain, another 10 miles and 20-minute drive from Heideveld TCC, and found that on the contrary, the waiting room was filled with people. After waiting for 4 hours without being seen, at 4:30 in the afternoon (at which time the Day Hospital closes) Melissa was told she would not be able to be seen, and that she should return to Heideveld.

In the words of Melissa: “When we came back to Heideveld, then my nightmare started.” With still no doctor on site, Melissa and the woman from Triangle Project waited to be seen until 10 in the evening. The regular doctor was on leave and had to be replaced by a colleague. Upon their return to the TCC, Melissa was sent to do some HIV testing with a counselor, who told her she “needed” to go through HIV testing because she was a sex worker. Melissa, however, because of the hazards of her job, kept very close track of her status and knew she was negative. The counselor insisted that she go through testing, implying that as a sex worker she almost certainly had HIV. In the waiting room with them was another woman that Melissa knew from working in a similar area downtown. The woman had just been raped for the second time in the space of 2 months.

Melissa’s acquaintance had been given pain medication by a nurse and was surprised to hear that Melissa had not been given anything, as her pain was visually very obvious. The woman kindly gave Melissa some paracetamol, but if

it was not for her, Melissa would not have received any painkillers as staff at the TCC refused to give her medication.

When Melissa was finally seen by the doctor, her experience became even more traumatic. The doctor, an older man from Nigeria, was described by Melissa as “barbaric” and “homophobic.” While he was not physically abusive to her, he subjected her to intense verbal abuse. He requested that the person who had come with her from Triangle Project wait outside, saying she was not allowed to come into the room. The woman from Triangle Project was in fact, a nurse, who should have been granted access to the room. After she put the hospital gown on, the doctor refused to touch Melissa and was adamant that there was no “proof” she had actually been raped. She took off her underwear, as initially requested, which had semen and blood on it. The doctor maintained that there was “nothing on it” and advised her to throw her underwear away. He addressed Melissa and said: “People like you, in my country, we lock them up in prison.”

It is unclear what he meant by “people like you” but this made Melissa feel even further traumatized and scared. As she laid on the table, she describes herself as paranoid and recalls thinking: “God, don’t touch me [any] further [...] please just go away, I don’t want to open a case, I don’t want to do nothing, just get away from me.” She asked the doctor “Didn’t you take an oath?” implying that he was

failing his duty to provide healthcare to her, to which she was told she “[knew] too much.”

The doctor never ended up examining her: he was adamant, despite Melissa repeating her story over and over, that nothing had happened because he could not “see” proof that she had been raped. He never looked at her underwear or touched her.

After leaving the examination room, Melissa went to see a nurse and asked for the doctor’s name, at which point she was told “No no, that’s not for you to know.” She threatened to report them for their discrimination and the treatment she experienced at the TCC. At no point was she given any kind of treatment: no painkillers, nothing to stop the bleeding, no Post-Exposure Prophylaxis. Melissa, once again displaying sound instincts, asked the nurses for medication and said that it was her right to receive the PEP. She was told that they were not “allowed” to give her anything and that “unfortunately [they saw] nothing wrong with [her].” When she asked the doctor and the nurse how they could treat human beings like so, Melissa was told that “people like [her] need God in [their] life, [they] need Jesus in [their] life.”

Aftermath:

A few months after her assault, Melissa fell very ill. She noticed regular swollen glands appearing on her body and intense fatigues. During one of her routine TB

and HIV testing, she discovered that she had contracted HIV. As mentioned previously, before the assault Melissa went for regular testing due to the risks of her profession, and she consistently used protection during intercourse. It is therefore apparent that she became HIV positive in the wake of her rape, something she blames on Heideveld TCC for not providing the Post Exposure Prophylaxis to her as they were supposed to. She maintains that had the doctor and nurses given her the right medication, she would not be suffering like she is today, physically but also mentally. She said: “I still blame him for my suffering [...] not my physically [sic] or emotionally [sic] but even my mentally [sic], because he really messed my head up.” Melissa was able to access counseling once and has since been involved with various NGOs such as SWEAT (Sex Workers Education and Advocacy Taskforce), Gender Dynamix and SistaazHood, a support group created by and for Cape Town-based homeless sex workers of which she was, at the time of our interview, the “Queen.”

Melissa, although single at the time of her assault, now has a boyfriend. Because of the trauma of her rape and the heavy consequences on her health, including her positive diagnosis of HIV, she says her and her boyfriend do not have sex. She still suffers the physical trauma of her assault. On several occasions, she stated how grateful she was to have a boyfriend that has stayed with her despite her sickness.

A few months after her diagnosis, she became so sick that she was unable to use her legs and was forced to be bedridden for 2 months, during which her boyfriend had to wash her, move her around the house and entirely take care of her.

Melissa described an instance where, following the appearance of a growth near her throat, her boyfriend encouraged her to go to the hospital. After she did, she was told she was suffering from kidney failure – a common comorbidity associated with HIV, referred to as HIV-Associated Nephropathy – and throat cancer. Hospital staff scheduled Melissa for surgery to try to remove the tumor in her throat but after receiving anesthetics, the growth ruptured, indicating that it was actually a cyst in her parotid gland. This phenomenon referred to as a benign lymphoepithelial cyst is another common occurrence in HIV positive patients. This misdiagnosis coupled with her traumatic experience of TCCs have deterred Melissa from seeking further medical help, and she and her boyfriend are now living as happy as they can be when compounded forms of discrimination inflict such traumas upon a single human being.

Melissa's experience, on various levels, is representative of the many flaws that plague the current medical system, especially Thuthuzela Care Centres, in South Africa. Her story highlights various compounded forms of discrimination: her status as a sex worker, her housing situation, her skin color, her gender, her sexual orientation and her status as a rape survivor. It is impossible to look at Melissa's story without adopting a

lens of intersectionality. Her experience, not only of TCCs but also in life, is shaped by the multiple identities she possesses, based upon which she has been and continues to be discriminated against and oppressed. The biases displayed by Heideveld TCC's medical staff and their lack of concern for Melissa as a survivor made her identity even more complex, rendering her vulnerable to further discrimination based on her now-HIV positive status.

Whilst not all survivors experience this level of discrimination, Melissa's story highlights a clear lack of accountability for medical professionals working in TCCs. After her visit at Heideveld, Melissa and the woman from Triangle Project wrote an email to the regular doctor at this TCC, informing her of what had transpired during their interaction with the male substitute doctor. The email was sent from the NGO (Triangle Project) in an attempt to assert legitimacy, but they never received any response.

While Melissa's identity is complex and multiple, the discrimination perpetrated by the doctor is also manifold. While Melissa appeared to think that the poor treatment she received was due to her housing situation (or lack thereof), one can reasonably argue – based on the religious comments made to her – that her gender identity and sexual orientation might also be a plausible cause of his discrimination. By saying that in “[his] country, people like [Melissa]” are put in prison, the doctor displayed not only transphobia and homophobia but also xenophobia. Sub-Saharan Africa has, over recent years, been the theatre of increased xenophobic attacks amongst nationals of neighboring countries, often migrants choosing a better life in South Africa, or refugees escaping persecution, conflict or simply seeking to survive. By letting so many of his personal

biases surface, the doctor not only displayed subjectivity, he also perpetuated many harmful stereotypes pertaining to survivors, reaffirming that if one presents identities that are not modest, heterosexual, cisgender and socio-economically well, they are not worthy of treatment.

It is important to point out that many elements in Melissa's story directly contradict the TCC Blueprint. When I informed her that TCCs should have showers available for survivors to wash up and change clothes, she was shocked and expressed how much she would have needed such services. While I do not know for a fact whether Heideveld TCC possesses showers on site, it is clear that the possibility was not offered to Melissa during her time at the TCC.

Laura and Isabel's story

Laura is a young white girl. I interviewed her mother, Isabel, in KwaZulu-Natal about their experience navigating SOCs. The year of her fourth birthday, Laura's father began sexual abusing her. Unemployed at the time, he would look after the child while Isabel was at work. Using the excuse of "bath time," Laura's father would regularly subject her to sexual abuse. It is unclear from my conversation with Isabel exactly how long her daughter endured this abuse. She did not reveal such details in her story, and I did not ask any further questions on the topic as it was visually quite apparent that she was not comfortable going into details.

Laura revealed the abuse years later, at the age of 7, when her parents had separated. She initially confided in Ann, her mother's longtime friend (and a child counselor) before sharing her story with Isabel. After the initial shock – she said it was “the last thing [she] expected,” – Isabel took Laura to a police station to report the abuse. She describes the services received as “actually quite good.” Upon arriving at a first police station in the Durban area, they could not be helped by SAPS officers and were directed to FCS (the Family, Violence, Child Protection and Sexual Offences Unit) instead. FCS handles most rape cases and cases of child abuse; when a survivor comes into a police station to report an incident, an FCS person is usually on call and able to get to the survivor's location within the hour. The FCS person usually accompanies the survivor to a nearby TCC in order to conduct an examination and a forensic exam, should the survivor later wish to open a case.

Laura and Isabel, although initially directed to one FCS unit, had to be redirected to another that had jurisdiction in the suburb where the abuse took place. Isabel and her daughter had to go through several interviews with FCS, which the mother describes as a “very difficult thing.” Laura's initial interview was conducted by a male officer, which was a source of concern for Isabel. When I asked if anyone had asked Laura what her preference was between a male and a female officer (as they should have), Isabel shook her head. She was able to sit alongside her daughter during the initial interview with the male officer and

describes this process as “intimidating.” Isabel maintains that this was her only “problem” with the way her daughter’s case was handled by officers.

Laura was taken to RK Khan Hospital TCC, in Durban, for her forensic examination. When I asked Isabel about TCCs, she did not seem to know whether they had visited one, but upon further discussion we came to the realization that she had indeed accessed services from one. She described the site as a “prefab house on the side of the hospital.” I did not probe Isabel on their visit at the TCC, but she did not seem to have any complaints.

A structural issue in the system that emerged from our interview was the lengthy process to get the case to court. It took more than a year for Laura’s case to reach a hybrid Sexual Offences Court in Durban, after the initial court date kept being postponed several times.

After Laura initially reported the incident to Ann, the first thing she said to her was to “forgive,” but according to Isabel, “with forgiveness comes forgetting” and for such a young child to remember crucial details of a gruesome abuse years after it occurred was very challenging.

Once the court proceedings began, Laura was interrogated three times by lawyers – a process for which Isabel says she was not allowed to be present in the room –

and the interrogations were so emotionally and physically tiring that she had to be the one asking for breaks several times. The SOC provided an Afrikaans interpreter for Laura, as her family speaks primarily Afrikaans, but she preferred using English, as everything so far (the reporting, interrogation, forensic examinations etc.) had been conducted in English and she did not, according to her mother, wish to code switch. Additionally, there were some words involved in her testimony that Laura only knew in English.

It appears, from Isabel's testimony, that the Durban SOC fulfilled most of its duties and provided the necessary precautions in dealing with Laura's case. Her interrogations took place in a separate room, on video, while her father was interrogated in the court room. The two never had to interact throughout the process.

The FCS officer attached to Laura's case remains, according to Isabel, the person who was most helpful to them in this process. While Isabel does not describe her experience of SAPS as inherently negative, she did regret the way they kept up with the case. The process altogether was slow. Each time Isabel attempted to reach a police captain or sergeant with questions about court appearances, she was met with ignorance about the process and/or her daughter's particular case.

Isabel described the overall reporting and court processes as complex, stating that “You have to be prepared before you go (...).” Luckily, the FCS officer in charge of Laura’s case went above and beyond to help the family, and especially the child, prepare for what was to come. Isabel describes the officer as being “on top of everything.” When I asked Isabel what she wished was different about her experience of all of the aforementioned services, she listed two things: communication between SAPS and her (she gave an example of not being informed of the case being remanded), and the time it took for Laura’s case to get to court.

Aftermath:

While Isabel maintains that for a variety of reasons, including geographical proximity and access to assistance, the Court process was the “easiest” for her and Laura to navigate, one thing that proved challenging was access to psycho-social resources. SAPS or FCS did not offer any psychological or counseling resources, burdening Isabel with navigating yet another system all while taking care of her daughter.

Given that Laura is of school age, finding an organization willing to work with her schedule was difficult. Laura now receives ongoing counseling from Open Door, a nonprofit organization and crisis care center focusing on child abuse. She goes straight from school to counseling, which her mother described as difficult, and as

a process that “takes time from yourself.” Isabel works in a different area of Durban than where Laura goes to school, and Open Door is located in yet another area of town, requiring a lot of planning and traveling back and forth between suburbs.

The counselor in charge of Laura’s case, however, was cited by Isabel as being one of the most helpful people in this process. She assists Laura with sensory exploration when the child smells or sees something that revives her trauma. She is, according to Isabel, available at all times, over Whatsapp, should Laura be triggered at any point. Further, services at Open Door are designed to be financially affordable, with the payment of a one-off R100 fee on the first visit (approximately \$5.40) and free counseling thereafter.

With the help of counseling from Open Door and Ann, her mother’s friend, Laura appears to be on a path to healing and coming to terms with the trauma she experienced. Although the family was set to attend another court date shortly after our interview, I have not heard back from Isabel but can only hope that they got the closure they deserved.

Laura and Isabel’s story paints a different picture than the story told by Melissa. These differences are not meant to question one account over another, but rather to

highlight the complexity and the normalcy of the differences between survivors. While Melissa's story was raw, painful, and combined extreme forms of biases and their drastic consequences for one's health, Laura and her mother's story is more 'balanced' or less extreme. I highlight these differences with such strong, antagonistic terms to show not that one of these experiences is more common and the other is so extreme that it is rare, but rather to affirm that both of these lived experiences represent what it means to be a survivor of sexual and gender-based violence in South Africa. Survivors have different needs, and as such, they perceived their experiences differently based on whether these needs were met or not. Although it may seem like Laura and Isabel's story is 'more' representative of the 'real' survivor experience (although I would argue that what is or is not representative cannot be quantified or measured because there is no standard, monolithic survivor experience), their experience does not map out into what some might perceive the system to be either, as demonstrated by the following interview with Captain Karen Jacobs.

Captain Karen Jacobs' testimony

Karen Jacobs is a police Captain in Durban, KwaZulu-Natal, with 30 years of service. At the time of our interview, she supervised a team of about 15-20 people and was in charge of "serious cases" which include murders, robberies, domestic violence cases, grievous bodily harm (GBH), attempted murders and rapes.

Jacobs, a coloured woman and Durban native, started her career in Gauteng (then

part of the Transvaal province) and has worked in the Northwest Province where she was promoted Captain, before coming back home to KwaZulu-Natal.

The first question I asked Captain Jacobs after she introduced herself was: “How does a rape investigation take place?” The first thing she mentioned was that if a woman is raped, “no man is allowed to interview her.” She affirms that there are departmental sanctions in place should a male police officer interview a female rape victim without first consulting her. Likewise, officers who interview underage victims without their parent or guardian risk being sanctioned. Children should indeed be interviewed in trauma rooms, which every police station across the country should possess. Jacobs affirmed that in the case of sexual offences perpetrated against children, the first rule is to make the child feel comfortable. Whilst this may take various forms, such as offering snacks, moving to a child-friendly room, etc., it may also involve letting whichever parent is the suspect in the case be in the presence of the child during their interview. If a child is being abused by their father but states that their father is the person they would feel comfortable talking in the presence of, then their wish should be respected. Shortly after giving their statement, victims are, if they consent to it, taken to a hospital or a TCC for a forensic examination. The preferred-gender rule extends to the examination room and, if a victim refuses to be examined by a doctor of a certain gender, the hospital is obligated to call another doctor of the preferred gender to perform the examination.

Jacobs explained that sometime between the victim's arrival at the police station and the forensic examination, the victim is referred to a social worker. Every SAPS station should have a social worker within its department, but sometimes, an external person is called. Jacobs described an instance of sexual abuse taking place at a child's school, that, for example, would warrant calling in a social worker who is also a school counselor. Following their initial report, if they are in a dangerous situation, the victim and sometimes their parent or guardian, is taken to a "place of safety."

According to Jacobs, trauma rooms are an initiative that started 16 years ago to create a victim-friendly space for survivors (especially children and adolescent survivors) to feel comfortable in. She explained that a significant number of trauma rooms take the form of a room or a container on SAPS grounds, and that these rooms are often donated by institutions in the private sector or built by nonprofit organizations. In some cases, people from these NPOs also offer court accompaniment or advocacy and support for survivors, ensuring that a survivor has access to counseling and any material resources they may need.

A key to this separate trauma room is kept in the main SAPS office of every police station and the moment a rape victim walks into the station, they are taken to this room while waiting for a social worker or for an officer to take their

statement. Captain Jacobs insisted that these rooms were victim friendly, “not designed only for children.” She explained that trauma rooms “are supposed to” have a TV, in the case where, for instance, a victim would prefer talking while watching something. Jacobs said that SAPS “[had] to provide this opportunity.”

Describing court-related issues that pertain to sexual offences, Jacobs explained that when giving a testimony in court, one must be “specific to the T, [which] can become an issue.” She added that although magistrates will allow for a recess if a plaintiff seems too upset to address the court, there is a chance that the case be remanded if the victim is not comfortable giving their testimony.

In cases involving children, cameras are used extensively. The child victim, whoever they feel comfortable accompanying them, the magistrate, the accused’s attorney and the prosecutor all sit in a separate room, guaranteeing that the victim and perpetrator never cross paths. Captain Jacobs explained that because of the vulnerability of children and adolescents, the gender preference extends to court proceedings as well: if a child does not feel comfortable with a male or a female cross examiner, then the defense has to get an attorney of the opposite gender. In some cases, the State is also required to get a prosecutor of another gender. Interestingly, Jacobs stated that “With adults, [they] are not very specific, but if [they] can see the trauma and distress in the person, then [they] offer those questions.” She gave the example of a situation where a victim that she described

as a “colored girl” refused to talk to anyone else than a colored female officer, prompting the tracking down of an appropriate officer on duty this day who could talk to her.

When I asked Captain Jacobs about the type of SGBV-related trainings SAPS employees undergo, she explained that there is a “sexual offences course” that new police recruits ought to take at police college, as well as another compulsory training course later when one starts working in the field. Jacobs claimed that for people in the detective track, these courses were “a must.” During her own training, she described being shown an “absolutely gruesome” video depicting a 9-year-old child being repeatedly raped by her father. She also described being given 2 or 3 different scenarios involving a mock statement, a mock interview of a rape victim (played by a peer), and a mock trial, including a statement, graded by the provincial office with a minimum grade required to pass. In these exercises, Jacobs explained that the way one talks, reacts, or acts when taking a statement etc. are highly judged and can be the basis for a significant loss of points should one fail to demonstrate adequate empathy. The people in charge of leading these training sessions are, according to Jacobs, trainers from the police department who have attended an “in-depth course at the national office.”

Jacobs affirmed that “this country [South Africa] is taking a stand against violence against women and children. It can’t tolerate it anymore.” As such, she

shed light on a new internal SAPS rule implemented in recent years, where, in cases of domestic violence, SAPS must arrest the suspect within 24 hours of a victim filing a report. She also described the lack of reporting for rape and other sexual offences as South Africa's "biggest headache (...) and worst problem." Captain Jacobs confirmed that "domestic violence and rape, in this country, are taken in a different light now, it's not like before." She described coming back to KZN in the early 2000s and being shocked by the violence of the crimes there. Coming from Gauteng/Transvaal in the 90s where she describes rape as being "not so bad," the scenes she saw in Durban were in comparison, "nasty." She remembers feeling very traumatized and scared as she, herself, had just had her first daughter. Jacobs spoke of the situation in the Northwest in interesting terms, describing it as a very rural area where alcohol and unemployment were determining factors in rape statistics. Further, she explained that in the rural communities she worked with, a lot of families refused to believe that members of their own community or sometimes even their own family were "raping their own." Jacobs affirmed that reported rape statistics in KZN were increasing considerably because "women have realized that they have a support [system] that supports them," thus encouraging survivors to come forward and report sexual offences. Likewise, she explained that there was an increase in the reporting of sexual offences involving women on women violence or women on men violence, for similar reasons. Jacobs further described that these increased reporting rates took place "amongst all the race groups" and that the types of crimes varied

considerably across provinces: in more urban places with important nightlife spots, SAPS saw more cases involving drugging a victim, whereas in rural areas crimes were often perpetrated by family members or people familiar to the victim.

Captain Jacobs' narrative is particularly revealing after reading Laura and Isabel's story, where many discrepancies between the regulations affirmed by Jacobs and the lived reality of Laura and Isabel transpire. On a narrower level, these two stories are representative of the larger system where there are significant differences between the legislation and the reality experienced by survivors and their families.

Captain Jacobs is a dedicated police captain who, I have no doubt, abides by the rules she presented (although many do not, as witnessed with Laura and Isabel's story). She clearly takes pride in her work and sees the systems internally implemented as innovative in many ways. Therefore, Captain Jacobs' optimistic description of the system in which she works should not come across as a distortion of reality uttered to please me as a researcher or make SAPS look good. As a mother herself who sees the horror associated with many of these cases, and as an agent working within the system, she truly believes in the mechanism she describes, and does not question its efficiency. It is likely that she leads her investigations according to the rules and regulations aforementioned and cannot comprehend that others may not.

While the processes Jacobs describes might truly be innovative in some ways, they cannot be considered efficient when they are not implemented evenly. Going back

to Laura and Isabel's story, a critical difference that impacted their life substantially is the rule (or lack thereof, in their experience) according to which a female or girl survivor cannot be interviewed by a male officer. Although Isabel narrated a rather neutral and even positive at times, rendering their experience, one thing that she mentioned several times as a source of anxiety and discomfort was that Laura's initial interview was led by a man. Furthermore, while I did conduct interviews in the Western Cape and KwaZulu-Natal provinces, Laura's abuse and thus reporting took place in Durban, in a suburb very close to that where Captain Jacobs works. Therefore, one might think – despite Captain Jacobs' testimony that these gender-preference measures have been implemented nationwide – that perhaps the implementation was slower or not as strict in one province than in the other, it is not the case here. The conflicting testimonies highlight a very tangible problem in the real-life implementation of protective measures for survivors. They also point towards a lack of accountability when processes are not respected, a theme that weaved throughout Melissa's story.

The discrepancies between the testimonies presented – namely those of the two survivors vs the testimony of Captain Jacobs – highlight a critical need to talk and listen to survivors, and to take their perspectives into consideration when implementing or reviewing legislation. This argument is a microcosm of the general argument presented in this thesis: that many systems might be trailblazing and appear to be efficient on paper, but without ways to verify that they operate adequately and without biases – which will only truly occur once survivors are regularly consulted and when their voice will matter –

these models will never reach their full potential and achieve their true goals of alleviating SGBV and encouraging survivors to come forward.

I chose all 3 of the stories in this chapter because through their praises or their complaints about different systems, they all reflect the complex and highly diverse reality painted by interviewees, of navigating support services in S.A.

The decision to narrow the 10 interviews I conducted to these 3 stories introduced in this chapter stems from the richness of these 3 narratives and their ability to capture the general findings. I am grateful to have been able to speak to each of the 10 survivors and/or service providers I interviewed for this research and the focus I adopt in my thesis does not in any way exclude or dismiss the importance of the 7 stories not told in depth. These stories, those of Elizabeth, Sam, Kathryn, Lee, Sarah, Thandiwe and Lorna, are all equally important to this research. Analyzing each story has allowed me to understand some of the themes that transpire for survivors when accessing support services. This process, in turn, has led me to present the three narratives that display these themes the most representatively. By introducing the stories of Melissa, Isabel and Laura, and Captain Karen Jacobs, I therefore echo the other 7 interviews that, from a survivor perspective, also pointed towards a lack of equality in accessing services. It is worth noting that, in my sample, White or white-passing cisgender participants generally had more positive experiences than Black, Coloured, Indian or transgender participants, or participants with less financial means, which suggests that race, gender, class, and sexuality may shape people's experiences with these services and how service providers

do the work of providing services to survivors. My interviews with service providers, although only a few, reflect a general trust and hope in the current system, its regulations and its future, which they are obviously invested in to some degree. Future research could explore further the dynamics of social locations, and particularly race, gender, class, and sexuality, in the context of service provision.

Understanding SOCs and TCCs' shortcomings:

As discussed earlier in this chapter, the three narratives shared by interviewees together highlight some clear themes and discrepancies in service provision. Some of the most substantial issues exacerbated in Melissa's story are the lack of oversight, the lack of accountability and, to a certain extent, inadequate training.

The Nigerian doctor who "examined" Melissa (although their conversation hardly resembled a medical examination) was a substitute doctor for the 'regular' female doctor at Heideveld TCC. The latter was on leave at the time of Melissa's assault, and the substitute doctor had to be called on site – leading Melissa and other survivors to incredibly long wait times – as he was not initially present. TCCs are open 24/7 and should therefore be prepared to receive patients at any time. The fact that when Melissa arrived, in the afternoon, no doctor was initially on site and one had to be called in (taking hours to come) poses a clear problem that can be tied to both a lack of adequate training about the importance of TCC services for survivors and a lack of oversight and/or programs in place to evaluate the efficiency of TCCs. Although it can be argued that this particular doctor's behavior might only imply his personal biases and not reflect

TCC staff as a whole, it is important to highlight that adequate training about TCC practices and sanctions for those not implementing these practices might have prevented these shortcomings. Likewise, the doctor's strong biases against the many identities of Melissa – her status as a sex worker, her homelessness, her identity as transgender and her sexual orientation – could have been prevented by stronger and more efficient training about the importance of cultural awareness and impartiality in the medical field. Staff at TCCs need to be trained on the importance of providing care – especially, in the case of TCCs, emergency and crisis care – equally to everyone, regardless of their socio-economic identity.

Melissa's story, through the various shortcomings it emphasized, highlights the dire lack of accountability and oversight in the TCC model. The doctor was able to assert his personal biases onto a patient in crisis and staff were consequently able to deny Melissa critical, mandatory care, without any repercussions that we know of (based on the follow-up email sent by Triangle Project inquiring about the experience). Other survivors have pointed out similarly 'inadequate' or nonchalant behaviors and attitudes from providers at TCCs, leading us to assume that these comportments are not rare and perhaps even common. Without a mechanism in place to ensure 1) that these errors do not take place (through better training and awareness of potential sanctions) and 2) that when providers do show a lack of professionalism or fail to provide care adequately and impartially to their patients, punitive measures are implemented, the TCC model is allowing such shortcomings to subsist and maybe even to become standard.

What Government institutions lack that community-based initiatives provide:

While TCCs and SOCs generate mixed responses from survivors and present some truly problematic shortcomings, community-based programs often rolled out through NGOs and other nonprofits are perceived in a much more positive light by survivors.

The Qualtrics survey I set up for this research did not receive as many responses as I anticipated. However, the seven responses I received did elicit some clarifying data about access to support services. Around 57% of people surveyed (4 out of 7) reported having sought services from NGOs following their experience of SGBV. Other sources of support mentioned included church-related services (28%), support groups, and legal aid (both 14%). These statistics appear to corroborate my conversations and interviews with other survivors, who reported reaching out to NGOs more easily than they would with official or Government institutions. This phenomenon is largely due to the fact that NGOs dedicate a significant portion of their time, efforts and budget to reaching out to members of the community – whether a geographic community or a community bound by common experiences or identities.

Because NGOs work with and are largely made up of community members or activists, they are often more familiar with the needs of their target population than outside program administrators might be. Their campaigns are done with the help and approval of the public, and they face little to no scrutiny when it comes to expected results – contrary to Government institutions who are often result-driven, leading them to work not for the people but for the achievement of a certain threshold.

NGOs often provide necessary bridges between a survivor and SOC or TCC. This is largely due to the fact that despite the Government's efforts to widen the scope of its support services, most South Africans remain unaware of the existence of such dedicated institutions. Further, the geographic situation of most TCCs or SOC prevent survivors from reaching them on their own. Most NGOs – at least in larger cities – are located in strategic, high density areas well served by public transportation, allowing survivors from all walks of life to access their services. TCCs and SOC however, are often difficult to reach for survivors who lack access to a car or the financial means to use a taxi service. For this reason, even when survivors do know about the dedicated institutions (like in the case of Melissa), they are still likely to use NGO services first and ask for accompaniment to a nearby TCC or SOC.

Beyond the failure of the South African Government to inform its citizens of the existence of dedicated institutions to palliate SGBV and secondary victimization, there is also an important knowledge gap when it comes to knowing one's rights as a survivor navigating the system. For instance, although Melissa knew that she was entitled to the PEP at Heideveld TCC (although she still did not receive it), many people are unaware that they have such rights, which is one of the underlying causes behind the underreporting of sexual violence. People often have a negative or intimidating first experience of a system (such as SAPS or a clinic) and believe that this treatment is standard and that little can be done to fight back, as such people hold a position of authority over them. NGOs are helpful navigators of the various systems available to survivors because they are able to provide reassurance, information that pertains to

survivors' rights, and patient advocacy to help fight back when these rights are not respected.

While NGOs are often the reason why survivors are able to speak out, begin their healing journey and access legal, medical or psycho-social services free of charge, there remain some shortcomings common to both Government institutions and nonprofit organizations.

Throughout this chapter so far, findings have highlighted inequalities in service provision experienced by survivors based on their various identities. However, inequalities in service provision and access to services also take place on a larger level and is dependent on survivors' location within the country.

In the Western Cape, NGOs supporting survivors of sexual violence are many. While some target a 'general' population such as Rape Crisis, others are sometimes more specific. Triangle Project for instance, works with transgender individuals. While residents of bigger cities are fortunate to have access to a variety of systems to navigate their healing journey, people living in more rural areas remain the forgotten ones when it comes to support services. The geographic implementation of not only TCCs and SOCs but also NGOs remains a problem for many survivors in less densely populated areas. The Northern Cape province for instance, is the largest South African province geographically – it represents almost 30% of the country's total land mass (Mpani, 2015) – yet it is also the country's most scarcely populated province. As such, the implementation of support services, whether Governmental or community-based, is

difficult. The province only has 4 TCCs, located at the Central Karoo Hospital, Galeshewe Day Hospital, Kuruman Hospital and Springbok Hospital. On a map, three of these are aligned on the far East border of the province, while Springbok Hospital is the only one on the far West Coast of the province. The entire central part of the Northern Cape has no TCCs. If a survivor like Melissa went to a first TCC only to be turned away and told to go to another one, they would have to drive at least 2 and a half hours (the smallest distance between any two Northern Cape TCCs, between Central Karoo and Galeshewe TCCs). However, while in most other provinces community-based organizations and NGOs are usually available to assist survivors should they not be able to reach a TCC easily, the Northern Cape is also lacking these community initiatives or nonprofit support services. The Shukumisa Coalition website, which contains ample information about the coalition members – a variety of non-State actors and organizations that support the fight against SGBV and/or provide services to survivors – only contains three links for the Northern Cape. Two of these are located in Kimberley, the province capital: Lifeline Northern Cape branch, a nonprofit that provides 24/7 telephone services and counseling for individuals struggling with trauma, mental health issues, pregnancy, HIV infection, SGBV or substance abuse, and Optimystic Bikers Against Abuse, a community group of bikers who identify as “survivors for survivors” and provide “assistance in crisis situations” as well as legal and medical resources. The third organization listed on the Shukumisa website for the Northern Cape is the Women on Farms Project (WFP) located near Upington, the second most populated city in the province after Kimberley. Amongst these organizations, it appears that Lifeline is the

only one offering counseling services to survivors, although these services are remote. There appears to be no record of any in person organization providing one-off or ongoing physical counseling to survivors in the Northern Cape. Keeping in mind that TCC counselors are mainly outsourced through provincial NGOs, it is concerning to know of the lack of nongovernmental organizations in the Northern Cape and leads to interrogations regarding the underreporting of rape in the province due to the lack of support.

A 2015 report written by Prudence M. Mpani and funded by the Tshwaranang Legal Advocacy Centre to End Violence Against Women analyzed the correlation between alcohol consumption and violence against women in the Northern Cape. Some of the findings concluded that: “Although the Northern Cape has the second lowest prevalence rate of HIV in the country, it has very high levels of alcohol abuse and violence against women.” This statement is confirmed by further findings indicating that in the province, 90% of perpetrators of violence against women abused alcohol or drugs (p. 18). The South African Crime Survey conducted in 2003 surveyed South Africans in each province on their perceptions and fears of what types of crimes they thought occurred most in their region. If 14.6% of respondents in the Northern Cape believed rape to be the most prevalent type of crime occurring in their area of residence, 40.8% of Northern Cape residents declared fearing rape the most. It is thus evident that although the province is less populated than others in South Africa, the prevalence of SGBV is no less of a threat. As such, better measures must be put in place to support survivors in all of South Africa, without geographic discrimination.

CHAPTER IV

CONCLUSION AND RECOMMENDATIONS

This thesis took on the complex task of analyzing the South African response – both governmental and from non-state actors – to sexual and gender-based violence and its associated issues. In doing so, it posed several questions: what are the current models in place from various actors and institutions to palliate the burden of SGBV and how do they operate? What is efficient in the way those models operate? What needs to be improved and why?

In order to better answer this question and to describe support services as accurately as possible, a survivor-centered approach was chosen. This approach placed survivors at the heart of this study, valuing their opinion, knowledge and lived experiences throughout the data collection and writing processes. The methods used to complete this research ensured that participants did not experience any secondary victimization and placed a strong emphasis on their privacy (whether interviewees or survey responders).

Information about the “mechanical” and theoretical functioning of government-based institutions such as SOCs and TCCs is largely available in South African literature. However, very little information exists about survivors’ perceptions of their experience in these systems. Applying a people-centered lens to this research in order to paint an accurate picture of the way human lives are impacted by institutions was a driving factor in the completion of this research, and something that I posit was critical.

Starting from a historical perspective, this thesis approached the events that shaped South Africa as we know it today, and proceeded to demonstrate that the widespread nature of sexual and gender-based violence in contemporary South Africa has many complex roots, mostly found in apartheid, the racial rule that ravaged its culture and population from 1948 to 1994. Apartheid created systemic, deep-rooted systems of oppression and racial divide, such as the Bantustans and their legacy as contemporary townships or the blatant abuse of Black, Coloured or Indian South Africans by the police, which led to a widespread mistrust in SAPS. These systemic issues converged to create and enable a climate of sexual and gender-based violence to take place.

Following the democratization of the country and a desire from the new democratic government to eradicate violence and instigate a human rights framework upon its legislation, many progressive laws were enacted to support and protect those most vulnerable to violence and discrimination. Judges in various High Courts throughout the country contributed to the ever-changing legal framework by creating new legislation out of a variety of important cases brought before them. Some of the most notable changes to the legal and medical systems were the dedicated government branches and taskforces appointed to specifically tackle the burden of SGBV, leading to the creation of a dedicated specialized Court system, Sexual Offences Courts, and a similar system for healthcare, in the form of Thuthuzela Care Centres.

The main purpose of this research project was to analyze how these institutions function, and the way they are perceived by their target population: survivors of sexual

and gender-based violence. One of the questions posed was to know whether they were providing adequate services, and how these services compared with those offered by NGOs and other community-based initiatives. Through in-depth interviews with survivors and service providers, this project found that although the blueprint for service provision is strong and appears to be efficient, the reality and lived experiences of many survivors accessing those services rarely correlates with the baseline. Service delivery is widely unequal and many survivors continue to experience and suffer from service providers' biases. For this reason, NGOs remain widely preferred by many survivors across gender lines for effective, helpful support. Nongovernmental organizations excel at democratizing information pertaining directly to survivors in order to empower them to claim their right to healthcare and justice; something government institutions largely fail to accomplish. Although the way that systems such as TCCs and SOCs are set up might be empowering for survivors, the lack of a model in place to evaluate the efficiency of these services and of a system of accountability for those failing to provide these services remains a barrier to success, in addition with the lack of communication about these dedicated services, and the unequal way they are spatially implemented, leaving many behind. Service providers in both the Western Cape and KZN converged around the idea that the various services currently in place to support survivors operate adequately and serve survivors with impartiality and care. The goal of my thesis is not to contest this idea, or to claim that the services provided are always inadequate. However, I posit that this disparity of perception between service providers and the survivors accessing services is one of the aspects that needs to be addressed in order to realistically improve

service delivery in the long term. Service providers have the power to help shift survivors' experience from negative to positive, by holding each other accountable for their failures and biases – when these do take place.

In answering the question “Do support services currently available in the Western Cape and in KwaZulu-Natal cater to all survivors equally?” it is clear from Melissa’s story that the answer remains negative. Survivors with complex identities like hers – or those who are disenfranchised, less fortunate, or at the periphery of society – still receive, in certain cases, poor to nonexistent treatment, and are forced to navigate a difficult system with the additional barriers posed by biases TCC or SOC staff might have against them. Survivors that present identities that differ from the stereotypical idea of a rape victim – a defenseless, modest woman or girl – whether these be gender, sexual orientation, national origin, race or HIV status, face significantly more obstacles in their access to justice and/or healthcare. In a country where sexual and gender-based violence and HIV infection are so prevalent, and where the former is still largely unreported, support services provision cannot remain uneven and flawed. The system as it is currently operating, although it may work for certain categories of survivors, creates further obstacles on the road to recovery, care and justice, for the people who need it the most.

Recommendations:

a. Better information campaigns around SOCs, TCCs and Know-Your-Rights

While the South African Government took serious legal and concrete measures to alleviate the burden placed on survivors of sexual violence – through the everchanging

evolution of its legal system and doctrines, the gathering of relevant actors in the form of taskforces or new specialized authorities, and most importantly, the financial commitment to building dedicated specialized establishments in the forms of TCCs and SOCs – there remains an evident lack of knowledge about these institutions amongst targeted populations. The confusing web of governmental and non-governmental agencies involved at different levels in TCC and SOC service provision led to ample confusion for the survivors I interviewed.

In my research, many survivors who used TCCs or took a case to an SOC for trial remained largely unaware that they had used such services, which prompts many questions and concerns. Amongst these is: why is it that the people who do know about these dedicated services and institutions are either affiliated with advocacy groups or specialized NGOs or NPOs like Rape Crisis or Triangle Project, or are people who are actively seeking to educate themselves on the topic of SGBV prevention? Information about such crucial Government initiatives should be made widely accessible to South Africans all around the nation, not only those who live in an urban setting and have access to various advocacy groups and events.

Furthermore, with information about services should come Know-Your-Rights information. I have witnessed many times, through interviews or casual conversations, that most survivors are critically unaware of their rights. Rape Crisis almost always run out of their ‘Know Your Rights’ and ‘What to do if you were raped?’ pamphlets when they bring them to events. These pamphlets are regularly updated and produced in English, Xhosa and Afrikaans, in accordance with the language diversity of the Western

Cape area. I argue that such pamphlets about survivors' rights should be comprehensive – they should address not only the reporting process but also counseling options, the rights of survivors in a medical setting, and the steps to a potential legal resolution – and available in all of South Africa's 11 official languages, as well as some major languages of migrant populations in relevant areas. Additionally, impactful campaigns containing Know-Your-Rights information in a clear and concise manner must be put in place throughout the country without geographic limitations in order to reach as many potential survivors as possible.

b. Access to information for refugee and migrant populations

The Cape Town area, for instance, is home to significant refugee populations from neighboring Zimbabwe and the Democratic Republic of the Congo. People from the latter often speak French, Swahili or Lingala, rendering them sometimes unable to navigate support systems or information available to them as these services are, in some areas, only provided in languages they are not able to express themselves in. Additionally, services such as shelters or counseling services through NGOs often limit access to their services to South African citizens, excluding, in certain cases, those who need the most help. In the case of domestic violence and sexual violence, for instance, many refugees from the DRC are forced to remain in abusive situations as they are not only unable to ask for help due to isolation and language barriers, but also, in some instances, simply barred from accessing services due to their national origin.

Information pertaining to such crucial and in some cases life-saving Government services should not be limited in any way and dedicating an important budget to ensuring those who are most vulnerable are able to not only inform themselves of their rights but also access services around them should be a priority.

c. Improving training and implementing accountability processes

As evidenced by the three stories shared in Chapter III, many obstacles to survivors accessing adequate services revolve around issues of appropriate training and mechanisms of accountability for adhering to regulations. Although Captain Jacobs spoke of internal regulations within SAPS and disciplinary measures in place to ensure these rules are respected, the reality of Laura and Isabel's lived experiences differ significantly. Additionally, Melissa's story showed us the grave reality of a survivor's life being further endangered by the current lack of accountability in place for service providers who act in discordance with their training and duty.

I propose more solid and reliable mechanisms of accountability, in the forms of dedicated and efficient channels for reporting reprehensible behaviors like that of the doctor who "examined" Melissa. Perhaps this takes the form of an ethics committee or a taskforce charged with handling all oversight of TCCs and SOCs in a given region. The behavior experienced by Melissa is unjustifiable and the medical team on duty that day at Heideveld TCC appears to be liable for her contraction of HIV, a significant threat to her life.

In addition to implementing accountability processes, improved training(s) are a necessity to ensure the best possible compliance with the blueprint for TCCs and SOC's. Firmer trainings should be implemented with a thorough explanation of the accountability processes in place for those who will not comply with their obligations to provide services to all without bias, and regular follow-up trainings should be put in place every few years. This would decrease the likelihood that personnel at TCCs especially but also SOC's would renege on their responsibilities. These trainings should be conducted by a variety of facilitators, including qualified service providers but also members of institutions such as the NPA or DoH/DoJ, NGO advocates, and survivors themselves. Stories like that of Melissa are a shocking yet very real example of all the obstacles that can pave one's road to recovery and health, and it crucial that such stories and such voices be heard regularly when it comes to implementing new SGBV measures and processes.

What might be the future of the fight against SGBV in South Africa since this research?

Since the completion of my research project, much has happened in South Africa when it comes to the fight against sexual and gender-based violence. Shortly after my departure, in August 2019, many young women and adolescents went missing. Many of these missing girls were found raped and/or murdered. One case in particular, that of Uyinene 'Nene' Mrwetyana, sparked outrage across the country, prompting nationwide protests demanding a response from the Government.

Nene was a 19-year-old student at the University of Cape Town. On the 24th of August 2019, as she was retrieving a package from the post office, she was abducted, raped, tortured and then murdered by Luyanda Botha, an employee of the Claremont post office. Nene's body was found dumped and burnt in a field in Khayelitsha. Botha was swiftly arrested and confessed to all charges held against him. He was sentenced to three life sentences for the rape and murder of Nene.

Following the arrest of Nene's rapist and killer, a wave of protests unfolded nationally. First, a memorial was held at UCT, then at the University of Witwatersrand, in Johannesburg. On September 4th 2019, during the World Economic Forum on Africa taking place in Cape Town, where President Cyril Ramaphosa was present, protests took place all over Cape Town, urging the Government to take additional measures to alleviate the country's SGBV burden. Soon after the protests, the President announced a five-point plan to tackle violence against women, including making public a register of sex offenders, media campaigns, and strengthening the criminal justice system – through harsher sentencing and the promise of increasing numbers of Sexual Offences Courts across the country.

A constant issue in the fight against SGBV in South Africa has been the repetitive promise by the government to roll out more SOCs or TCCs, when in fact, what gravely needs to be addressed is how to improve the systems that are currently in place. Many NGOs are well aware of these needs and have been trying to address the issue with members of the Government for years, without success. I hope that this project helps shine a light on the reality of lived experiences for survivors in the systems. These

experiences point to an urgent need to address the shortcomings of the rape litigation system that often fails to fulfill its commitment to support and serve survivors.

On a more worrisome note, with the recent developments of the Covid-19 pandemic, many people in precarious situations or situations of domestic abuse are at heightened risk of dying every day in South Africa. Many people in abusive households are trapped inside with their abuser(s), unable to get physical help. Many NGOs have started developing Whatsapp counselling – a widely used communication tool in South Africa – in an attempt to reach survivors discretely and allow them to share any abuse they might be experiencing with diminished risks of being overheard. This system, of course, is not perfect, and many victims are heavily policed by their abuser, rendering them, in certain situations, unable to even send a few texts without fearing for their safety.

I have been thinking about Melissa and the other members of the SistaazHood collective in particular, wondering how difficult life might be for them with the pandemic – homeless in the upcoming Cape Town winter, out of their main source of income, and for some of them, with an autoimmune disease rendering them so much more vulnerable. Situations like the one we are experiencing globally highlight the need for better systems of support for all types of survivors, everywhere, as those more vulnerable see their vulnerability increase manifold and their resources or access to (already limited) help diminish considerably. One might hope that this is the push the South African government needed to implement better and more reliable solutions for all survivors of sexual and gender-based violence.

APPENDICES

LIST OF ACRONYMS USED

CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women

DoH – Department of Health

DoJ (&CD) – Department of Justice & Constitutional Development

FCS – Family Violence, Child Protection and Sexual Offences Investigation Unit

HIV – Human immunodeficiency virus

KZN – KwaZulu-Natal province

MSF – Médecins Sans Frontières (Doctors Without Borders)

NGO – Non-governmental organization

NPA – National Prosecuting Authority

NPO – Non-profit organization

PEP – Post-exposure Prophylaxis

RCCTT – Rape Crisis (Cape Town Trust)

RSJC – Rape Survivors' Justice Campaign

SA – South Africa

SAPS – South African Police Services

SGBV – Sexual and Gender-based violence

SOC – Sexual Offences Court

TCC – Thuthuzela Care Centre

WHO – World Health Organization

SAMPLE POPULATION FOR INTERVIEWS

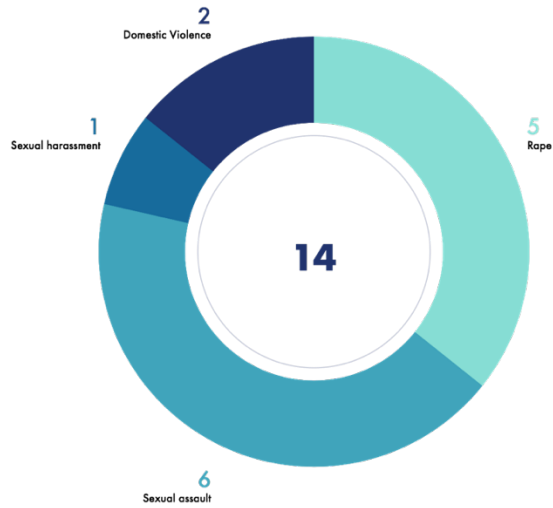
Name*	Status	Location	Age range	Gender	Service accessed	Experience
Melissa	Survivor	WC	35-40	Transgender	TCC/NGO	Negative/Positive
Elizabeth	Survivor	WC	20-25	Female	SOC	Negative
Isabel/ Laura	Family member of survivor	KZN	40-45/5-10	Female	SOC/NGO	Neutral-positive/Positive
Sam	Survivor	WC	20-25	Female	TCC/NGO	Neutral-negative/Positive
Kathryn	Survivor	KZN	50-55	Female	TCC/Faith-based organization	Positive/Positive
Lee	Survivor	WC	25-30	Transgender	TCC/NGO	Neutral-negative/Positive
Sarah	Survivor	WC	20-25	Female	TCC	Negative

Name*	Status	Location	Age range	Gender	Type of organization
Thandiwe	Service provider	WC	30-35	Transgender	NGO
Lorna	Service provider	KZN	60-65	Female	SAPS Trauma room volunteer counselor
Karen Jacobs	Service provider	KZN	45-50	Female	SAPS Police Captain

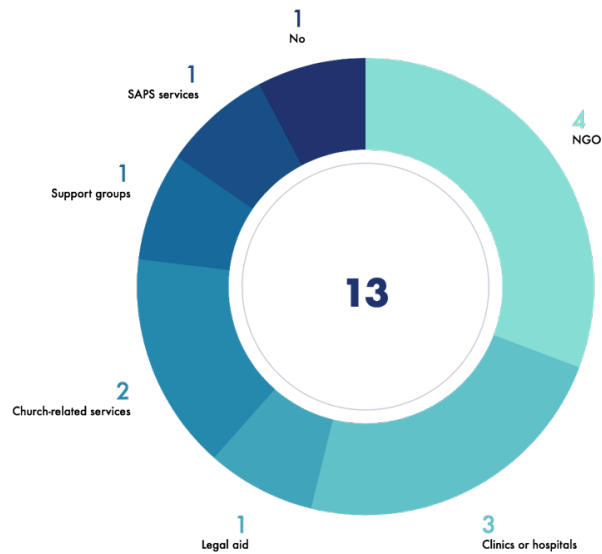
*These are all pseudonyms used to protect participants' anonymity.

VISUAL EXCERPTS FROM SURVEY RESULTS

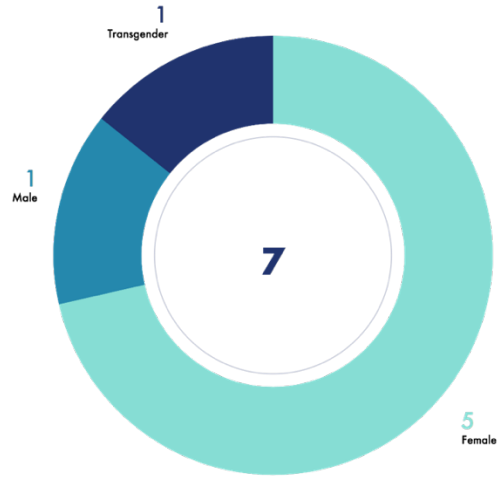
Have you ever experienced SGBV?



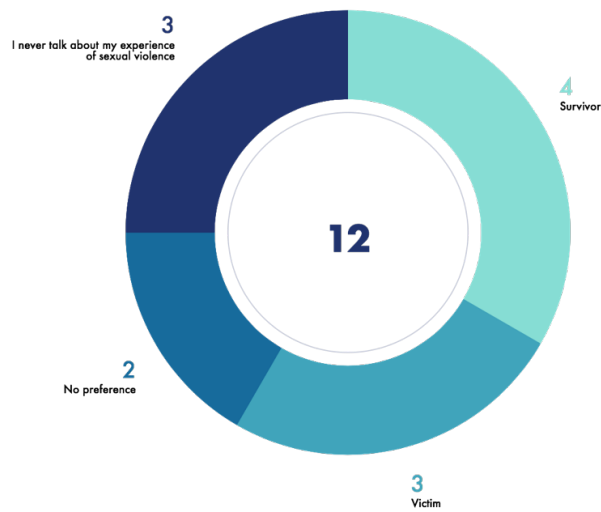
Did you seek support services? If yes, where from?



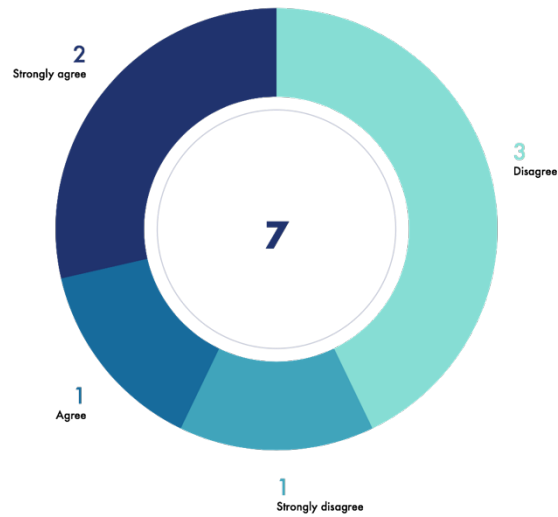
What is your gender?



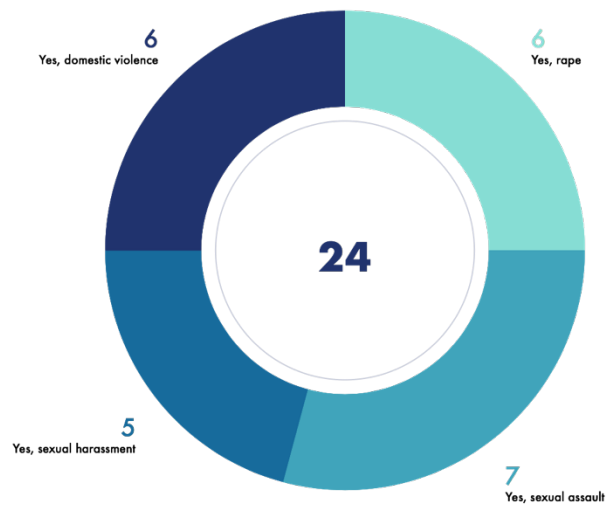
When talking about your experience of sexual violence, how do you prefer to refer to yourself?



To what extent do you agree to this statement: it was easy for me to access support services



Do you know someone who has experienced SGBV?



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