Masiphephe Network

KwaNdengezi
05 December 2019
GBV Stakeholder Mapping Report

Table of Contents

CBO	Community Based Organisation
CCI	Centre for Communication Impact
CCN	Collaborative Community Networks
CLO	Community Liaison Officer
COJ	City of Johannesburg
CPF	Community Policing Forum
CSA	Child Sexual Abuse
DOH	Department of Health
DOJ&CS	Department of Justice and Correctional Services
ECD	Early Childhood Development
FCS	Family Violence, Child Protection and Sexual Offences Investigations Unit
GBV	Gender-Based Violence
GHJRU	Gender Health Research and Justice Unit
HIV	Human Immunodeficiency Virus
IDT	Independent Development Trust
IR	Intermediate Results
KZN	KwaZulu Natal
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Asexual
M&E	Monitoring and Evaluation
MER	Monitoring and Evaluation Reporting
NPA	National Prosecuting Authority
OMC	One- Man- Can
OVC	Orphans And Vulnerable Children
PEP	Post-Exposure Prophylaxis
PSASA	Project Support Southern Africa
RM&E	Research Monitoring and Evaluation
SAPS	South African Police Service
TCC	Thuthuzela Care Centre
TIP	Trafficking In Persons
TVET	Technical and Vocational Education and Training
USAID	United States Agency for International Development
YFHS	Youth-friendly health services

Table of Contents

Background 3

1. Project Objectives 3

2. Masiphephe Stakeholder Mapping 4

2.1 Purpose and Objectives of Stakeholder Mapping 4

2.2 Methodology for Stakeholder Analysis 5

Mapping in KwaNdengezi 6

3.1 Overview of eThekwini and KwaNgengezi 6

3.3 Ethembeni Crisis Centre 6

FINDINGS 8

4.1 GBV Stakeholders Identified and Mapped in KwaNdengezi 8

4.2 Preliminary Classification of Stakeholders 9

GBV Services Offered 9

Stakeholders providing care, treatment and support of victims and survivors of GBV 10

Access to Thuthuzela Centre 10

Staffing And Capacity of Stakeholders 13

General insights from the mapping 19

Community Media Access and Use 24

Preferred Media 24

Communication With Communities 24

General Insights from the Mapping 26

Bibliography 26

Background

Centre for Communication Impact (CCI) is implementing the 5-year, United States Agency for International Development (USAID) funded "Local Governance to Improve Gender-Based Violence (GBV) Response" Project. The project aims to Strengthen Local Governance to Improve Gender-Based Violence response, which is essential to achieving South African Police Service (SAPS) Human Immunodeficiency Virus (HIV) epidemic control in South Africa. The project builds on The Cycle of Flawed Integration, which explores the limitations local structures face in efforts to lead GBV responses through conventional coordination bodies, which have had insignificant impacts despite being mandated by law. CCI and Fixed, it's Strategic Partner, will use the What it looks like when it is Fixed methodology. A methodology which was developed by Fixed that enables multi-sectoral stakeholders to collaborate in a Community Collaboration Network (CCN) that contains mechanisms for collaboration that are visible, transparent, measurable, and accountable.

The goal of this project is to reduce vulnerability to GBV through improved local governance and service delivery through strengthening the capacity of local structures to lead, coordinate and manage a community response to GBV and GBV prevention and mitigation.

The GBV Response project is implemented in the following provinces and communities:

Gauteng (City of Johannesburg – Regions D (Diepkloof- Soweto, Community Partner is Sonke Gender Justice) and E (Alexandra, the Community Partner is Agisanang Domestic Abuse and Training-ADAPT)
KwaZulu-Natal (eThekwini – KwaNdengezi, the Community Partner is Ethembeni Crisis Centre and KwaMashu, the Community Partner is Gugu Dlamini Foundation);
Mpumalanga (Mbombela – KwaNyamazane and Emalahleni, the Community Partner is Project Support Southern Africa (PSASA).

1. Project Objectives

The project aims to achieve the following:

Objective 1 (Intermediate Results [IR] 1)
Strengthen community governance and accountability;

Address the spectrum of violence against children, adolescents and young women, including sexual, physical, and emotional abuse and neglect;

Objective 3 (IR 3 and 4)
Mitigate gender-based violence (GBV) harm and improve access to justice to impact on the incidence of violence against children, adolescents, and young women.

The expected results include strengthened community governance and accountability; increased primary and secondary GBV prevention; improved mitigation of GBV harms (tertiary prevention) and improved access to justice for all victims and survivors of GBV.

2. Masiphephe Stakeholder Mapping

As part of the inception process for this project, CCI undertook to assess, map and analyse existing GBV prevention and mitigation efforts, including statutory service providers, community resources and stakeholders with an interest or a role in GBV mitigation and prevention within targeted communities at district and municipal levels. **In this regard, CCI;**

- Developed a tool for mapping stakeholders, organisations currently involved in mitigation efforts and opportunities for leverage in the **Year 1 implementation sites**.
- Collected data through stakeholder interviews guided by the mapping tool and engagement across guided by the mapping tool).

2.1 Purpose and Objectives of Stakeholder Mapping

The main purpose of this report is to identify stakeholders who are engaged in the GBV response, from prevention, care and support, right through to the formal and informal justice systems, divided up into statutory (government) and non-statutory institutions (non-governmental and community).

Through the mapping process, CCI aims to:

- Determine which stakeholders are most useful to engage with?
- Determine if there are any glaring gaps in KwaNdengezi in the delivery of services to survivors of GBV;
- Assess existing coordination mechanisms including collaboration structures to address GBV in KwaNdengezi.
- Identify the stakeholders that participate in local collaboration structures;
- Contribute towards the identification of existing community resources that can be leveraged to scale up and sustain successful community-based GBV prevention and response interventions
- Build lasting relations through the Community Collaborative Network (CCN) between key GBV service providers .

2.2 Methodology for Stakeholder Analysis

CCI embarked on mapping Gender-Based Violence (GBV) stakeholders in partnership with the community partners, whose role was primarily to identify the stakeholders as well as secure interviews for the CCI mapping team. This was followed by rigorous individual stakeholder interviews using a standard mapping tool, developed by CCI. The tool used a semi-structured questionnaire to probe and assess GBV work undertaken by various stakeholders in KwaNdengezi. This process included interviews with a range of pre-identified statutory and non-statutory stakeholders, organizations working with orphans and vulnerable children (OVC), local government officials, health facility employees, non-government organizations (NGOs) in the GBV prevention and response sphere, as well as other organizations and individuals working on GBV.

The initial and piloting phase of the mapping process was conducted in Alexandra on the 27th of November 2018. The approach was refined thereafter merging the inputs from the project Strategic Partners, Fixed and Gender Health Research and Justice Unit (GHRJU). Mapping in KwaNdengezi was undertaken from the 10th to the 14th of June 2019.

The Mapping tool was used to explore and understand stakeholders' roles, capacity, needs and willingness to participate in a collaborative structure: Community Collaborative Network (CCN) to address gender-based violence in Alexandra. **The following thematic areas were explored:**

- Organisational details
- Staffing and capacity
- Population served
- Services rendered
- Resources needed to enhance their services
- Current participation in GBV response and willingness to participate in a collaborative structure such as a CCN
- Communication needs and resources
- Community communication needs and preferences

This report will focus on the above and how and which stakeholders are relevant for this project in **KwaNdengezi**.

Mapping in KwaNdengezi

3.1 Overview of eThekwini and KwaNgengezi

eThekwini Municipality is located on the east coast of South Africa in the Province of KwaZulu-Natal (KZN). The Municipality spans an area of approximately 2 297km² and is home to some 3,5 million people. In 2011, KwaNdengezi had an estimated 53 843 residents, of whom 30.4% were children under the age of 14. KwaNdengezi is largely rural, with 53% of people classified as living in tribal/rural conditions. Africans make up the majority at 99.4%. For UNAIDS (2013), the link between gender-based violence and HIV as a cause and consequence of HIV is increasingly recognized. Studies show that women living with HIV are particularly vulnerable to sexual, physical and psychological violence, reporting violations of their sexual and reproductive rights, including coerced abortion and forced sterilization (UNAIDS,2013). Addressing gender-based violence is therefore critical to preventing new HIV infections.

3.2 Domestic Violence in KZN

Based on an a 2014 GBV indicator study conducted in KZN, 37% percent of women in KwaZulu-Natal (KZN) are said to have experienced some form of gender-based violence in their lifetime, this includes partner and nonpartner violence. Additionally 43% of men admit to perpetrating some form of violence against women.

3.3 Ethembeni Crisis Centre

Ethembeni is a registered non-profit organization, based at eMangangeni in KwaNdengezi Township, Ward 12 of Ethekwini Municipality, in KwaZulu-Natal province. Ethembeni has five satellite centres -Nazareth, Dassenhoek, Kwasanti, and Kwadesai - where volunteers provide counseling and refer clients to the main office in KwaNdengezi for further screening and assistance. Ethembeni is a crisis shelter for abused women and their children. The shelter provides psychosocial support to survivors who stay in the shelter for a minimum of 3 to 6 months. Ethembeni's purpose is to counsel abused people, train volunteers and conduct awareness campaigns in the community and schools. In 2003, founder of Ethembeni, Mrs Abegail Mbongwa-Dlame, realized the need to establish a local Community Based Organisation (CBO) due to the increasing numbers of Orphaned and Vulnerable Children (OVC), high rates of abuse of women and children, poverty, and lack of information on human rights. Towards the end of the year 2004, Operation Jumpstart leased a house and it was converted to two offices and a shelter for abused women and children – Ethembeni, which means Place of Hope.

Ethembeni’s vision is to contribute towards the reduction of GBV in Kwandengezi by;

- Counselling the survivors of GBV and their children, and
- Empowering women and children in KwaNdengezi and surrounding townships with awareness campaigns and education programmes on GBV.

The mission of the organization is to protect, support and accommodate abused women and children in the shelter and also provide support to the survivors of trafficking in persons.

To date, Ethembeni has;

- Started support groups for young mothers to talk about their current challenges as young mothers.
- Started a drop-in centre at Kwandengezi High School where young mothers drop off their children whilst they attend school. This is to ensure young women and girls remain and complete their studies. To date this drop-in centre is functional and has allowed young mother to continue with their schooling.
- Engaged Independent Development Trust (IDT) to train women for prospective employment opportunities and financial emancipation.
- Started a Shushuzela Care Centre - which cares for children who are normally abandoned and left in the care of their grandparents

FINDINGS

4.1 GBV Stakeholders Identified and Mapped in KwaNdengezi

In KwaNdengezi, a total of **21 Stakeholders** were mapped from the 10th to the 14th June 2019. The distinctive features of the organizations **mapped were as follows:**

Figure 1 Public, Civil and Private Sector Stakeholders (KwaNdengezi)

Public Sector	Civil Society	Private Sector
Civil servants and departments	**Community based organizations**	**Legal institutions**
1. DSD Service Office-Pinetown 2. Kwa-Ndengezi SAPS	3. Ethembeni Crisis Centre 4. Mbalesizwe Zulu Royal Reed 5. Qoqisizwe Senior Citizens 6. Vusumuntu Project 7. Khethiwe Multi-Purpose Centre 8. Philokwazi Crisis Care Centre 9. Community Policing Forum (CPF)	10. Thuthuzela Care Centre (TCC) R.K.Khan Hospital 11. Legal Aid Pinetown
Courts	**Schools**	**NPOs**
12. DOJ &CS (Durban Magistrates Court)	13. Nkosenye Intermediate School 14. Ndengezi High School 15. Dick Ndlovu High School	16. Life Line
Traditional Representatives	**Health Facilities**	**War Rooms**
17. Traditional Healers Organisation 18. Induna Mkhize	19. KwaNdengezi Clinic	20. Operation Sukuma Sakhe (OSS) War Rooms
Research Organizations		
21. MRC -HPR unit ***(Disbannded due to lack of funding)		

4.2 Preliminary Classification of Stakeholders

Based on the interviews conducted with key informants representing the KwaNdengezi stakeholders, the stakeholders are classified according to their interest and power/ level of influence on the Masiphephe network as indicated below.

High Power, Low Interest 1. KwaNdengezi SAPS	**High Power, High Interest (These are key players who ought to be fully engaged and close alliance built with them)** 2. DOJ &CS (Durban Magistrates Court) 3. DSD Service Office-Pinetown 4. Ethembeni Crisis Centre 5. Thuthuzela Care Centre, R.K.Khan Hospital 6. KwaNdengezi Clinic 7. Legal Aid Pinetown 8. Operation Sukuma Sakhe (OSS) War Rooms 9. LifeLine 10. Induna Mkhize
Low Power, Low Interest (Need to forge better relations and buy-in from these Stakeholders). 11. Nkosenye Intermediate School 12. Ndengezi High School 13. Traditional Healers Organization	**Low Power, High Interest (These might benefit from the programme).** 14. Khethiwe Multi-purpose Centre 15. Philokwazi Crisis Care Centre 16. Dick Ndlovu High School 17. MRC -HPR unit 18. Mbalesizwe Zulu Royal Reed 19. Qoqisizwe Senior Citizens 20. Community Policing Forum (CPF) 21. Vusumuntu Project

GBV Services Offered

The mapping process identified a range of services provided by stakeholders. These include counseling services, medical care, traditional healing and guidance from ancestors, attorneys and paralegals, victim empowerment, youth development, psychosocial services, career guidance, teaching, safety and security, childcare, court preparations casework and GBV advocacy.

Stakeholders providing care, treatment and support of victims and survivors of GBV

Access to Health Sector in KwaNdengezi

It is imperative to include Public health approaches when responding to GBV. In line with this, the National Department of Health (NDOH) has implemented a policy to guide the treatment and care of victims of sexual assault and domestic violence. The main health policy-related documents include the Primary Health Care Package and National Management Guidelines for Sexual Assault Care. However, interviews with the public health sister in KwaNdengezi clinic revealed that care and treatment for GBV survivors are applied on an intuitive basis. Thus this application forgoes the structured approach and tweaking services based on the case at hand. Form the mapping interviews it is evident that the clinic, police station and social welfare are not in offering services to GBV survivors/ victims in line with the norms and standards of treatment and care of victims of sexual assault and domestic violence as outlined in Appendix A **(*see the detailed list of norms and standards in Appendix: A*)**. Therefore GBV victims/survivors are prone to experiencing secondary victimization.

Access to Thuthuzela Centre

The NPA's Thuthuzela Care Centres (TCCs) were established as one-stop facilities to provide services to victims of sexual offenses. These one-stop centres were established to curb secondary victimization of the victim of rape and various attributes of GBV. The closest TCC servicing KwaNdengezi is located at R.K. Khan Hospital which is **17kms** away from KwaNdengezi. Although, the TCC is highly active, working mostly with minor victims (i.e. both male and females below 18 years), Ethembeni crisis centre seems to be the preferable service provider for the people of kwaNdengezi as they are in proximity to the community in comparison to the TCC and they have a track record of efficiently redressing and attending to GBV related matters in the region. However, this should not trump on the important role of the TCC and eThembeni ought to aim to work better and refer cases to the TCC on a needs basis.

The TCC Manager at RK Khan illustrated passion, drive and a deep understanding of the statutory issues and limitations relating to addressing GBV and sexual violence against women, children and minority groups such as the mebers of the LGBTQIA+. This wealth of knowledge and passion was also evident in the other staff members at the TCC. In the interview, the TCC manager relayed how the vast number of their clients were mainly children who have been violated and over the years their client demography has shifted from mainly catering to as victims of sexual assault to include both girls and boys victims and this shift in demography is on the rise in the areas they service. Therefore, it is

important for programmes to not only see victims as females and address preventative and redressive programmes targeting all sexes including members of the LGBTQIA+ communities, populations living with disability.

Stakeholders Dealing With the Justice System

One of the most important components of a comprehensive response to gender-based violence is access to justice for victims and survivors. As part of the mapping in KwaNdengezi, critical justice stakeholders; such as the Durban Magistrate's Court and LegalWise in Pinetown were interviewed. Insights gleaned from the interviews are summarised below:

Domestic violence is viewed as a high priority crime by the Department of Justice (DoJ) (represented here by a prosecutor in the Domestic Violence Unit). The interview revealed that the prosecutor, together with other team members in the unit are often called upon to be available at night and over weekends to provide the required legal services related to domestic violence and other family court matters.

He acknowledged that sometimes cases are withdrawn due to the parties deciding to follow other routes of reconciliation such as consultations within the family. The unit often does outreach and community awareness campaigns throughout eThekwini to inform and contribute to the reduction of gender-based violence. Another stakeholder involved in providing para-legal services to complainants in the area around KwaNdengezi is LegalWise, which is located in the city center is Pinetown, nearly 20km away. The manager confirmed that they provide services to the community, this includes people on both sides of the law, i.e. victims as well as perpetrators. Not much was known about access by people from KwaNdengezi specifically, as this is a service that serves people from around Pinetown.

Scarcity of Expertise

An important consideration is that if people are not trained to work with children to identify cases of child abuse, they are often scared and would rather refer to Ethembeni, rather than find themselves too involved in a particular case where they do not have expertise. Therefore there is an urgent need in KwaNdengezi to train all stakeholders dealing with children and the LGBTQIA+ community and develop a protocol on remedies and referrals.

In summary, KwaNdeNgezi stakeholders are invested in redressing and remedying the social ills that are linked to GBV, this is evident in the roles and narratives we encountered with

the various stakeholders who were mapped and their enthusiasm of join and be part of the CCN was evident in the interviews conducted.

Lack Of Organizations Deadling Directly With GBV

Based on the mapping process, a majority of the stakeholders do not feel as though they have the necessary skills to address GBV or assist GBV victims/survivors. Thus, most stakeholders are likely to refer a majority of their clients to Ethembeni, as it is perceived as a go-to organization for assisting

The mapping process allowed CCI to identify the skills required in comparison to an employee's actual skill level. The table below is a succinct breakdown of the qualifications as well as skills stratified by the organization.

Staffing And Capacity of Stakeholders

One of the important aspects of the mapping process was assessing whether the prospective stakeholders' educational background and skills were closely correlated to the work they did concerning GBV. Having skills to deal with GBV cases adequately is vital to victims and survivors. Adequate services are important as well as protecting the victims from secondary victimization.

Figure 2 Staffing and Stakeholder Capacity

	Name of Organization	Staff Profile	Staff Qualifications
1.	**Ethembeni Crisis Centre**	10 Staff Members	Social Workers Manager Data Capturer Administrator Cleaner Housemothers and Handyman
2.	**Kwa-Ndengezi SAPS**	1 Constable 1 Commander	Counselling
3.	**Sukuma Sakhe/War Room**	Umbrella body of stakeholders involved in development work, focussing on vulnerable people, elderly having problem with grandchildren, alcohol & drug abuse. They do GBV awareness campaigns & events. Work with Community Heath Care Workers who go around profiling homes abuse is taking place. Have Task teams - for events, youth in business, gender, vulnerable, skills development	GBV specific programmes, going to schools educating pupils on GBV issues. Profile households that are only dependent on child support grant and recommend hiring at least one member of the family
4.	**Community Policing Forum**	9 Community Elected Members	No qualifications one needs passion to assist the community, combat crime and other social ills.

5.	**Lifeline Durban**	21 Staff Members 15 Auxilliary Social Workers 6 Social Workers	B.A Degree (Social Work) and Auxilliary Certificate
	Nkosenye Intermediate School	2 Staff Members	Teachers Diploma
6.	**Mbalesizwe Zulu Royal Reed**	1 Staff Member	Grade 8
7.	**Qoqisizwe Senior Citizens**	5 Committee Members. 1 Manager 1 Chairperson 1 Deputy Chairperson 1 Treasurer 1 Secretary	No Qualifications, one needs the following skills Humility, empathy, ability to identify people with challenges, trustworthiness
8.	**Thuthuzela Care Centre, R.K.Khan Hospital**	18 Staff Members 2 Case Managers (Pinetown) 1 Case Manager (Court) 1 Victim Assistant Officer 1 Permanent Social Worker (Childline) 1 Doctor 1 Sexual Offence Coordinator 7 Nurses 2 Social Workers (Life line) 4 Auxilliary Social Workers	7 year degree in forensic; collect evidence annditionally testifying in court and prescribe the correct meds. Assess where to refer survivors. Nurses-counselling skills, pre and post for HIV counselling
9.	**Kwa Ndengezi Clinic**	37 Staff Members 1 Operational Manager 6 Professional Nurses 8 Enrolled Nurses 4 Assistant Enrolled Nurses 2 Lay Counsellors 3 MATCH Counsellors	N/A

		3 MATCH Navigators 2 MATCH Data Capturers 2 DoH Data Capturers	
10.	**Dick Ndlovu High School**	35 Staff Members 1 Learner Support Agent 1 Administrative Clerks 33 Educators	Teachers Diploma; Degree in teaching; Certificate in auxilliary social work;
11.	**Traditional Healers Organization**	5 Committee members & 1 Chauirperson	N/A
12.	**Dick Ndlovu High School**	35 Staff Members. 1 Learner Support Agent 1 Administrative Clerk 2 Interns 31 Educators	BA degree; Teacher's diploma
13.	**Nkosenye Intermediate School**	25 Staff Members (Teachers)	Confidentiallity and empathetic
14.	**Vusumnutu Project**	3 from church, some onsite training from Ethembeni	trianed teacher and libriarian. Communication, listen, organising and leadership
15.	**Khetiwe Multi purpose Centre**	5 Staff Members 1 Teacher 1Libriarian and 3 Assistants	leadership, empathy, caring
16.	**Philokwazi Crisis Care Centre**	5 Boardmembers	Advocay and Comm, counselling, programming soocial workers
17.	**MRC -HPR unit**	HIV prevention Research, 3 mmebers community team. Role is to work with the community foused mainly on HIV. From Umlazi to KwaDabekato	
18.	**Ndengezi High school**	Staff members, dealing with Children in need; poor school; teenage pregnancy; not aware of gbv related issues.	Skills to identify or observations skills, empathy communication skills
19.	**DSD Service Office - Pine Town**	Forster care, Elderly, Child abuse, early childhood development centre, service centres for the elderly. Monitoring and Evaluations, cretches and elderly. Service centre; Supervisors; 30 Socail workers	Child abuse and Counselling skills

20.	**Legal Aid Pinetown**	Legal	Legal Administration and Protection Orders Courses on Domestic matters and harassment
21.	**Induna Mkhize**	Incomplete information for the Induna***	

Population/Audiences Served

Most of the stakeholders offer their services to children, women, young women and families as their primary beneficiary stakeholders. Three of the twenty-one stakeholders serviced the elderly, however, not as their primary beneficiaries.

Based on the mapping results, the majority of the stakeholders have services towards meeting the needs of children, women, young women and families as their primary beneficiary stakeholders in the area. The mapping process identified six stakeholders who serve men and immigrants, three out of the six stakeholders only served men as their primary beneficiaries and two organizations served the needs of people with disabilities.

Although the mapping process did not identify any organization dealing or servicing the needs of the LGBTQIA+ community, this does not mean that the area does not have members of the LGBTQIA+ community. However, it highlights the nuances, norms, cultural definition of what constitutes a *"Real Man/Woman"* in KwaNdengezi. Consequently, this brings to light that the area might not be open to members of the community who do not conform to or are not aligned to their definition of *"Masculinity or Feminity".*

Based on observations despite having members of the LGBTQIA+ community, the community members chose to turn a blind eye to those men who showed feminine gestures or females showed masculine gestures. However, if a community member was to disclose their sexuality, they would be ridiculed, shunned and verbally as well as physically abused. Therefore programmes that are meant to curb GBV in the area are not targeted to the members of the LGBTQIA+ community and exclude the experiences of lesbian, gays, bisexual, Transwomen and man, queer, intersexes and Asexuals. Additionally foregoing open conversations, learning, and understanding the concerns of the LGBTQIA+ community concerning sexuality, in the community, as well as other issues such as coming out and the services which are accessible to the members of the LGBTQIA+ community.

Services Offered In Line With the 3 IRs (analyze key areas of intervention per IR and identify gaps)

Most of the stakeholders mapped are small CBOs that are not well resourced to respond adequately to cases of GBV. They serve more of a referral role to Ethembeni Crisis Centre as mentioned by one interviewee ***"Most of the organizations in this area are still fairly new and we have not worked with them, as an organization, we prefer to just work with Ethembeni and we do not refer to any other stakeholders".***

-**Interviewee 8, 48-year-old.**

Most of the stakeholders mapped lacked the basic understanding of GBV and TIP. As a result, this limits the stakeholder's ability to screen and assess victims who might benefit from their services. Consequently impacting negatively on the stakeholder's ability to deliver effective services to GBV survivors, victims. It is important to establish preventative measures that are targeting issues concerning TIP and GBV.

The stakeholders, knowledge regarding the meaning or identification of Trafficking in Persons (TIP), as well as reporting and adequately assist those who are trafficked.

The mapping process did not identify any organization working with the LGBTQIA community. This does not mean that there are no members of the LGBTQIA+ community. However, it might highlight the nuances, norms, cultural definition of what constitutes a "Real Man/Woman". Furthermore showing that the non-conventional sexuality was not part of the community discourse and alluded to resistance to engage in discourses relating to gender-nonconforming identities.

GBV programmes in the area target members of the LGBTQIA community, excluding the GBV experiences of lesbian, gays, bisexual, Transwomen and man, queer, intersexes and Asexuals must limit our understandings of the needs, fear and appropriate interventions aimed at the LGBTQIA+ communities we work with. Consequently forging open conversations about sexuality, accessible services to members and other important factors faced by the LGBTQIA+ community.

Stakeholder Resource Needs

The below-mentioned resource needs are based on all the needs of the **21 Stakeholders** who were mapped in the process.

- Staffing and capacity development
- Screening and
- identification of GBV and TIP
- Financial resources to carry their work efficiently
- Vehicles to reach people residing in far to reach areas
- Service packages
- Office supplies
- Financial backing to fund the traveling needs of service providers, as they travel long distances to service their beneficiaries.

Mechanisms for coordination

The interviewed stakeholders had a very limited understanding of collaboration as well as coordination, both terms mean *"Ukusebenzisana"* in isiZulu. Therefore the stakeholders for the majority of the stakeholders felt that the collaboration and coordination questions were the same questions asked twice and this created some tension from those being interviewed.

Forums

Of the **21 Stakeholders** who participated in the mapping process, 11 stakeholders belong to a forum whereas, 10 stakeholders do not. Of the 11 stakeholders belonging to a forum, 6 belonged to the "War rooms" (which are ward-based structures run by the provincial government), but most of the members complained about the travelling distance from their place of work to the war room *"I am part of the War Room forum, but I rarely attend the meetings. The meetings are held in Embuthumbuthu and that is far away from Zwelibomvu. Transportation to Embuthumbuthu is a challenge".*

-**Interviewee 2, 38-year-old.**

General insights from the mapping

Some insights gleaned from the engagement with stakeholders are summarized below. These emerged during the interviews using the mapping tool.

Unique Insights That May Critically Impact On the Project which will Require a Strategic Approach From The Project

Child sexual abuse and Orphans and Vulnerable Children (OVC)

One of the issues that were mentioned during the interview of a school teacher at Nkosenye Intermediate as well as Khethiwe Multipurpose Centre is that of child sexual abuse. (CSA) exists and is sometimes difficult to address as it often goes unreported by the children. The teacher reported that they were not trained in identification and dealing with the issue, however, due to their concerns and interest can identify and assist children. A concern raised was that some families do not report child abuse due to fear of the perpetrator. Another issue affecting children is that of poverty- this affects a majority of children at the school. The main assistance they provide is through the school nutrition programme. They also have a relationship with a well-resourced school, where they can obtain uniforms and other necessities for children in need.

Teenage pregnancy and HIV

A few of the stakeholders interviewed mentioned that teenage pregnancy and HIV are an issue in the community of KwaNdengezi. A few cases related to incest and child sexual abuse were also mentioned. It is difficult for teenagers to access sexual and reproductive health (SRH) services in some instances due to some nurse attitudes and a general lack of awareness regarding HIV and SRH. The available services are not youth-friendly therefore thwart the effort of youth to access and utilize these services. Epidemiologically, adolescents and young women are at increased risk for STIs and HIV infection, however they continue to face major barriers in accessing HIV testing and treatment. When young people can access services, they may feel embarrassed, face stigma on sexual matters, or have concerns about judgmental service providers. Therefore it imperative that we perceive Youth-friendly health services (YFHS) as a promising approach to delivering health services and to meet the sexual and reproductive health of young people. This would help curb teen pregnancy and limit the high rates of female student dropout due to teenage pregnancy, as highlighted by the high school principal at one of the schools in KwaNdengezi.

Adolescent drugs and delinquency

The interview with the school principal at Ndengezi High school revealed a deep concern for the learners and the community. While the principal stated that to her knowledge there was no real issue of violence, in particular, gender-based violence, issues of concern included a rising drug problem and delinquency among students. She also mentioned that poverty was a real issue and that many students benefitted from the school nutrition programme. Additionally, she expressed an urgent need to deal with drugs and mentioned one particular case of a learner who recently absconded from school after being confronted about her drug use.

Domestic and Marital Violence

GBV is a by-product of gender inequality in South Africa, which remains patriarchal. The underlying factors include male control of women and unequal power and gender relations in intimate relationships (O'Sullivan et al, 2006; Wood et al, 1998; Langen, 2005; Pettifor et al, 2004b; Jewkes et al, 2003; MacPhail & Campbell, 2001, Dunkle, 2004b). Men's control over women is seen as a mark of masculinity. Culture, religion, and media reinforce these norms and promote the view that men should be in power within homes and public institutions while women ought to be in a position of subservience consequently intrenching and validifying practices which trump on women's rights.

Practices such as ukukipita (i.e. non-marital cohabiting) or ‘ukuthwala’(Ukuthwala is a form of abduction in which men kidnap a girl or a woman and force the woman's family to endorse marriage negotiations) perpetuate norms that are in place to oppress women and

elevate the social positioning of men- while utilising culture and norms to justify the unsavory violations against women.

Among young people, an issue that was mentioned was that of abuse and violence in cohabiting relationships (i.e. living together outside of traditional or legally recognized circumstance). This puts young women in particular at risk of violence and helplessness as they are unable to leave their partners as they “cannot expect” family or community support as they chose to live with their partners without the traditional or legal support mentioned above. This practice of non-marital cohabitation is widely viewed as unacceptable in Zulu society unless the man has initiated ilobolo (bridewealth) negotiations and concrete marriage plans are in place. Cohabitation without "ilobolo" payment is widely interpreted as akin to behaving disrespectfully towards Zulu culture and tradition, the immediate family and the Zulu community more broadly. Therefore, creating fertile grounds for intimate partner violence, as families cannot intervene such practices to remedy or curb the scourge of violence among the cohabiters as that is not recognized culturally as being a married in the Zulu culture.

Abuse of elder women was somewhat mentioned from third-person narratives, as previously mentioned a majority of the service providers in the region depended on Ethembeni Crisis Centre to assist with GBV issues as they are perceived as “Experts” in the area.

People With Disabilities And Children With Special Needs

One of the stakeholders mentioned that there was a school for children with special needs including those with autism (Sonke School). This was not an issue that was mentioned by others and is an important issue to highlight lest People living with Disabilities (PWD) and children are forgotten.

Abuse Of The Elderly

The abuse of the elderly is an issue that is not open for discussion in the area, an interviewee who worked with the elderly painted a positive picture of how the elderly were not victims of GBV, but they are the victims of neglect and poverty. In KwaNdengezi some young parents tend to abandon their offspring and leave their grandparents to care for their children while they travel to cities to seek a “better” life or to pursue a relationship without the burden of having to care for children.

Child neglect is a real issue in this area. Therefore there is a state of relying on or needing the elderly for aid, support, or caregiving of their grandchildren without the financial backing from the parent of the children. This state of affairs exerts more pressure on the

grandparents already stretched social grant, as it has to fulfill the needs of the grandparents along with those of the grandchildren.

Child Neglect

Child neglect is defined as any confirmed or suspected egregious act or omission by a parent or other caregiver that deprives a child of basic age-appropriate needs and thereby results, or has reasonable potential to result, in physical or psychological harm. Younger children are neglected most, and more girls suffer from neglect than boys.

Child neglect encompasses abandonment; lack of appropriate supervision; failure to attend to necessary emotional or psychological needs; and failure to provide necessary education, medical care, nourishment, shelter, and/or clothing. Neglect is usually typified by an ongoing pattern of inadequate care that may be readily observed by individuals in close contact with a child. School personnel, for example, may detect indicators of neglect such as poor hygiene, low weight gain, inadequate medical care, or frequent absences.

Human Trafficking

None of the interviews conducted highlighted this as an issue. The team had to spend time explaining what it was and many people said that this did not happen in the community of KwaNdengezi. A few people, however, reported that perhaps it is an issue that needs to be highlighted in the community to raise awareness in case it happens as some were aware or have heard of this in the news/about other communities/towns/provinces.

Ukuthwala- forced abduction of young women into marriage

Interlinked to the aforementioned issues of dependence and entitlement. Based on the macho ideologies what define and separate boys from men, these ideologies have created a sense of entitlement in males that makes them undermine, control and take the female body as an object of ownership. The Ukuthwala culture is an example of objectifying women and this practice is prominent and persists in this province. Besides, this process has been identified as one of the drivers of HIV infection in KZN.

Ukuthwala is a form of abduction in which men kidnap a girl or a woman and force the woman's family to endorse marriage negotiations. This is one common form of GBV in the province that is carried out under the guise of culture. We were informed of girl children who were forced to get married to older man and dress in the traditional regalia, which is commonly worn by married women, as a to separate them form single ones. The girls would leave their home in the traditional regalia, take it off by the school gates and assume the clothing suitable for a school going girl. This would create tension between the two roles of being a child and a wife, in the school ground the girls' peers do not see a wife but a

potential girlfriend and this is likely to create a rift between the husband and the school, going suiter. While this was mentioned, the impression given was that this was something that happened in the distant past rather than a prevalent practice currently.

Ukuthwala is a topic that many stakeholders either found too difficult to talk about or dismissed it outright as something that does not happen in KwaNdengezi. An insightful interview was conducted with a young traditional leader, who mentioned that he once facilitated at least four abductions of young women, who are now still married to their husbands. He admitted that at the time (more than 10 years ago), he did not realize that this was wrong and took it as part of the cultural landscape of his community. He now is repentant and discourages the practice which he said he has nor heard of for more than a decade.

Virginity testing

An interview conducted with a traditional stakeholder involved in cultural activities with young girls revealed that virginity testing was part and parcel of these activities. According to the interviewee, this was a purely voluntary activity steeped in culture and pride. The interviewee supported this practice and did not see anything wrong with that. This is a controversial practice that may be viewed as an act of violence against girl children and needs deep and ongoing discussion with all stakeholders in the community.

Challenges in KwaNdengezi

Reporting of gender-based violence- Generally all interviewed stakeholders were aware that GBV needs to be reported to the police, however, some mentioned that there was poor reporting. This was attributed to poor trust in the local SAPS and pressure from the family in some instances to resolve matters within the family.

Limited training of the police- There was a deep lamentation by the family court representative about the quality of investigation and general handling of domestic violence cases in the larger Durban area. This was seen to be as a result of the limited training of many police officers on matters relating to GBV and the law. Many police officers have undergone very limited policing training and are ill-equipped to understand and uphold the rights of individuals affected by GBV.

Community attitudes towards GBV (as a "family matter")- Although this view was not prevalent, it was mentioned in a few cases. In one of the interviews, we were told of how a son-in-law raped his mother-in-law each time his wife went to work. When the elderly lady relayed the abuse to her daughter and social worker, the daughter accused her mother of hanging their dirty laundry in public.

Instead of punishing the husband for violating her mother, she shunned her and accused her of bringing shame to the family.

Poor awareness of Thuthuzela Care Centre and related services- Generally, many interviewed individuals were unaware of the existence of a Thuthuzela Care Centre and what services are offered there. Many people mentioned that cases of GBV were referred to either the local clinic or to the Ethembeni Crisis Centre. They were also unaware that there is post-exposure prophylaxis (PEP) which can be given to rape victims to reduce the risk of HIV acquisition.

The Thuthuzela Care Centre programme manager at RK Khan was one of those service providers who illustrated passion, drive and a deep understanding of the Statutory issue and its limitations. This wealth of knowledge and passion was evident in the other staff members at the TCC. In the interview, she relayed how the vast number of their clients were mainly children who have been violated and over the years the trends have shifted from having female children as victims of sexual assault to both male and female being victims and this trend is on a rise in the areas they service. Therefore, it is important for programmes to not only see victims as females and address preventative and redressive programmes targeting all genders. More so children, people living with disability and members of the LGBTQIA community.

An important consideration is that when people are not trained to work with children to identify cases of child abuse, they are often scared and would rather refer to Ethembeni, rather than find themselves too involved in a particular case. This means that there is an urgent need to train all stakeholders dealing with children and develop a protocol on how best cases should be referred and addressed.

In summary, KwaNdeNgezi stakeholders are invested in redressing and remedying the social ills that are linked to GBV, this is evident in the roles and narratives we encountered with the various stakeholders who were mapped and their enthusiasm of joint and being part of the CCN was evident in the interviews we had.

Community Media Access and Use

Preferred Media

Two modes of communication are popular in the area, these are radio and the community newspaper.

Communication With Communities

Radio: in particular, Ukhozi FM emerged as a leading medium that could be used to communicate messages on GBV with the community. Many participants agreed that this would reach most of the population, especially the older population. In the same vein, Vuma FM was seen as a preferred medium to reach younger people. Most respondents did not believe that newspapers were widely read and could reach a lot of people.

Community Dialogues And Other Community Events: led by community and development workers such as Ethembeni were mentioned as most trusted and with a high potential to reach people. There were mixed reactions with regards to using local and national celebrities for messaging related to GBV. Some people saw them as potentially useful, while others doubted their legitimacy and authority.

Social Media Communication

With regards to social media use, none of the stakeholders interviewed had a dedicated Facebook page. A few were aware of national pages that were run by people at "national level". WhatsApp emerged as an important and leading tool for communicating within organizations. This platform was used mainly to share with colleagues updates on issues and was not ever used to facilitate discussions or share information with beneficiaries. This means that this platform can possibly be used by a future established CCN.

In instances where Facebook was previously used to share school highlights and communication, this process was stopped due though the students misusing and abusing the process. In Dick Ndlovu School the students highjacked the school's Facebook page and drew a big male genetalia and an elephant and posted it on the Facebooks page to mock and make fun of the school's name. This incident led to the shutdown of the school page.

Social Media Communication

With regards to social media use, none of the stakeholders interviewed had a dedicated Facebook page. A few of the stakeholders were aware of national social media pages that were administered at "national level". Nonetheless, WhatsApp emerged as an important and leading tool for communicating within organizations as an easily accessible and relatively cheap mode of communication. Stakeholders mainly used Whatsapp to communicate with colleagues' for updates on issues and were not ever used to facilitate discussions or share information with beneficiaries. This means that this platform can be used by a future established CCN.

Communication with Communities

Community dialogues and other community events led by ADAPT were mentioned as the most trusted and with a high potential to reach people and having them as the community partners increased the buy-in from the other stakeholders. There were mixed reactions with regards to using local and national celebrities for messaging related to GBV. Some people saw them as potentially useful, while others doubted their legitimacy and authority.

General Insights from the Mapping

Some insights gleaned from the engagement with stakeholders are summarized below. These emerged during the interviews using the mapping tool.

Stakeholder Relations

Ethembeni has strong relations with the various stakeholders in the region. The centre is perceived as a"experts /go-to" stakeholder in the region, the perception and the centres work on GBV resulted in a swift mapping process.

Availability of Financial and Communication Resources

Several stakeholders interviewed (except government) operated with very little financial and communication resources. Many did not have offices, laptops, boardrooms, offices, etc. and relied on their cell phones as a means of communication. Many often have to use their airtime and data for communicating issues related to their work. This demonstrated a deep passion and willingness to help their communities in addressing GBV.

Willingness to be Part of a Network on GBV

All stakeholders interviewed expressed that they would be willing and eager to join a forum/network aimed at addressing GBV in their community. A few were not sure what their role would be but expressed a desire to be part of or informed of activities undertaken by such a network/forum.

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Appendix A

The policy states the provision of counselling and referral of victims, STI prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence. **The norms and standards for service include that:**

- Every clinic should establish working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
- A member of staff of every clinic should receive training in the identification and management of sexual, domestic and gender-related violence. The training includes gender sensitivity and counselling.
- A clinic should have a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.
- A clinic should have a list of names and addresses of NGOs or other organisations (e.g. CBO) which undertake appropriate counselling (e.g. FAMSA, ATIC) for violence, child abuse and sexual offences.
- A clinic should have a room available at short notice for private, confidential consultations.
- A clinic should have adequate stock of emergency contraceptive pills.
- Clinic staff should fast track in a confidential manner any rape victim to a private room for appropriate counselling and examination.
- Clinic staff should always include a question on gender violence in the history-taking from women with depression, headaches, stomach pains or a known abusive partner.
- Clinic staff should include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.
- All cases of sexually transmitted disease in children should be managed as cases of sexual offence or abuse.
- When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation should be assumed to be true and the victim should be made to feel confident they are believed and are treated correctly and with dignity.
- A detailed medical history should be recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for three years.

- Clinic staff should explain that referral is necessary to an accredited health practitioner and arrange35 (Department of health report 2011-2012) http://www.doh.gov.za/docs/reports/annual/2012/Health_Annual_Report_2011-12.pdf 89 ments are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.
- The victim should be given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.
- Victims should not wash before being seen by an accredited health practitioner.
- Women who have been raped or abused should be attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another woman is present during the examination.
- The victim should be given brief information about the legal process and the right to lay a charge.
- If the victim indicates a desire to lay charges the police should be called to the clinic. (Adapted from The Primary Health Care Package for South Africa)