

SHELTERS SERVICES FOR WOMEN SURVIVORS OF INTIMATE PARTNER VIOLENCE: FACTORS THAT ENHANCE THE LONG-TERM RECOVERY OF WOMEN THAT EXIT DOMESTIC VIOLENCE SHELTERS

Written by Kailash Bhana and Claudia Lopes

This policy brief is the last in a series of briefs which consider the provision of shelter services to victims of domestic violence. It does so in relation to the last research study (Long-Term Impact of sheltering services) of the “Enhancing State Responsiveness to GBV: Paying the True Costs,” a project of the Heinrich Böll Foundation and the National Shelter Move-

ment of South Africa. The project, which is funded by the European Union, aims to support state accountability for adequate and effective provision of domestic violence survivor support programmes, specifically those associated with the provision of shelters for abused women.

INTRODUCTION

South African women face lethal abuse at the hands of their intimate partners, with as many as three women being killed every day, making South Africa’s femicide rate five times higher than the global average¹. Research studies estimate one in three South African women experience physical violence in their relationships, with one out every five women experiencing sexual violence too². These rates of violence against women (VAW) are of significant concern particularly as they appear to be increasing. For example, over the 2017/2018 financial year, the police reported a total of 177 620 social contact crimes having been committed against women. These crimes include 2 930 murders (11% increase from the previous year), 3 554 attempted murders (6.7% increase), 81 142 common assaults (3.9% increase), and 53 263 assaults with the intention to commit grievous bodily harm (2.5% increase) having been reported.³

Intimate Partner Violence (IPV) is known to be cyclical, endemic and frequently involves multiple victims with children in particular often the ‘silent’ victims, witnessing their mother’s abuse

or getting embroiled in it⁴. The impact of this is felt by all – it holds significant costs to those directly affected by the abuse, to society at large and to the economy. For every contact a woman affected by IPV (and her children) make with State services, costs are incurred to government. At each stage the private, welfare and health sectors and communities also incur extensive pecuniary losses as a result of the consequences of IPV⁵. The cumulative economic impact of IPV negatively affects South Africa’s economic growth and stability.

For the victims/survivors who work (even in informal work), high absenteeism may result in a loss of income and even job loss. This economic setback is further compounded by additional expenses incurred when seeking reprieve from the abuse such as those related to multiple moves, school transfers for children, costs associated to travelling to police stations or courts, seeking medical care, psychological support and so on. Long-term costs include but are not limited to legal fees, medical and psychological treatment, and ongoing court dates.⁶

1 Abrahams et. al., 2009

2 Gender Links and Medical Research Council, 2010

3 Stone, K and Lopes, C, 2018

4 Stone K, Watson J and Thorpe J. et. al., 2013

5 ibid

6 Stone K, Watson J and Thorpe J 2013



Seeking to leave abusive relationships is incredibly complex, arduous and risky especially if women lack the resources to move out on their own and/or do not have social support networks that they can rely on. Those who do not have safe housing or shelter services face the risk of being forced into unsafe income generation activities, precarious tenure, criminality and increased risks and vulnerability to further violence. Returning to abusive partners places women at risk to intensified abuse, and additional physical and psychological trauma, if not death.

Shelter provision for women and their children can literally make the difference between life and death. Shelters play a fundamental, mitigating role in responding to, and addressing, violence against women and their children. Shelters offer more than just safe accommodation. They provide women with opportunities for healing and for re-building their self-worth. Most importantly, shelters play a significant role in interrupting and breaking the cycle of violence. Rendering shelter services requires significant expertise, care, and resources. Yet, shelters are often undervalued, with those rendering such services often facing precarious challenges.

Over the years, the Heinrich Böll Foundation (HBF) along with the National Shelter Movement of South Africa (NSM) have undertaken several studies on shelters⁷. These studies have all proved vitally important to understanding the complexity of rendering shelter services to a largely vulnerable population. They provide information on the women who accessed shelter services, what their needs were and those of their children, and the extent to which shelters were able to meet those needs within the context of government funding allowances, and what those funding allowances should effectively be. What these prior studies have not done, is to talk to the women who actually made use of these services. Understanding women's experience of the variety of services offered by shelters and the factors that aid or hinder their long-term recovery from abuse is crucial to improving government and non-profit sector policy and practice.

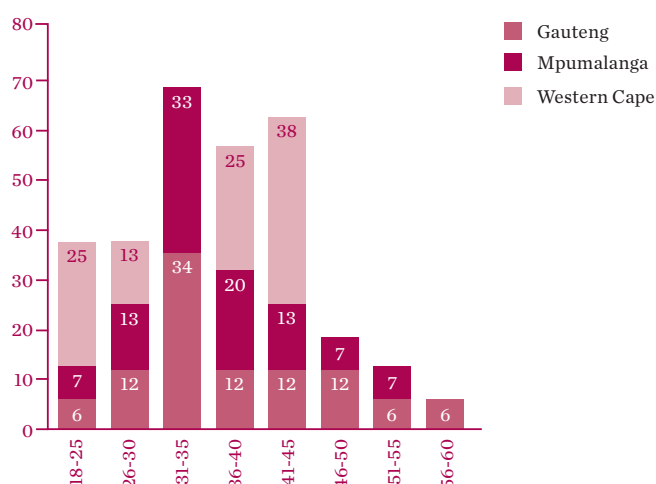
This brief is based on the findings of the last study (Long Term Impact Study) undertaken by the HBF and the NSM through their "Enhancing State Responsiveness to GBV: Paying the True Costs" project. The Long-Term Impact Study (LTIS) sought to answer three questions: to what extent are shelters able to effectively meet survivors' immediate needs; did shelters services hold long-lasting impact for survivors; and what other interventions/strategies/resources are needed to meet survivors' needs in the long-term?

The methodology employed focused on 40 former shelter residents' experiences of having accessed shelters 1 – 3 years prior to the study and their perspectives on the extent to which the services they accessed had helped them in the long-term. Women were interviewed telephonically or in person, while shelter personnel from the 11 shelters that women had resided in were interviewed in person during data collection. These 11 shelters are located in three provinces, namely Gauteng (4 shelters), Western

Cape (2 shelters) and Mpumalanga (5 shelters) – 10 were run by non-profit organisations while one was government-run.

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PROFILES OF WOMEN WHO USED THE SHELTERS



Slightly more than half of the 40 women in the sample (55% or 22) were Black African women. Coloured women made up just over a third of our sample (13), while the remainder of women were white (3) and Indian (1). The ages of women ranged from 24 to 60; the highest proportion being women in their child-bearing and rearing years 31-45 years (25 or 58%) with the single largest category of women being in the 31-35 year age group.

Among profiled shelters, those from the Western Cape had a majority of residents in the 41-45 age group, while shelters from Gauteng and Mpumalanga had more residents in the 31-35 and 46+ age cohorts. Due to small sample sizes in the Western Cape, there were no residents in the 31-35 and 46+ age cohorts.

Women in this study (like other HBF and NSM studies) had largely low levels of education with 82% (33) of the sample having only attended high school and only five women specifically mentioning having completed matric. Only three women reported having some form of tertiary education. Nineteen women (47%) reported to be unemployed; six of these unemployed women said they survived solely on a State support grant – five on child support grants and one on a disability grant. Other sources of income for women in the unemployed category included maintenance from a partner (4 women), family support (2 women), and a learnership stipend (2). Women who reported to be unemployed were spread evenly across three age categories, namely 26 – 40 years. The remainder of women (21) were working on a full-time (11) or regular (8) basis or were self-employed (1). The majority of these women were between the ages of 31 – 35, followed by those

⁷ See Bhana et al. 2012; Bhana et al. 2013; Lopes and Mangwi, 2017a; Lopes and Mangwi, 2017b; Vetten and Lopes, 2018.

between 41 – 45 years of age. One woman was a pensioner and thus lived off an old-age pension.

Thirty-four women (85%) in the sample had experienced significant physical abuse by their intimate partner⁸ in addition to other types of abuse such as emotional, verbal and sexual abuse. Women's partners were often incredibly violent and cruel, their actions inflicting serious trauma, pain and suffering upon them. In addition to the psychological and emotional trauma sustained, women incurred physical injuries such as torn lips, blood-shot eyes, broken limbs and other wounds from being attacked with objects.

At least eight women had been threatened with death and/or had experienced actual attempts on their lives. For four women

this had included being shot at by their partner. Three women managed to escape the situation uninjured, however, the child of one of these women was not so fortunate and spent weeks in ICU recovering from injuries sustained when the child got caught in the cross-fire. The fourth woman was shot four times including once in the head. When her partner threatened to kill her as soon as she arrived home after being discharged from hospital, she knew she would die if she did not leave him. Although two of her older children were not at home that day, she says she had no choice but to grab her youngest child and run as soon as her partner had left for work that evening. She was reunited with her children once at the shelter.

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8 Although one woman had also experienced abuse by her drug-addicted son.



PROFILE OF SHELTERS & THEIR SERVICES⁹

	SHELTER NUMBER	CAPACITY	STAFF	EXCLUSIONS	
WC	Shelter 1 <i>urban</i>	26 women & children	<ul style="list-style-type: none"> • <u>Shelter</u>: Manager, 2 HMs (FT), 1 HM (PT), 1 SW, 1 SAW • <u>Crèche</u>: 2 teachers; crèche coordinator & cook/assistant teacher • <u>Other</u>: Receptionist; PA; Operations/Finance Manager 	Men; unaccompanied minors; children over ages of 5, women with psychiatric conditions unless on treatment.	
	Shelter 2 <i>urban</i>	100 women & children	<ul style="list-style-type: none"> • <u>Shelter</u>: manager, assistant, 1 SW, 1 SAW, 1 night supervisor, 3 relief workers (diff units), 2 paralegals (serving both shelter and centre), ECD practitioner • <u>Centre</u>: Director, finance manager, PA to director, researcher (PT), fundraiser (PT), administrator, receptionist, child counsellor (PT), psychiatric counsellor (advocacy programme). • <u>Catering programme</u>: chef, assistant chef, 2– 3 clients p/d stipend 	Men; unaccompanied minors; destitute women; women with untreated psychiatric conditions	
GP	Shelter 3 <i>peri-urban</i>	20 women & children	<ul style="list-style-type: none"> • <u>Shelter</u>: Shelter manager, 1 SW, 2 SAW, 1 SW supervisor, 2 HM (full-time), 1 relief HM. • <u>Centre</u>: info not provided 	Men; unaccompanied minors; elderly women; women with psychiatric conditions	
	Shelter 4 <i>peri-urban</i>	16 women and children	• <u>Shelter staff</u> : Shelter Manager, 1 SW, 2 SAW, 2 security guards, 2 HMs	Men; boy children over the age of 12; women with psychiatric conditions; undocumented migrants	
	Shelter 5, <i>peri-urban</i>	22 women & children	<ul style="list-style-type: none"> • <u>Shelter</u>: Manager/SW, 1 HM, 2 counsellors • <u>Other</u>: NGO staff include Director, Finance Manager, Receptionist and other. 	Men; unaccompanied minors; boy children over the age of 12; women with psychiatric conditions; women with substance dependency unless on treatment	
	Shelter 6, <i>peri-urban</i>	12 women & children	• <u>Shelter</u> : Director, Centre Manager, Administrator, 2 SWs (shelter & other), 2 HMs, 3 volunteer psychologists (PT), 1 Volunteer Coach	Men; unaccompanied minors; boy children over the age of 12; women with psychiatric conditions; undocumented migrants	
MP	Shelter 7, <i>rural village</i>	6 women & 4 children	• 1 shelter manager/SW, 3 caregivers, administrator, HM, general worker, 2 security (at night), 3 outreach officers (do not work at shelter)	Men; unaccompanied minors	
	Shelter 8, <i>developed town</i>	10 women with their children	<ul style="list-style-type: none"> • <u>Shelter FT</u>: Manager/social worker, 2 care workers, • <u>Centre (PT shelter)</u>: 2 SAWs, 1 SW, administrator, cleaner, 1-day worker 	Men, unaccompanied minors, substance-dependant persons, persons with psychiatric conditions (referred as soon as discerned)	
	Shelter 9, <i>large town</i>	10 women with their children. Males accommodated separately	• 2 SWs (one also works as shelter manager), child & youth care worker, 5 general care workers, administrator, paid intern, security guard outsourced	Substance dependant persons and those with psychiatric conditions or physical disabilities.	
	Shelter 10, <i>small town</i>	8 women & children. Males accommodated separately	• 1 shelter manager/SW, 1 coordinator, 2 caregivers, 1 gardener/ gatekeeper, administrator, general worker, 1 x general worker	Unaccompanied minors	
	Shelter 11, <i>rural village</i>	8 women, 4 children	• Shelter manager, 1 SAW, 3 caregivers, administrator/admin support, gardener/caretaker	Substance dependant persons and those with psychiatric conditions; facilities not ideal for persons with disabilities.	

9 Legend: SW = social worker, SAW = social auxiliary worker, HM = housemother, FT = full-time, PT = part-time

SERVICES OFFERED	STAY/DURATION	MAIN FUNDERS
<ul style="list-style-type: none"> Accommodation & food, basic essential items, counselling (one-on-one & group); legal support, skills training programmes, assistance with job seeking, crèche services, play therapy for children incl. Music therapy. Referrals/assistance to access other service providers. The shelter will cover the costs of private medical doctors & medication when the need is urgent and warranted. 	4-6m + access to 2nd & 3rd stage housing	DSD; Community Chest; International funders; CSI; Community members
<ul style="list-style-type: none"> Accommodation & food; basic essential items, Counselling (one-on-one & group), Children's counselling & play therapy, skills development, job skills training. Shelter has an ECD centre. Shelter able to assist with applications for IDs, birth certificates etc. through mobile unit (ID applications paid for by shelter). Onsite applications for Protection Orders. 	4m + 6-9 m additional at 2 nd stage housing at a cost of R500 p/m at 2 nd stage. R100 of this contributes to maintenance & upkeep of housing unit and R400 is banked and returned to client in full on their departure.	DSD; National Lottery; Trusts; Foundations; Corporate funders
<ul style="list-style-type: none"> Shelter & basic needs, counselling, skills training, children's psychosocial assessment, children's individual counselling only if need identified, school placement, group work during school holidays, homework assistance, transport to school by HMs. 	3-6m + 9m extension for those with children at school	DSD, fundraising, Woolworths & individual donations.
<ul style="list-style-type: none"> Accommodation, food & basic needs, counselling (group & one-to-one), assistance to access medical care, legal support, children's programme incl. counselling & play therapy and referrals to child psychologist in cases of extreme trauma, placement & transfer of children in school. 	6m	DSD
<ul style="list-style-type: none"> Accommodation & basic needs; counselling, support groups (internal & external facilitators); skills development; legal advice & representation; CV writing workshop; assistance to access medical care, children's developmental programme and counselling, school placement, referral to specialist child services when needed. 	3-6m	DSD; local business donations
<ul style="list-style-type: none"> Accommodation & basic needs; individual counselling; couples therapy; group sessions as well as life coaching, skills dev & job seeking support; spiritual care; ECD centre, school placement programme; child psychologists provide individual & group therapy; supervised visits with the father; home based care programme to support HIV+ clients esp. with adhering to meds (this programme is not funded), youth care programme, schools clubs & agriculture programme. Youth Diversion programme. 	3-6m	DSD; National Lottery
<ul style="list-style-type: none"> Shelter, counselling for women, awareness-raising. Shelter does not provide skills-development but has an agreement with an external provider to offer clients computer skills training. 	6m	DSD
<ul style="list-style-type: none"> Shelter & basic needs, counselling (one-on-one), spiritual counselling through external service provider, skills training no longer offered due to staff and funding shortages 	6m	DSD
<ul style="list-style-type: none"> Sheltering and basic needs, counselling (one-on-one), Group sessions conducted by youth and childcare worker, skills development. Referral to other services. 	6m	Govt. run shelter, also receives in-kind donations
<ul style="list-style-type: none"> Accommodation & basic needs, counselling (one-on-one and group), assistance to obtain govt. services, referrals to other services, skills development on and off depending on availability. 	3-6m	DSD & donations
<ul style="list-style-type: none"> Sheltering, counselling, life skills, childcare 	6-12m + 3m aftercare	DSD & donations

MAJOR FINDINGS & POLICY IMPLICATIONS

1. SHELTERS HELP WOMEN AND THEIR CHILDREN BREAK FREE OF THE CYCLE OF ABUSE

"[The shelter] made a difference, a big, big difference. Had I not been in the shelter, I would have been dead, dead. I was never going to tell a story about my life... [The] shelter saved my life; it saved my children's lives to tell you the truth!"
(M, 49-year-old Coloured woman, employed full time with 3 children, stayed in Shelter 4)

Interviews with former shelter residents/clients revealed that shelters work. Besides providing women with emergency accommodation, physical and psychological safety, shelters helped women and their children break free of the cycle of abuse. Twenty-eight women (70%) were living independent of their abusive partner at the time of the interviews.

Shelters intervene at two levels: immediate crisis support with short-term interventions assisting women in crisis management and medium term interventions that assist women in planning, and to put in place strategies and skills for life after the shelter. Crisis intervention has safe accommodation as well as ensuring psychological and physical safety and care as a priority and is the most common service offered by all shelters. Crisis intervention and containment is the most immediate need for women who arrive at shelters in the aftermath of their worst experiences of abuse and/or upheavals in their lives because of IPV. Containment in the form of emotional support and counselling is provided on a one-on-one basis, but some shelters are also able to extend this to group counselling sessions. Medium-term interventions include skills training, and assistance with job applications, schooling for children as well as legal interventions such as accompanying clients to court to apply for protection orders or helping them to institute divorce proceedings or lay charges against their abusive partners. Shelters are better able to meet client's health, legal and social support needs through the development of networks or informal partnerships with government departments.

2. SHELTERS OFFER DIFFERENTIAL SERVICES BASED ON RURAL/URBAN LOCATION AND THEIR ABILITY TO SECURE RESOURCES

"At one time last year we were sitting with a R40 000 water and electricity bill. There have been other instances where we have had to delay paying salaries and had to make do with an absolute minimum of provisions for clients."
(Shelter manager, Shelter 3)

Although all shelters attempted to provide the range of services that their clients required, this was not always possible. Services offered by rural and urban shelters were found to be different and based on whether or not shelters were able to secure donor funds apart from the grants received from the Department of Social Development (DSD). The two rural shelters and five shelters in smaller towns were solely reliant on DSD grants and donations and as a result

were unable to offer the variety of services offered by urban shelters. They also had less human resource capacity to do so. However, all shelters (except the government-run shelter) experienced funding challenges, having to juggle priorities at times of financial stress. This coupled with protracted delays in the receipt of funding from DSD meant that staff at less resourced shelters especially, went without salaries so that women and their children's basic needs could be met. Programmes at shelters were also sacrificed. Limited funding also means that shelters cannot render services to the extent that they need to. For example, one Mpumalanga-based shelter is dependent on the use of a staff members' car as the shelter itself does not have a vehicle. This meant that women could not be readily transported to access important hospital, clinic, court or police services when needed, especially after hours. At another peri-urban shelter, the building was very basic; without ceiling boards and sparsely furnished, meaning women and their children slept on mattresses on the floor and the building was very draughty and cold. While at another rural shelter, women and children were housed in refurbished containers.

Whether rural or urban, shelters experienced challenges in covering the costs of utilities i.e. electricity and water and in the majority of instances were not offered rebates by the municipalities. Shelters also had difficulty in setting up adequate security measures. This is often insufficiently or not at all funded by the department.

"In 2015, there was a break-in at the shelter and the robbers threatened to rape the women who were at the shelter. At that point, we fell short of providing a safe haven for our clients because this was trauma added to the issues they were already dealing with, so there is a strong need for a security at our shelter. I made a report to DSD and in the report motivated for funding for armed response or a security guard at night. The only thing we were able to do for the clients was to provide debriefing. The clients were very afraid of being on their own, so I spent the whole week staying at the shelter together with the housemother."
(Shelter 5, Gauteng)

3. COUNSELLING STANDS OUT AS A MAJOR CONTRIBUTOR TO WOMEN'S ABILITY TO DEAL WITH THE ABUSE AND COPE FOLLOWING SHELTER EXIT

"[Counselling was] very important. For instance, in the counselling sessions that I went through; I was not even aware that because of my abuse I was not treating my children right. I thought I was a good mother. The counselling sessions I went through opened-up my eyes."
(S, 42-year-old Coloured woman, resided at Shelter 2 for 10 months with her two children)

"You know counselling helped me a lot, because I was at that point where I was thinking of killing myself. I thought of killing myself because I had been abused too much. But when I went to the shelter, they showed me a different side of life. They told me I need to live for my children."

(L, 42-year-old Black women, resided at Shelter 3 for two months with three of her children)

All shelters strive to meet the complexity of women's needs with basic necessities; safe accommodation and counselling being a minimum level of service for all shelters. Women reported that the counselling and the relationships they developed with social workers was one of the major factors that aided their recovery. The regularity of counselling varied however depending on the shelter resources/staff capacity and the length of shelter residency.

Not all shelters offer follow-up services after women exit shelters. Some wished that follow-up support from the social workers as well as the support they received with childcare was possible in the longer-term as this would assist them with feeling connected and being able to seek employment/go to courts/follow up with police etc. with greater ease.

"I didn't feel like I resolved my issues - I could have benefitted from more counselling and also more time to plan my future away from my abuser. And I think this is one of the reasons I went back to him. When I first left the shelter, I lived alone with my son. Then he threatened to kill us if I did not reconcile. But I told myself I will give the relationship until the end of the school year. Then I went to my mother in the Eastern Cape where he could only harass me over the phone and not physically. Follow-up is another important thing that I would improve at the shelter- just that support of knowing the social worker who was so close to us during our time at the shelter has an interest to know how we are doing"

(N, 33-year-old Black woman resided at Shelter 3 for three months with her child).

4. SHELTER FUNDING & NETWORKS AID WOMEN ACCESSING OTHER SERVICES AND BENEFITS SUCH AS EMPLOYMENT OPPORTUNITIES

The efficiency and efficacy of shelter services is also dependent on the networks that shelters are able to forge with appropriate service providers in the health, criminal justice and social welfare sectors. These networks enable women to access other services. The study finds that urban shelters have a wider network of stakeholders than rural shelters including networks with the business sector. This, along with the shelters ability to render viable a skills-development programme and access to other resources, facilitated women's access to employment opportunities.

"We assisted one client last year by extending her stay because she was heroin addicted and pregnant; and she did so well - I still personally check in with her since she left the shelter. Now she's even willing to speak at public engagements; she addressed representatives of Pick n Pay with several other former clients of [Shelter 1] and shortly thereafter we were phoned by a store manager who said our clients could start working there immediately."

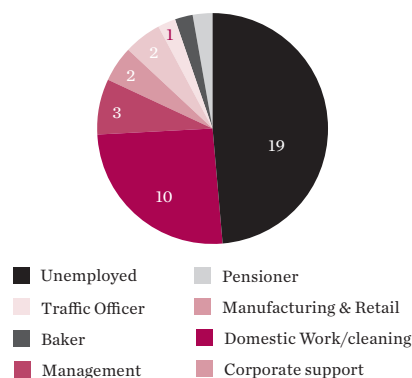
(Shelter Manager, Shelter 1)

5. SKILLS-TRAINING IN SHELTERS IS IMPORTANT TO CAPACITATE WOMEN FOR EVENTUAL FINANCIAL INDEPENDENCE AND HAVE TO BE ASSESSED FOR THEIR APPROPRIATENESS, THE EXTENT TO WHICH THEY PREPARE WOMEN FOR THE LABOUR MARKET, AND MUST BE LINKED TO OTHER ROLE-PLAYERS WHOSE FUNCTION IT IS

"DSD does not cover the organisations operational budget. In addition, the money received from DSD does not have a budget line for training, yet the shelter is still expected to carry out trainings and to cover the associated expenses of these trainings as well as other expenses such as children's programmes."

(Shelter 3, Gauteng)

Skills-training was offered unevenly with six of the 11 shelters offering some form of training that ranged from skills in crafts to computer training. Some women reported having received no training whilst other women received programmes that helped them to secure jobs.



As mentioned earlier, women in this study had largely low levels of education with the majority having only attended high school. Nearly half (19) of the women were unemployed, while the remainder of women occupied various part-time or full-time jobs. Those working part-time often had low-skilled jobs that did not pay very much.

The need to support survivors in finding employment in order to sustain themselves post the shelter stay cannot be underscored. According to a 2004 study conducted by Lynch and Graham-Bermann, employment is a critical determinant of a woman's sense of self, and self-esteem related to experiences of abuse. The same study also concluded that being employed was positively associated with a woman's decision to leave her abuser. Essentially, this implies that securing a job has mental health benefits beyond self-sufficiency by decreasing helplessness.

The nature of crisis sheltering however, does not always allow skills development at the shelter because the duration of a woman's stay is too brief and/or the focus of service provision is to respond to immediate basic needs, safety and security and health needs. The study also highlighted that this service was dependent on the availability of funding for such programmes (as DSD funding rarely factors in skills development despite it being a requirement). Lack of human resource capacity played a role here too; the provision of skills-development training is not the expertise of social workers.

"The skills that shelters provide are basic sometimes and not in demand within the job market. This means that often shelter clients cannot afford rent when they leave here because they earn entry-level wages, R2 000 or R3 000, which is not enough to sustain a woman with children, which is why clients often go back to an abusive partner."

(Shelter 4, Gauteng)

An audit of the skills programmes offered by shelters has not been undertaken. When shelters were able to offer some form of skills-based training programmes women found them to be of great benefit. Women interviewed specifically asked for improved and a greater variety of skills development programmes at shelters.

These findings raise important considerations for how the non-profit, state and private sector can begin responding to women's needs for up-skilling. Skills development programmes can aid women to develop marketable skills that promote their financial independence in the long term. An assessment of skills programmes at shelters as well as linking up with specialist and skilled service providers and relevant government departments would be useful to women's long-term needs.

6. DSD GRANTS RARELY FACTOR IN THE NEEDS OF WOMEN'S CHILDREN IN SHELTERS

“DSD is reluctant to allocate funding for children who accompany their mothers to shelters since children are catered for by places of safety, which means there is a funding gap in terms of children accompanying mothers to shelters, which undermines shelters’ ability to offer the best possible service for these children.”
(Shelter 6, Gauteng)

Thirty-eight (95%) women in the study sample had a total of 117 children between them. At the time of the interviews, more than half of these women were caring for children under the age of five. Only three of the women had children who were all adults. Four women have had babies since leaving the shelter while another two are caring for the children of siblings who are deceased in addition to their own. Numbers of children per woman vary from one to seven with the average being three.

Children's welfare are inextricably linked to that of their mothers. Children growing up in abusive households are negatively affected by the abuse and at serious risk for developing long-term physical and mental health problems¹⁰ including the potential of being violent or accepting violence as the norm in future relationships.

Depending on their ages, children have differential needs when entering shelters with their mothers, and require support to deal not only with the traumatic impact of experiencing or observing abuse but also with their immediate crisis of being removed from a familiar environment and having to adjust to shelter living. Often, the children that accompany their mothers to the shelter are young and of school-going age whose schooling gets disrupted more than once.

Children's services/specialist staff are a major gap in services at shelters dependent on DSD funding. This is chiefly a consequence of DSD grants for women in shelters not factoring in the

needs of women's children that accompany them to the shelter. Children's domestic violence services are an essential component for disrupting the intergenerational cycle of violence.

7. NPOS BEAR THE BULK OF COSTS FOR SHELTERING WOMEN AND THEIR CHILDREN

Shelter studies¹¹ preceding the LTIS found that DSD funding across and within provinces lacked uniformity and were largely insufficient to meet the complexity of needs of IPV survivors and those of their children. DSD subsidies are highly variable.

In the financial year pertaining to the study (2015/2016), DSD funding to shelters in Western Cape and Gauteng was set at a largely similar unit rate per beneficiary at R1,400 or R1,500 p/month (equivalent to about R48.92 in Gauteng and R49.31 in Western Cape depending on the number of women that shelters could accommodate). DSD funding also factored in some subsidies towards shelter personnel such as social workers and housemothers and some funding towards administrative expenses and project funding. Only two shelters received funding for community outreach or skills development. In Mpumalanga, shelters receive lump sums of funding (thus not distributed across budget line items) except in some instances where funding is specifically earmarked for subsidising the salary of a social worker. At the time of our research, DSD was either the main or the sole funder of the NPO-run shelters in this province.

The unit rate per beneficiary subsidy is meant to cover costs such as food, transportation and other essentials for shelter residents. While these unit rate subsidies have since increased, they remain insufficient when compared to actual costs of providing services¹² to meet the needs of shelter residents.

There is a failure on behalf of the state to fully comprehend the variety of services that are required to respond to the complexity of survivors' needs, such as medical, mental, and emotional health services, financial help, services for children, and safe accommodation for survivors with physical and other disabilities.

NPOs bear the bulk of costs for meeting the full range of women and their children's needs and are forced to find alternate funds to cover the gaps left by insubstantial DSD grants. DSD provides capacity and financial support to NPOs but this is done in ways that are often inadequate, posing a threat to effective provision of services to victims.¹³

Running a shelter is costly. In addition to needing to cover operational costs such as rent, water and electricity, other costs are incurred in the daily business of helping shelter clients to access services outside of the shelter such as at courts, clinics, police and so on. A few shelters remarked that having a car is a necessity but funds to purchase cars are hard to come by.

10 Office on Women's Health. Effects of domestic violence on children. US Department of Health and Human Services; <https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children>

11 Bhana et al. 2012; Bhana et al. 2013; Lopes, et al 2013, Lopes et al 2017; Lopes et al 2017 (b); Stone et al, 2013; Vetten, 2018

12 Vetten, 2018

13 Watson and Lopes, 2017

“Transport is certainly a challenge for the shelter – it has only one car that is used for everything from fetching and dropping children at school, to taking clients to their court appearances, to transporting clients and their kids to hospital or the psychologist, to purchasing food and buying other amenities for the shelter. DSD had in principle committed to providing some form of assistance to shelters with transport challenges but this has not as yet materialised”
(Shelter 6, Gauteng)

All shelters (again, except for the government-run shelter) were found to have experienced some difficulties with DSD grants. The staff member at Shelter 6 for example says she finds DSD funding processes cumbersome; it feels more like “rubber stamping” as opposed to substantively engaging with issues. Sometimes the shelter proposes new projects or puts forward suggestions; but they continue to receive the exact same amount when DSD gives them a new Service Level Agreement (SLA). This suggests that DSD never adjusts the SLA according to the business plans they receive e.g. staff salaries have not been adjusted for years despite the organisation’s growth which undermines the staff’s ability and capacity to do more work. The low salaries of housemothers are especially worrying particularly considering their workload and the essential nature of the support they provide to both the shelter and its clients. Several managers also spoke of the difficulties that they face when tranche payments are delayed. Delays can hold disastrous consequences for shelters especially for those that rely on DSD as their sole or main source of funding.

8. NPOS FUNDING CHALLENGES IMPACTS ON THE RECRUITMENT AND RETENTION OF QUALIFIED, SKILLED STAFF AND SERVICES

“It is also difficult retaining staff because the shelter is unable to offer a salary that includes benefits such as pension-fund and medical aid contributions like other institutions – the shelter can only pay its social worker a flat rate of R9000 per month”
(Shelter 4, Gauteng).

With regards to staff subsidies provided by the DSD, these two varied across the provinces. In the financial year pertaining to the study (2015/2016), all shelters in the Western Cape received social worker (SW) subsidies to the value of R13,943 per month and housemother subsidies at a rate of R2,116 per month. One Western Cape shelter received an additional subsidy to employ a social auxiliary worker (SAW) – this amount was set at R6,020 a month. Shelters also received a minor subsidy towards the employing of a relief housemother when housemothers are on leave/part-time basis.

In Gauteng, housemother and SAW subsidies were slightly higher than that of the Western Cape, whereas the subsidy for SW’s was lower. One Gauteng shelter only received a subsidy to employ a part-time social worker despite the shelter being able to accommodate 22 women, while another Gauteng shelter received a subsidy for a full-time SW at a rate of R11,698 a month yet accommodated fewer beneficiaries (20). However, it must be noted that

this latter organisation runs two shelters located in different areas requiring one SW to split her time between both shelters but with the assistance of two SAWs.

Gauteng DSD did, however, factor in subsidies for other categories of personnel that Western Cape DSD did not such as a youth care worker at a rate of R1,200 a month at one shelter and a centre manager at a subsidy of R5,000 at another. Shelter 3 received substantially more post funding towards the salaries of a cook, a financial manager and a project coordinator.

Shelters that were more reliant on DSD funding found recruitment and retention of staff more of a challenge than those shelters with a diversified donor base. In one rural shelter, the shelter manager was also the only social worker and splitting time between management tasks and therapeutic services was a major challenge. Similarly, a peri-urban shelter had only one social worker, and when she was engaged in awareness raising or community-based activities on GBV, women had to go without counselling.

“Care workers are not able to assist with the intake of clients and are also not able to conduct group sessions or home visits. Having auxiliary social workers to assist would be a great help, especially to assume responsibility when the social worker is not immediately available or off-site (in the past this has sometimes led to the shelter losing clients who could not be processed at their time of need.) A shelter manager would also be useful. Currently the social worker has to manage both roles. If she’s running a workshop outside the shelter, then client’s psychosocial needs aren’t met, which is not an ideal situation.”
(Shelter 7, Mpumalanga)

Even in better-resourced urban NPOs, shelters attempt to do the maximum in terms of service delivery with the few staff they have, leading to increased work stress in an already challenging work environment that deals with traumatic issues.

“Everyone has such a full-plate already and we [keep] pushing the envelope expecting them to push more and more; we just don’t have more staff to reduce the stress that they’re feeling.”
(Shelter 2, Western Cape)

Central to this funding problem is that while DSD does recognise its responsibility to fund shelters and says so in various policy/strategic documents, such as in its 2013-2018 *National Strategy for Sheltering Services for Victims of Crime* (hereafter referred to as the National Strategy for Sheltering Services), it does not, however, specify how shelters should be funded and the extent of support that DSD should provide.¹⁴ This is further hindered by the Policy on Financial Awards which states that NPOs funded by government must meet the deficit in their finances through their own fundraising initiatives; this, despite the state being ultimately responsible for the social welfare of its citizens. Fundraising and securing alternate sources of funding is by no means an easy feat. It takes significant know-how, time and energy.

¹⁴ DSD, 2013; Watson, J. and Lopes, C., 2017.

“The only proposal that has come through is for a Hyundai HI bus, and this has taken almost two years! This is frustrating because it takes a significant amount of time to compile proposals and meet the varying criteria. Funders don’t fund salaries, and yet what shelters urgently need is to augment salaries, to add on to what DSD currently provides”

(Deputy Director, shelter 4)

9. ADMISSION CRITERIA USED BY SHELTERS CAN EXCLUDE SOME CATEGORIES OF WOMEN REQUIRING SPECIALIST SERVICES LIKE THOSE FOR WOMEN WITH DISABILITIES, UNDOCUMENTED MIGRANTS, PSYCHIATRIC CONDITIONS AND WOMEN WITH OLDER BOY CHILDREN

All shelters have admission criteria with regards to who they can accommodate. For example, most shelters are unable to accommodate women with substance dependencies, psychological or psychiatric conditions, especially if untreated, as they are not specialised mental health/substance abuse facilities and thus not equipped to render these specialist services to those who need it. This is made more difficult by a shortage of psychologists and psychiatrists in public health care settings. While some shelters can assist residents with physical disabilities, a few noted that their facilities are not equipped to accommodate the needs of those residents i.e. wide doorways, rails/ramps and bathroom facilities. Two of the four shelters in Gauteng are not able to admit undocumented migrants as they do not have the necessary expertise or resources to assist undocumented persons.

“We had a foreign client who was being abused by her partner. She was unemployed and when she came to the shelter her passport had expired. I knew of an organisation in Pretoria that deals with visas and passports because I had attended a workshop run by this organisation on immigration, trafficking, etc. Unfortunately, they could not assist our client to renew her passport because she was facing deportation so in the end she had no option but to return to her abusive partner.”

(Shelter worker, Shelter 9)

Admission criteria also extend to the age limit of children accompanying their mothers. Some shelters are not able to cater for children who are older than the age of five, while others will not accommodate boy children over the age of 12. This is deliberate at some shelters as women’s length of stay can range between one to six months and the shelter is located a distance away from schools, meaning that children have to miss school for extended periods. In other instances, it is a consequence of staff capacity, skill, programme availability and funding. Separating mothers from their children in times of crises and trauma is not in the child (or mother’s best interests). Women escaping violence are loathe to leave their children behind for fear of their children being abused and children who are separated from their mothers and who have experienced direct or indirect trauma, experience setbacks in psychological recovery when plagued by concerns about their mothers (and other siblings) safety.

10. DSD SHELTER POLICY AND BUREAUCRACY ENGENDERS DISCRETIONARY FUNDING PRACTICES AND NON-STANDARDISED SERVICES FOR SHELTERS NATIONALLY AND INTRA-PROVINCIALY

“There was a case where a client was referred by a cancer organisation, but the shelter could not assist her because she did not fit the admission criteria. DSD wants us to work with all victims of crime, which is not feasible with the current funding shelters receive.”

(Shelter 5, Gauteng)

Despite not fully-funding shelter services, DSD notes the importance of shelters as representing “absolutely critical point[s] of crisis intervention” for vulnerable women and children (*Minimum Standards on Shelters for Abused Women*, 2001:1) and as such, shelters are required to meet a set of standards in the way that they are run and managed in order to “ensure quality assurance in service delivery”. Findings 2, 6, 7 and 8 discuss the impact of DSD shelter policy and funding practices on the women seeking shelter services and the funding implications of service providers of sheltering.

Shelter staff felt strongly that the DSD needs to both standardise services and provide increased funding to shelters. Standardising shelter services for women and their children will allow an accurate costing for equitable services to all women.

“We’re extending a service to the community that should be rendered by the state. We’re happy to continue to provide but they should cover the cost. The expectation is that services must be available but very few make allowances for salaries... [The issue of funding] needs to be addressed at a national level – there must be a problem in forecasting. If there is a national instruction that speaks to the fact that GBV is far too pervasive in this country and serious focus needs to be given to that, surely this should go hand-in-hand?”

(Shelter 2, Western Cape)

11. LACK OF SAFE, AFFORDABLE AND SUBSIDISED HOUSING IS A BARRIER TO WOMEN LEAVING ABUSIVE RELATIONSHIPS

“Access to housing is a key priority – facilitation by government (prioritisation of victims by the Department of Human Settlements would go a long way to assisting them to overcome housing challenges). RDP list is very long, and this is crippling hope. Access to a Transitional home is also important – preferably one managed by an NPO. Women would be able to stay here when they leave a shelter, while they become established instead of having no option but to return to an abusive situation.”

(Shelter worker, Shelter 8)

A major factor hindering women when leaving shelters other than unemployment is the general unavailability of second and third stage sheltering and/or safe and affordable housing options from government. Coupled with financial dependency (amidst other factors) a lack of real housing options often contributed to women returning to abusive partners.

“There have been cases where clients return to dangerous environments because they do not have an alternative and so they tell us as social workers: “if I leave this man, how will I survive?”

The social worker feels that she has failed in such cases because she is not able to provide the client with an alternative except to follow up with them afterwards and clients feel trapped because they really have nowhere else to go to.”

(Shelter 8, Mpumalanga)

Only two shelters in the sample are able to offer second stage housing, allowing residents to live more independently from the shelter while still benefiting from its services. The duration of residency at second-stage housing facilities ranges from nine or twelve months. Only one shelter in our sample was able to render third stage housing to residents. Third stage housing is a longer-term housing option for women who have completed a second stage programme (often a year) but still need subsidised housing and support in their community. Third stage housing may result in permanent housing for survivors of IPV. Second and third stage housing services, however, are very limited.

“We are unable to offer second stage housing, so a former client who was sheltered felt she had no option but to give her children to a foster parent. She ended up living with another abusive man. The exit plan had been for her to get her own accommodation, but by the time she had to leave the shelter she was still unemployed, and she had three children all under the age of three. We have since heard that she passed away from AIDS related complications, so in that case there was no positive impact made by sheltering.”

(Deputy Director, Shelter 4)

From the interviews with residents, it is clear that the length of stay at a shelter is related to how well a resident will cope after leaving the shelter. However, the length of stay at shelters is dependent on each shelter's rules as well as access to resources. DSD funding of shelter residents also determine the length of stay¹⁵. Seventeen women stayed between three to 12 months in the shelter. Many of them were able to adjust to life after their stay and were able to take care of themselves and their children independent of their partners. Twenty-eight women (70%) were living in their own home after leaving the shelter, a third were living with relatives or other types of shelters. Some women had left their children with relatives.

For many residents having an income related to the kind of housing they could access after exiting the shelter. Women were willing to take whatever was financially affordable and available including staying in shacks in other people's backyards. Residents with children and no regular income found it more difficult to find housing.

Some women interviewed stated that an admission period of 3-6 months at a shelter without other alternatives available to women post the shelter is a source of great distress and in some cases contributes to the decision to go back to the abuser. Suggestions for improvements in this regard included extending accommodation periods at shelters; establishment of second stage housing at shelters; and easier access to state subsidised housing.

The latter, particularly as a strategy for responding to the crisis of VAW in the country, needs to be one of local, provincial and national government's priorities.

There is an urgent need for the sheltering movement and government to have a policy and resourcing conversation about safe, affordable state subsidised housing options for women survivors of IPV and their children.

12. WOMEN'S AND CHILDREN'S HEALTH NEEDS

“The shelter helped me a lot, because before I went to the shelter, I was not taking my medication. When I got to the shelter, they took me to the clinic. My health is far better.”

[N, 22-years old, Black, no children, part-time job, stayed in Shelter 11]

All previous research studies found that women (and their children) presented at the shelters with varying health issues as a direct consequence of IPV including HIV, physical injuries or psychological trauma or general health issues. Many former residents of shelters interviewed for the LTIS, as well as shelter personnel interviewed, spoke of the importance of accessing health care while at shelters. Shelter residents were transported to clinics when required and those on medication were supported with treatment adherence.

“We assisted a client who was being abused and threatened with death by her partner for a long time but who had not reported this. We informed her about her legal options and helped her to apply for a protection order at SAPS. We also helped her to access healthcare, and she was prioritised for treatment and didn't need to sit in lines. All of the different stakeholders played their role, and everything went smoothly, and she was very empowered by the time she left the shelter.”

(Shelter worker; shelter 9)

“One client who came to the shelter was abused and had a disabled child. She had full blown AIDS, so the shelter assisted her: to access to treatment; for her child to receive physiotherapy; to complete a hair dressing course; to find a job at a hair salon, accommodation of her own and place for her child in a school”

(Deputy Director; Shelter 4)

Helping women to access health care necessitates relationships with health care facilities. In better-resourced urban areas, a network of services with healthcare providers (public and private) enable shelters to refer women for health care. In less resourced rural areas this is much more challenging as the following quotes illustrate.

“Access to psychologists is critical: government shelters have dedicated psychologists, but DSD doesn't provide for psychologists at NGO shelters (or even for consultations and clients often have to wait for months to see a psychologist at a public hospital)”

(Director; Shelter 5)

“Accessing psychological/psychiatric assistance is critical. Currently there is only one psychologist in the area who already has a heavy caseload and also attends to hospital and clinics”

(Shelter Manager/Social Worker; Shelter 7)

15 Watson and Lopes, 2017



While the South African Department of Health (DoH) does not adequately record statistics relating to the presentation of domestic violence cases in emergency medical care settings, domestic violence is well documented as a public health issue including by the World Health Organisation¹⁶. Martin and Artz (2012) suggest that IPV is the most common reason for a woman to present to her health care practitioner.¹⁷

However, in this study, only one woman was referred to a shelter by a health care facility, which illustrates a gap for detection of IPV in the health sector. Whilst much can be done by health care practitioners (HCP) in the way of universal screening, treatment and referral for IPV, this practice is likely limited¹⁸ due to

various factors including healthcare professionals' heavy case-load, inadequate privacy in health settings and a lack of appropriate training. This is further compounded by the fact that while IPV is a major public health problem, it is still not recognised as such in South Africa and so suffers from poor, almost non-existent, resource allocation.¹⁹

Government must conceptualise prevention services for IPV holistically, so that a common thread runs laterally across key government departments along with a budget to enable implementation. The point being made is that the locus of control and continuum of preventive work rests with many other government departments and not DSD alone.

RECOMMENDATIONS

The LTIS found that shelters provide a wide variety of emotional, psychological, attitudinal and concrete benefits to residents. However, not all women received the same level and quality of service. For example, those living in peri-urban/rural areas were not offered the same levels of expertise and skills as women in urban areas, and did not have the benefit of as many services as women in urban areas. There is also much more that shelters can and should offer inclusive of dedicated children's programmes and skills training. Participants interviewed shared how services such as psychosocial support and skills development enabled them to deal with and/or break free of the cycle of abuse. These services and others, such as subsidised childcare, need to be available to women upon leaving a shelter to increase women's independence. However, whether these are provided by shelters as an extension of their service offering or by other service providers requires considering.

The following recommendations are based on the overall conclusions of the research findings and what these mean for the consideration of a more comprehensive service rendering to survivors of violence.

1. REVIEW DSD SHELTER POLICY, STRATEGY, FUNDING MECHANISMS AND PRACTICES IN LINE WITH EVIDENCE-BASED RESEARCH ON WOMEN (AND THEIR CHILDREN'S) NEEDS IN SHELTERS

The non-profit sector offering shelter services bear the bulk of financial costs for service provision to women and children affected by domestic violence in the home. Shelter personnel interviewed contest that the DSD funding that their shelters received was inadequate to fund the plethora of needs of women in crisis. This left shelters strained for resources to cover shortfalls. The discrepancies and variations in funding by DSD means some women are inclined to receive fewer services than their counterparts in shelters where the funding allocation is slightly higher.

DSD funding also does not sufficiently factor children into the financial quantum they provide to shelters. Policy needs to be dynamic and give expression to the reality that women remain the primary caregivers of their minor children, especially more so in circumstances of domestic abuse.

As a result of incoherent policy, it is not clear how shelters should be funded, there is no standardization across the board, and this promotes discretionary funding practices which undermines women's equal access to services of the same standard. DSD policy should remove ambiguity and discretion on what government will fund and how funding is to be allocated and disbursed so improving the practice of implementing policy. This is critical to avoid financial and operational crises at shelters.

Standardised service levels and monitoring implementation is only one way of ensuring consistency and equitable distribution of resources. DSD has drafted a *Victim Empowerment Support Services Bill*. The purpose of the Bill is to regulate victim empowerment services, such as shelters for abused women and children. The Bill presents a strategic opportunity for social advocacy and mobilisation in developing a policy response to shelters that addresses the current gaps and loopholes of the existing legislative and policy framework, including funding in this regard. Active engagement from civil society on the Bill is essential.

2. STANDARDISATION OF SHELTER SERVICES AND REGULATIONS

Shelter managers felt strongly that there must be standardisation of shelter services by DSD so that clients are afforded similar standards and equitable treatment regardless of where they live. This is important particularly considering the feedback from participants where some have benefited from diverse services such as parenting and skills training ini-

¹⁶ Artz, L et al, 2018

¹⁷ Martin, L. J and Artz, L., 2006

¹⁸ Artz et al., 2018; Martin, L. J and Artz, L., 2006

¹⁹ Ibid

tiatives while others have not due to limited resources and a failure by DSD to support such initiatives.

DSD minimum standards for shelters must be reviewed so that these areas are addressed. This must be done in consultation with shelters that have the practical experience with this kind of service provision and are able to advise DSD accordingly. Service levels must then be standardised across provinces, including monitoring and ensuring compliance with standards so that shelters are properly regulated and appropriately aligned with core guiding principles for quality care and services. This would also ensure consistency in service delivery.

Standardisation should also include easy fixes like intake criteria and standardised forms (e.g. intake forms). Lack of standardisation in this regard implies that shelters are not all gathering the same information which is important to further build an evolving understanding of women's needs and for reflexive policy responses.

3. INCREASE AND IMPROVE FUNDING AND CAPACITY FOR SHELTERS

Government needs to expand investment in and institutionalisation of IPV survivor services, including psychosocial care and safe sheltering facilities. While the state holds the principal responsibility for the safety of IPV survivors, the non-profit sector especially those providing sheltering have an important role to play in this regard. NPOs have deep knowledge and extensive experience of offering support and services to survivors of IPV and need to be provided with the necessary resources to sustain these efforts. The majority of shelters struggle with funding shortfalls which impede the number of residents they can admit. In addition, funding shortfalls impede many of the existing shelters from effectively providing all the services they aim to provide for residents and communities at large. Services must be based on and shaped by survivors' needs and experiences.

Increased funding for skilled human resource capacity within shelters is a definite need highlighted by this study, particularly those within semi-urban and rural areas which experience serious staffing challenges that impinge effective service delivery. This is especially relevant where counselling staff double as shelter managers, or where there is only one qualified social worker available, and no skilled staff to deal with the trauma that women's children bring with them to shelters.

While shelters are making a significant impact in victims' lives, such efforts can only be sustained if adequate resources are available. It is therefore imperative that the state address the current gaps within the shelter funding structure inclusive of doing so uniformly across all provinces.

Consideration of a Costing Framework developed for the operations of shelters as proposed by Vetten (2018)²⁰ could assist greatly in that regard. This framework is based on a determination of what is actually necessary to render shelter services, as opposed to services being driven by what funding is available. It proposes a more adequate client to staff ratio; improved subsidies towards key personnel (which also ensures that no staff member earns less than South Africa's national minimum wage of R20 p/hour); and more equitable funding distribution towards the running of the shelter and to covering direct costs related to sheltering of women and their children.

4. THE NSM AND GOVERNMENT NEEDS TO CONDUCT AN EVALUATION OF SKILLS TRAINING PROGRAMMES OFFERED BY SHELTERS

An evaluation of the skills training programmes offered by shelters is necessary to determine how well they prepare women for entering the job market. The evaluation must consider and suggest how: (1) programmes may be improved by linking to the Departments of Labour, Economic Development and Trade and Industry, Small Business as well as SETAs whose speciality this is; (2) how job placement and business bursaries where appropriate, can be utilised; and (3) how these services are to be funded and extended to all shelters as part of the core or essential services they offer survivors of IPV.

5. AN URGENT POLICY CONVERSATION IS NEEDED ON SAFE, AFFORDABLE HOUSING OPTIONS FOR SURVIVORS OF IPV AND THEIR CHILDREN

Access to safe and affordable housing alternatives remains a critical unmet need for women and is an urgent priority for all shelter residents. These alternatives should not be limited to RDP housing.

The Emergency Housing Programme (EHP) is a programme provided for in Part 3 Volume 4 of the National Housing Code (2009). The Housing Code states that the main objective of this Programme is to "provide temporary assistance in the form of secure access to land and/or basic municipal engineering services and/or shelter in a wide range of emergency situations of exceptional housing need through the allocation of grants to municipalities...The Emergency Housing Programme aims to be a responsive, flexible and rapid programme to address homelessness, hazardous living conditions, and temporary or permanent relocation of vulnerable households or communities²¹.

An analysis of the EHP and its categories of assistance conceptualises homelessness as a result of unforeseen disasters, both natural and through societal strife. Emergencies that are hazardous to health and well-being, or threatened eviction warrant temporary emergency housing measures through grants provided to a municipality. The policy, however, is silent on IPV as a category of inter-personal hazard that renders women and their

20 "What is Rightfully Due: Costing the Operations of Domestic Violence Shelters" report was prepared for the Hlanganisa Institute, HBF and NSM.

21 Housing Development Agency, 2012

children homeless, and the measures suggested such as temporary housing and assisted relocation for example, may not meet the needs of women and their children.

Whilst government's EHP does not speak to the realities of IPV, given its prevalence and devastating effects on women and their children a compelling case can be made for government housing programmes to respond to women's housing needs. In the context of domestic violence, access to housing equals safety and minimises women and children's vulnerability to a range of further negative consequences.

The long-standing priority of addressing GBV needs to be discussed in terms of government's policy obligations ranging from putting in place/and or adequately funding shelters, providing women who experience GBV (and their children) with long-term safe, subsidised housing options. The Department of Human Settlements, led by the presidency together with the shelter movement should explore options for safe tenure including subsidised public rental, second and third stage housing expansion services for survivors of IPV. The Special Needs Housing Policy drafted in 2015 must also be expedited so that shelters are able to broaden shelter/housing expansion services for survivors of IPV. This, and other potential interventions, must be factored into government's current GBV & Femicide agenda.

NPO and National Shelter Movement members who are represented on the President's GBV and Femicide interim structure must ensure that the needs of shelters and IPV survivors are strategically placed onto the agenda in order to ensure that shelter policy and funding gaps are addressed.

6. IPV AS A PUBLIC HEALTH CONCERN NEEDS TO BE PRIORITISED BY THE DEPARTMENT OF HEALTH TO MAINSTREAM UNIVERSAL SCREENING FOR GBV

Again, this is an issue that the GBV and Femicide interim structure needs to champion. IPV is not only an issue for the justice sector. Although universal screening guidelines for IPV exist, the extent of how widely this is implemented in primary and secondary health care settings is unknown. Women are more likely to present with symptoms of IPV at health settings long before seeking criminal justice solutions. More research and programmes on this area is required, suffice to say that the public health system is an important node in the continuum of holistic prevention and remedial services for IPV.

In relation to shelters, DSD funding can also be more purposefully directed towards therapeutic services, instead of social workers' time going to activities like community awareness. Bringing the health care sector into the sheltering network would be of great benefit. This could include visitations by doctors or nurses to shelters on a regular basis and/or the placement of student/intern mental health practitioners. Shelter workers (including housemothers) could also benefit

from training in relation to mental health conditions and how to best support women who present with mental health conditions including adherence to treatment.²²

7. GUN CONTROL NEEDS TO REMAIN ON THE AGENDA

South Africa has the highest reported rate, globally, of women murdered by shooting in a country not engaged in war.²³ Firearms play a significant role in VAW; they are used by perpetrators to kill, rape, threaten and intimidate. The frequency and impact of gun-related violence in the LTIS study was alarming. At least five women experienced some form of gun-related violence from an intimate partner; four were directly shot at and one case involved a child getting caught in the crossfire.

Two research studies on femicide by the Medical Research Council (MRC) first in 1999 and then later in 2009 found that women were extremely vulnerable to being killed by a variety of weapons or objects. In 1999, death by shooting resulted in the deaths of 1,147 women killed in South Africa, 692 of these homicides occurred at home. The research found a decrease in this type of homicide a decade later. Of the 462 of women killed by gunshot, 405 of those shootings were as a result of IPV.

A potential reason for the evidential drop in intimate femicide over these 10 years could be attributed to the implementation of the DVA, and in relation to gun-violence, the implementation of the Firearms Control Act (2000).

However, although the overall homicide data suggest that death by shooting is decreasing, data for IPV is not readily available so there is no certainty that this remains the case today. Gun control in respects to IPV should remain high on the legislative agenda.

It is also vitally important that victims of domestic abuse are made aware that the DVA grants magistrates the right to have firearms or any dangerous weapon removed from a perpetrator of abuse, whether the perpetrator owns the weapon or simply has access to it. The DVA also grants the courts the power to declare a gun-owner unfit to own a gun if said person has been convicted of any offence involving physical or sexual abuse occurring in a domestic relationship as defined in the DVA.

8. COORDINATED, INTEGRATED SERVICES BETWEEN RELEVANT GOVERNMENT DEPARTMENTS FOR COMPREHENSIVE SERVICE PROVISION

Government Departments like Police, Justice, Health, Human Settlements, Social Development, Labour, Economic Development and Trade and Industry and Basic Education etc. need to coordinate with DSD and NPO shelter service providers to provide a network of services to women to meet the range and complexity of their needs. This will promote the continuation in services for women (and their children) who leave crisis or medium-term shelters and minimize women and children falling through service provision gaps.

²² Vetten and Lopes, 2018

²³ Abrahams, et al. 2010



REFERENCES

- Abrahams, N., Mathews, S., Jewkes, R. (2010). Guns and gender-based violence in South Africa. *South African Medical Journal*; On-line version ISSN 2078-5135
- Artz L, Meer T, Aschman G. Legal duties, professional obligations or notional guidelines? Screening, treatment and referral of domestic violence cases in primary health care settings in South Africa. *Afr J Prm Health Care Fam Med*. 2018;10(1), a1724. <https://doi.org/10.4102/phcfm.v10i1.1724>
- Bhana K, Vetten L, Makhunga L and Massawe D. (2012). Shelters housing women who have experienced abuse: policy, funding and practice. Johannesburg: Tshwaranang Legal Advocacy Centre.
- Bhana, K., Lopes, C., & Massawe, D. (2013). Shelters housing women who have experienced abuse: Policy, funding and practice—profiling three shelters in the Western Cape. Heinrich Böll Foundation, Cape Town.
- Gender Links & The Medical Research Council (2010). The war@home: Findings of the Gender Based Violence Prevalence Study in Gauteng, Western Cape, KwaZulu Natal and Limpopo Provinces of South Africa
- Housing Development Agency (2012). Guidelines for the implementation of the Emergency Housing Programme
- Lopes, C. (2016). Intimate partner violence: A helpful guide to legal and psychosocial support services. *SAMJ*, October 2016, Vol. 106, No. 10, Pgs. 966-968. <http://www.samj.org.za/index.php/samj/article/view/11409>
- Lopes, C., and Mpani, P. (2017a). Shelters Housing Women Who Have Experienced Abuse: Policy, Funding and Practice, Profiling Shelters in Mpumalanga. Cape Town: Heinrich Böll Foundation. <https://za.boell.org/en/2018/02/14/housing-women-who-have-experienced-abuse-policy-funding-and-practice-mpumalanga>
- Lopes, C. and Mpani, P. (2017b). Shelters housing women who have experienced abuse: policy, funding and practice. Profiling shelters in KwaZulu-Natal. Cape Town: Heinrich Böll Foundation. <https://za.boell.org/en/2018/02/14/housing-women-who-have-experienced-abuse-policy-funding-and-practice-kwazulu-natal>
- Lynch, S. M., & Graham-Bermann, S. A. (2004). Exploring the relationship between positive work experiences and women's sense of self in the context of partner abuse. *Psychology of Women Quarterly*, 28(2), 159-167.
- Makhubu Ntando, Gender-based violence costs SA R42 billion a year, 25 November 2016
- Maluleke, R (2018) Crimes against women in South Africa. Statistics South Africa
- Martin, L. and Artz, L. (2006). The health care practitioner's role in the management of violence against women in South Africa. *CME February 2006 vol.24 no.2*
- Office on Women's Health. Effects of domestic violence on children. US Department of Health and Human Services; <https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children>
- Safer Spaces. Gun violence and prevention in South Africa. <https://www.saferspaces.org.za/understand/entry/gun-violence>
- Stone K, Watson J and Thorpe J (2013) Proposal for Reform: Combatting Domestic Violence Against Women and Children in the Western Cape by Increasing Access to Shelters and Improving the Quality of Services. Cape Town: Commission for Gender Equality.
- Stylianou, A.M, and McGinnis K. (2017) Beyond Shelter: A Longitudinal Needs Assessment of Domestic Violence Survivors (the Lang report.) Roberts, L and Pacheco, B. (eds), Safe Horizons. Retrieved 1/6/2018 www.safehorizon.org
- Sullivan, CM. (2012). "Domestic Violence Shelter Services: A Review of the Empirical Evidence". National Resource Centre for Domestic Violence: Harrisburg, PA. Retrieved 1/6/ 2018 <http://www.dvevidenceproject.org>
- Vetten, L. (2018). What is rightly due: costing the operations of domestic violence shelters. Hlanganisa Institute for Development South Africa (HiDSA). <https://za.boell.org/en/2018/10/30/what-rightfully-due-costing-operations-domestic-violence-shelters>
- Vetten, L and Lopes, C. (2018). Out of Harm's Way: Women's Shelters in the Eastern and Northern Cape. Cape Town: Heinrich Böll Foundation. <http://za.boell.org/2019/05/30/out-harms-way-womens-shelters-eastern-and-northern-cape>

Watson, J. and Lopes, C. (2017). Policy Brief: Shelter Services to Domestic Violence Victims- Policy Approaches to Strengthening State Responses. Cape Town: Heinrich Böll Foundation.
<https://za.boell.org/en/2017/11/13/shelter-services-domestic-violence-victims-policy-approaches-strengthening-state>

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HEINRICH BÖLL STIFTUNG SOUTHERN AFRICA

8th Floor Vunani Chambers,
33 Church Street
Cape Town 8000,
South Africa
Tel: +27 (0) 21 461 6266
Fax: +27 (0) 21 462 7187
www.za.boell.org

NATIONAL SHELTER MOVEMENT OF SOUTH AFRICA

19 Link Street, Extension 1, Lenasia
Johannesburg, 2000
South Africa
Tel: +27(0)11 854 5804 / 5
www.nsmsa.org.za

