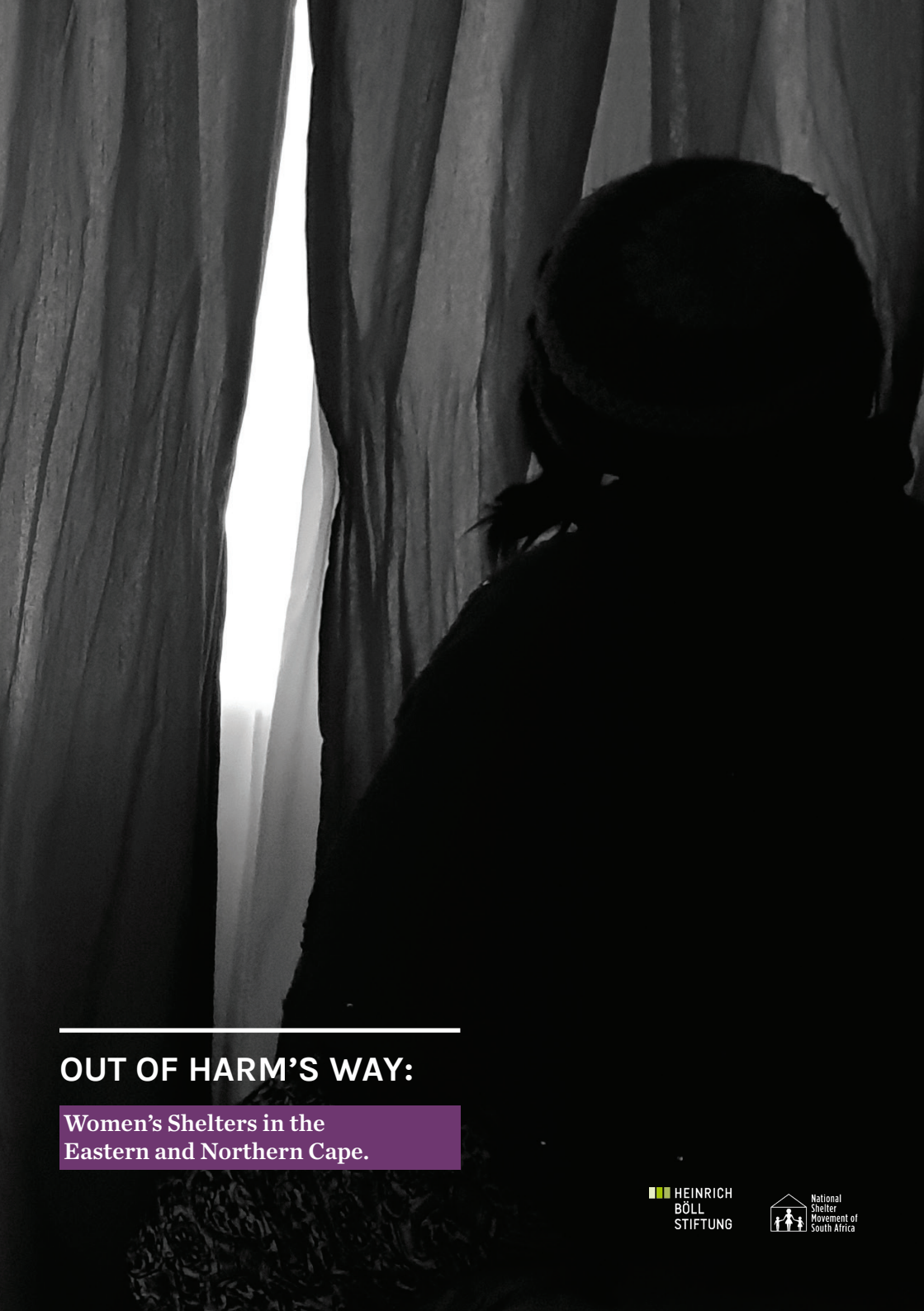

OUT OF HARM'S WAY:

Women's Shelters in the Eastern and Northern Cape.

HEINRICH BÖLL STIFTUNG

National Shelter Movement of South Africa

OUT OF HARM'S WAY: WOMEN'S SHELTERS IN THE EASTERN AND NORTHERN CAPE

The National Shelter Movement of South Africa and the Heinrich Boell Foundation

This publication is the last of a series of provincial shadow reports that the Heinrich Böll Foundation and the National Shelter Movement of South Africa have produced in relation to their 'Enhancing State Responsiveness to Gender Based Violence: Paying the True Costs' project.

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ACRONYMS

DSD	Department of Social Development
IPV	Intimate Partner Violence
NSM	National Shelter Movement
NPO	Non-Profit Organisation
POWA	People Opposing Women Abuse
PTSD	Post-Traumatic Stress Disorder
PES	Provincial Equitable Share
SLA	Service Level Agreements
SADHS	South African Demographic and Health Survey
SASHS	South African Stress and Health survey
VEP	Victim Empowerment Program

OVERVIEW OF REPORT

This research report focuses on women's use of six shelters distributed between the Eastern Cape and Northern Cape and is based on a review of 310 client case files opened by the shelters between 1 April 2015 to 31 March 2018. Its objectives are threefold:

- detailing the budget allocated at provincial level to shelter services, as well as how this translates into allocations to individual shelters;
- describing all women who turn to shelters for assistance, regardless of their reason for doing so; and
- reviewing the effects of intimate partner violence (IPV) on women's mental health while also documenting the mental health needs of all women in shelters.

Different readers may be more interested in some parts of the report than others. To point them in the direction of their interests we provide a brief summary of the key findings for each objective and highlight the relevant reading sections.

I. BUDGETING FOR SHELTERS IN THE EASTERN AND NORTHERN CAPE (PAGES 15 TO 29)

Analysis of government expenditure on violence against women shows care and support programmes to receive less funding than prevention and immediate response services (referring to policing, the courts and health services). This deprioritisation is very evident in the Department of Social Development's budget. Overall, victim empowerment receives just 3% of the budget for social welfare services – the second-least allocation. In the two provinces studied the victim empowerment budgets are also clustered at the lower end of expenditure. Analysis of expenditure in these two provinces also reveals a declining share of the budget being transferred to non-profit organisations generally, as well as shelter programmes specifically. As a result, certain shelter employees receive subsidies below the minimum wage that came into effect on 1 January 2019. Their ability to offer comprehensive services is also limited. Onerous and inefficient fund-

ing procedures further got in the way of organisations' ability to offer their services.

II. WHO THE WOMEN ARE WHO TURN TO SHELTERS AND WHY THEY DO SO (PAGES 34 TO 54)

This study is the first to document the effects of the Department of Social Development's 2001 decision to transform domestic violence shelters into shelters for all victims of crime and violence. Although women accessed shelters for a variety of reasons, including homelessness and their involvement in sex work, the study finds that violence was certainly, at some point or another, interwoven into the fabric of most of their lives. The section also shows how, in key respects, the various groups of women are more alike than different in the disadvantages they face. In addition to providing contextual information as to why women accessed shelters, this section also traces the various roles shelters play in their lives, as well as how government departments utilise their services.

The report also points to the unexpected use of shelters as places of safety for children and their adult care-givers.

III. THE MENTAL HEALTH NEEDS OF WOMEN IN SHELTERS (PAGES 10 TO 12 AND 47 TO 55)

South African research finds relationships between IPV and different forms of psychological distress. In addition, all the factors thought to contribute to women's higher rates of anxiety and mood disorders generally – violence, HIV, poverty and the peri-natal period – have also been identified in women who turn to shelters. We estimated that 21% of our sample had experienced a neuropsychiatric disorder in the past year – which is higher than the 16.5% last year prevalence reported in the only national survey of South Africans' mental health to date. Access to psychiatric and psychological services is thus key. However, because mental health is largely the competence of the Department of Health, it has not been well-addressed in shelter policy, which is the responsibility of the Department of Social Development. Our findings also show that by the time women arrive at shelters some of them will already have been in contact with the mental health system for help with different forms of psychological distress, including bipolar disorder, depression and suicidality, post-traumatic stress disorder and anxiety. This strongly implies that shelters have become part of revolving door patterns of care. Our recommendations propose ways in which the work of shelters could be integrated into the ***National Mental Health Policy Framework and Strategic Plan 2013-2020.***

1. INTRODUCTION

The National Shelter Movement (NSM) and the Heinrich Boell Foundation have completed four studies describing the provision of shelter to women escaping intimate partner violence (IPV) through two multi-year projects supported by the European Union. Combined, these studies have focused on the provinces of Gauteng (Bhana et al, 2012), Western Cape (Bhana et al, 2013), Mpumalanga (Lopes and Mpani, 2017a) and KwaZulu-Natal (Lopes and Mpani, 2017b) (subsequently summarised in Vetten, 2018). This report, the fifth in this particular series, takes an in-depth look at six shelters distributed between the Eastern Cape, the poorest province in the country, and the Northern Cape, the least populous province in the country. Like the previous studies it scrutinises the budgets allocated at provincial level to shelter services, as well as what is then made available to individual shelters. However, it also goes beyond the previous studies to focus not only on women who have experienced IPV, but on all women who turn to shelters, regardless of reason; and pays particular attention to the mental health services required by women in shelters. These additional emphases are important from a policy perspective.

In 2001 when the Department of Social Development (DSD) issued its ***Minimum Standards on Shelters for Abused Women*** it stated that a shelter "must be generic in its approach and should accommodate all types of victims" (DSD 2001: 6). Today the effects of this decision are clear: women experiencing intimate partner violence (IPV) currently comprise approximately half of all shelter residents (Vetten, 2018). Yet there has been no attempt to date to explore which other groups of women are turning to shelters, what their needs are and how these may differ (if at all) from women who have experienced IPV. This presents something of a paradox in policy terms: on the one hand shelters are expected to be accessible to all while, on the other, service standards are clearly oriented towards women experiencing IPV (see DSD, 2004). Further, as the four previ-

ous studies showed, mental health has not been given sufficient attention by shelter policy either. By making both the 'other' women visible and foregrounding mental health needs this report seeks to contribute towards the development of comprehensive, appropriate policies and budgets for shelters.

The report begins with a brief summary of what is known about IPV and mental health in South Africa. From the neglect and under-funding of mental health services that concludes this section, the report turns to the funding of shelters by Eastern and Northern Cape offices of the DSD. How these provincial funding processes and practices translate at the level of individual shelters follows next and introduces the findings from the case files. We texture and nuance this section by tracing how violence and psychological distress become entangled within women's lives. This section underscores the significance of the reparative dimensions of shelters' work with women, as well as the recommendations which conclude the report.

1.1 METHODS

We consulted the contacts database of the NSM and the directory of shelters compiled by the DSD, as well as the directory produced by the Department of Justice and Constitutional Development to identify all shelters in the two provinces. This produced a list of 24 shelters in the Eastern Cape and four in the Northern Cape. Seventeen shelters were then excluded from the Eastern Cape sample on the following grounds: 10 were able to accommodate a small number of women and children (six or fewer people) and for a short period of time only (three days or less); five were no longer operating as shelters but as victim empowerment centres; and two accommodated homeless persons only. The remaining seven shelters were then approached by the NSM provincial representative to participate in the study. One declined while a second agreed but could not accommodate the field workers during the study period and thus had to be excluded. The Eastern Cape sample thus comprised five shelters. While this represents the majority of larger and longer stay shelters in the province, the findings cannot be generalised to the smaller, short-term shelters.

Of the four shelters identified in the Northern Cape two were run by non-profit organisations (NPO) and the other two by the provincial government. However, only one shelter agreed to participate in the research.

The final six study sites served both urban and rural populations and were largely established services, having been in existence between 13 and 60 years. Even

though two of the shelters were opened as recently as 2015 the organisations they form part of were established more than 10 years ago. Only one shelter is a stand-alone service dedicated solely to accommodating women; the remaining five provide a range of additional services and programmes to women (and sometimes children too).

STUDY DATA COLLECTION

To allow for comparability this study utilised the same methodology employed by the previous four but adapted the data tool to include all women's circumstances, rather than IPV only. Information for the three-year period 1 April 2015/16 to 31 March 2017/18 was drawn from shelters' attendance registers and client case files according to a pre-coded questionnaire comprising both open and closed-ended questions. At some sites the shelter social worker was present to assist the field workers with additional information on women's stays that may not have been contained in the case files. No names, contact details or other information with the potential to identify women was documented. To further preserve anonymity, none of the shelters has been identified in the report. All names used in the report are pseudonyms.

Field work took place between May and June of 2018, with data collection revealing both repeat as well as cross-stays. For the 17 women found to have stayed at the same shelter at least once before only information about the most recent stay was captured. Three cases of women staying at more than one shelter were also identified. To prevent double counting of women all three cases were included when analysing shelter stays but previous stays excluded when reporting on women's demographic details. We also excluded the case where a woman was brought to the shelter but then refused entry when drugs were found in her possession.

Reviewing case files also revealed the use of shelters as places of safety for children and the family member accompanying them. Two of these 37 cases were included in the analysis because the 16 and 17-year old girls concerned stayed at the shelter as a result of IPV and were not accompanied by adults, while the remaining 35 were excluded. Although not part of the body of the analysis, these are briefly discussed for the insight they provide into the place of shelters in South Africa's social welfare and mental health services landscape.

These decisions produced a final sample of 307 women and 310 stays, with 46 women drawn from the Northern Cape and 261 from the Eastern Cape shelters. The data schedules were then captured in Excel and analysed in SPSS.

In addition to the file reviews, interviews were conducted with staff at each shelter, typically the person most directly involved in its day-to-day running (usually a shelter manager or director) but sometimes also the social worker. On one occasion the finance manager was also interviewed. Questions focused on a brief history of the

shelter, its funding and staffing, and services and programmes. This information was then situated within an analysis of the budget and expenditure of the relevant provincial office of the DSD. Except where noted otherwise, all data are derived from the annual reports of the Eastern Cape DSD and the Northern Cape DSD. The annual reports are based on the fiscal year (1 April to 31 March), but the data shown here are represented as the calendar year making up the bulk of the fiscal year at issue, e.g., 2016 data are taken from the 2016-2017 annual report.

The findings are limited by the varying quality and scope of organisations' records which impacted upon the completeness of information. In addition, while the researchers anticipated stays of around one month or more (the pattern in most of the prior provincial studies), this was not the case in practice. Most women stayed but a short period of time, limiting the amount of information that could be gathered by the shelter's staff – as well as the nature and extent of shelters' services. The data, as a whole, are also skewed towards the Eastern Cape which contributed 85% of records in comparison to the 15% provided by the Northern Cape. Being reflective of one shelter only the Northern Cape data cannot be treated as representative of the entire province, any more than it can be neatly compared with the Eastern Cape data. The analysis of records is thus largely at the level of the shelter or the presenting problem, rather than the province.

2. INTIMATE PARTNER VIOLENCE AND MENTAL HEALTH

Neuropsychiatric disorders make the third-largest contribution to South Africa's overall burden of disease after HIV and other infectious diseases (Department of Health, n.d.). Yet information regarding their prevalence is dated and mental health services under-funded. Now more than 14 years old the South African Stress and Health (SASH) survey is still the only source of national data on mental health in the country. This found a lifetime prevalence of 30.3% for any mental disorder – but with both the Eastern and Northern Cape demonstrating lower rates than this average (25.7% and 28.7% respectively) (Herman et al., 2009). The 12-month prevalence for any disorder was 16.5%, with men dominating in the category of substance use disorders and women reporting higher rates of mood and anxiety disorders that were also categorised as more severe *(ibid)*. The predominance of women in the latter two categories has been attributed their higher rates of poverty, HIV, violence and motherhood – the peri-natal period in particular (Moultrie and Kleintjes, 2006). While each of these life circumstances can be experienced independently of each other, IPV ties them together in challenging ways.

IPV AND ITS ASSOCIATION WITH PSYCHOLOGICAL DISTRESS

International data finds a host of adverse mental health outcomes associated with IPV. These include suicide attempts (Devries et al, 2013), mood and anxiety disorders and psychoses (Trevillion et al, 2012), as well as perinatal depression (Howard et al, 2013). With IPV the form of violence most frequently experienced by South African women (Kaminer et al., 2008), it is important to determine how comparable these findings are locally.

IPV certainly does contribute to anxiety disorders in South African women – post-traumatic stress disorder (PTSD) specifically. While the SASH survey found rape to have the strongest association with PTSD, IPV, because of its frequency, was associated with the greatest number of PTSD cases amongst women at population level (Kaminer et al, 2008). In a Gauteng survey PTSD was reported by 15.4% of women who had experienced sexual or physical IPV (Machisa et al, 2010), with 34.2% of women reporting high levels of depressive symptoms. Approximately 10.1% had attempted suicide while 10.8% had suicidal thoughts in the month preceding the survey *(ibid)*.

Substance use may also be elevated among women who have experienced IPV. SASH data indicated that abused women were 1.7 times more likely to report ever smoking and 1.9 times more likely to report current smoking. They were nearly twice as likely to report ever drinking and 2.4 times more likely to report regular drinking and non-medical use of sedatives. Lifetime and past-year non-medical use of analgesics was almost double for abused women and use of cannabis (or *dagga*) ever 3.8 times more likely than non-abused women (Gass et al, 2010).

The SASH study also found in relation to the population generally that limited levels of education were predictive of mood disorders like major depression and dysthymia (or mild persistent depression) (Seedat et al., 2009). Nationally, 27.4% of the population is in possession of a matric certificate (Eastern Cape Department of Economic Development, Environmental Affairs and Tourism, 2017: 43). Because almost-equivalent percentages of women and men complete their secondary schooling (50.9% of women vs 49.1% men [Statistics South Africa, 2016b: 16]), this percentage can be compared with the percentage of abused women who have matriculated. According to the South African Demographic and Health Survey (SADHS) survey 17.3% of abused women in their sample had completed matric (Statistics South Africa, 2016a).

TABLE 1: EXPERIENCES OF IPV BY SELECTED SOCIO-ECONOMIC INDICATORS

	WOMEN EVER EXPERIENCING PHYSICAL VIOLENCE (%)	WOMEN EXPERIENCING VIOLENCE IN LAST 12 MONTHS	
		OFTEN (%)	SOMETIMES (%)
Employed	22.4	1.7	5.6
Unemployed	19.2	1.6	6.2
No education	21.4	1.7	2.7
Incomplete primary	23.8	1.6	6.5
Completed primary	30.7	2.7	8.9
Incomplete secondary	23.0	1.7	7.8
Completed secondary	17.3	1.8	5.5
More than secondary	12.4	0.7	1.6
Lowest wealth quintile	26.4	3.2	10.1
Second quintile	21.2	1.3	6.1
Middle quintile	21.1	1.5	6.2
Fourth quintile	21.4	1.2	5.4
Highest quintile	13.0	1.0	2.2

(Source: Statistics South Africa 2016a: 55)

The SADHS data report a slightly higher rate of IPV for employed, rather than unemployed, women except for the category of women sometimes abused in the last 12 months (Statistics South Africa, 2017). This is in contrast to women in shelters who report a far greater degree of economic disadvantage.

WOMEN, SHELTERS AND THE POLITICS OF MENTAL HEALTH

The summary of the four shelter studies found almost two-thirds (64%) of women to be unemployed, 51% to have no access to any sort of income (including grants) and 16% to be in possession of a matric certificate (Vetten, 2018). Approximately 13% of women in the Western Cape were HIV-positive but up to one in three women in Gauteng shelters. Although many shelters excluded women with substance abuse problems (unless they were already in treatment), 17% of women in the Western Cape were reported as having difficulties with substance abuse, dropping to 7% of women in Gauteng and just one woman in KwaZulu-Natal[1] (ibid). Varying percentages of women were also pregnant or had children under the age of one year. In KwaZulu-Natal 6% of women were pregnant at the time of their stay in the shelter, with the percentage of pregnant women rising to 13% in the Western Cape and 18% in Gauteng. Overall, 4% of all children in shelters were under one year (ibid). Mental health concerns featured consistently and more frequently than most other health needs. Depression, anxiety and suicidal ideation affected 20% of Gauteng shelter residents, 23% of women in Mpumalanga, 24% of KwaZulu-Natal women and almost one-third (32%) of women in the three Western Cape shelters (ibid).

Thus all the factors posited as worsening mental health – HIV, violence, poverty and the peri-natal period – are present (if not concentrated) in women in shelters. Yet attention to women's mental health has not been a prominent feature of shelter policy and practice. While this is likely reflective of the low priority generally accorded mental health, other factors have also complicated attention to the relationship between IPV and mental health.

Historically, family preservation was the chief aim of social workers[2], with clinical interventions largely drawing on theories of individual pathology that located IPV within abused women's assumed personality disorders, which ranged from being 'masochistic' and 'passive-dependent', to 'paranoid' or 'borderline.' This emphasis effectively denied the socio-political dimensions of such violence and severely circumscribed the scope and nature of assistance offered abused women (Segel and Labe, 1990). The emergence of organisations like People Opposing Women Abuse (POWA), which also opened the first domestic violence shelter in the country in 1984, mounted a challenge to such indi-

1 *Substance abuse was not reported in Mpumalanga.*

2 *As it is once more, following the DSD's 2012 White Paper on Families.*

vidualised explanations. The feminist analysis they adopted provided a crucial social and political framework for understanding IPV that located its occurrence in women's legal, political and economic subordination to men, rather than their supposed personality defects. Nonetheless, these socio-political conditions do not exist in the abstract but are lived out at the level of individual lives where they may cause real hardship. The psychological dimensions of IPV thus cannot be ignored – nor need they be addressed in ways that pathologise women.

Further relegating the psychological dimensions of IPV to the background is the way services to women are funded. Mental health is chiefly the responsibility of the Department of Health, while victim empowerment is the mandate of the DSD (although both dabble in the other's territory).[3] Because most shelters managed by NPOs are subsidised by the DSD they will be providing victim empowerment, rather than mental health, services. This division also determines the nature of the professional posts subsidised by the DSD – almost always those trained as social and social auxiliary workers. The funding of psychologists' positions falls to the Department of Health which, to date, has played no real role in supporting shelter services.

At some point in the early to mid-2000s the National Directorate of Mental Health in the Department of Health did moot the development of a women's mental health policy – but this was subsequently shelved due to capacity constraints (Lund et al., 2008). When the South African country report for the Poverty and Mental Health Project was issued in 2008 the approach had changed from a stand-alone women's policy to one recommending the mainstreaming of gender into the development and implementation of mental health policy. Two of the three areas highlighted by the report in relation to gender concerns were particularly relevant to IPV: responding to the mental health implications of violence towards women; and recognising the economic, social and emotional impact upon women of being the chief providers of community-based care and ensuring they received appropriate support to do so[4] (ibid: 86).

When South Africa's first mental health policy finally appeared, the *National Mental Health Policy Framework and Strategic Plan 2013-2020* ("the Framework"), one of its stated principles was gender sensitivity, or attentiveness to the gendered nature of women and men, girls' and boys' experience and needs. 'Special populations' were also identified as a key area for action:

Certain vulnerable groups will be targeted for specific mental health needs. These include women, children, adolescents, the elderly, and those living with HIV and AIDS (Department of Health n.d.: 28).

3 *See the Comprehensive Report on the Review of the White Paper for Social Welfare, 1997 (DSD, 2016), especially the discussion on pages 134 – 138.*

4 *The third guideline was concerned with the use of same and mixed-sex mental health facilities.*

The Framework also made a number of recommendations aimed at encouraging and supporting collaboration between the Department of Health and DSD to ensure that the links between poverty and mental health featured on the policy agenda and were integrated into all policies and programmes aimed at poverty alleviation and community upliftment. These various initiatives were also to address the social determinants of mental illness by improving daily living conditions and reducing inequalities (Department of Health n.d: 27). The Framework also foresaw an important role for NPOs in providing health education and information on mental health and substance abuse (Department of Health n.d: 33).

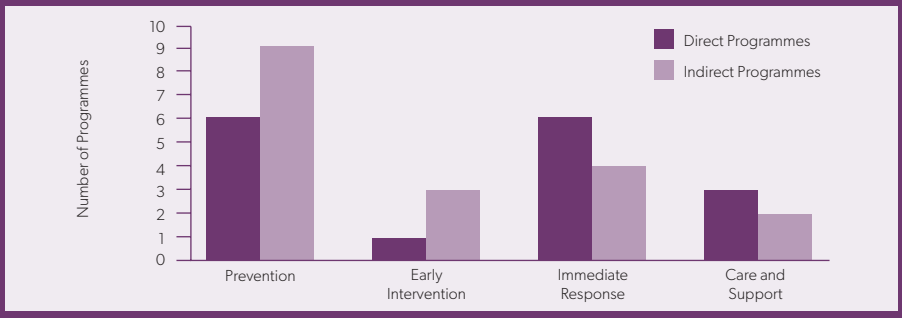
The Framework thus provided most of the foundational materials required to craft a solid approach to abused women's mental health needs. The Framework does not however, appear to have been implemented and there is certainly no evidence of formal collaboration between the two departments around violence against women and its relation to mental health. Indeed, the last policy to deal substantively with shelters, was the 2004 *Minimum Standards for Service Delivery in Victim Empowerment (Victims of Crime and Violence)* (DSD, 2004) – issued almost a decade before the Framework.

Instead, women who have experienced abuse must, for the most part, turn to what mental health services are available generally. And these are limited. According to the Framework the human resources available to mental health work in the Department of Health and NPOs totals 9.3 per 100 000 (Department of Health n.d.: 16). A paper published in 2010 (Lund, 2010) found the Northern Cape to have just six out-patient clinics addressing mental health needs – versus 700 in the Eastern Cape, the highest number in the country. The Northern Cape had neither mental health out-patient clinics for children or adolescents, nor day treatment centres or psychiatric in-patient units. It had just one mental hospital. The Eastern Cape, by contrast, had five mental health hospitals, 10 community residential facilities, four psychiatric in-patient units and one day treatment centre *(ibid*). Impressive as this may seem in comparison to the Northern Cape, the province's mental health facilities appear to be in a state of neglect and disrepair, as well as seriously understaffed (Special Programmes, 22 May 2018; Office of the Health Ombud, 2018).

3. SHELTERS AND SPENDING ON THE VICTIM EMPOWERMENT PROGRAMME

It is not just mental health services that are underfunded; so are services intended to provide care and support to women and children who experience violence. Figure 1, taken from a 2016 diagnostic review of government departments' responses to violence against women shows 'care and support' to receive half of what of 'prevention' and 'immediate response' (referring to policing, health and court services) receives (KPMG, 2016). Of course, this division of funds would be acceptable if the number of women and children experiencing violence and abuse were low. But it is not[5], raising questions about the efficacy both of these prevention programmes, as well as the seriousness with which violence's consequences are viewed (the prior discussion on mental health and IPV being but one example of these consequences).

FIGURE 1: SPREAD OF PROGRAMMES ACROSS THE CONTINUUM OF CARE



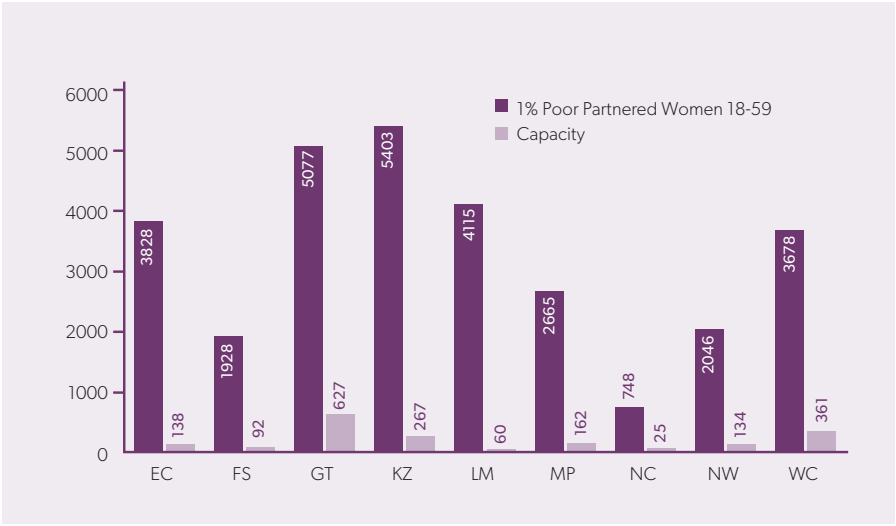
(Source: KPMG 2016: 149)

5 *See Abrahams et al., 2013; Statistics South Africa, 2018 (although it should be noted that the data pertaining to femicide specifically has been withdrawn - see Africa Check, 20 August 2018); and South African Police Service, 11 September 2018.*

ESTIMATING THE NEED FOR SHELTER

The under-resourcing of care and support not only limits existing services but constrains the expansion of shelter services. Indeed, until very recently no basis for estimating need had been offered by the DSD. The 2016 ***Review of the White Paper for Social Welfare*** (DSD, 2016) proposed 1% of poor women aged 18 to 59 years who were either married or cohabiting as the proxy for need and compared the current capacity of domestic violence shelters (as reflected on DSD's infrastructure database) with the need for this service. Figure 2 illustrates the significant gap between the current situation and the projected need (DSD 2016: 176). Gauteng was calculated as meeting 12.3% of the estimated need and the Western Cape 9.8%. The Northern Cape was able to house 25 (or 3%) of the 748 women estimated to need shelter and the Eastern Cape 138 (or 4%) of 3 828 women estimated as requiring accommodation.

FIGURE 2: COMPARISON OF NEED AND CAPACITY – SHELTERS FOR ABUSED WOMEN



(Source: Department of Social Development 2016: 176)

An estimate of need should also be informed by the prevalence of IPV, with the 2016 SADHS providing the most recent, national data in this regard.

According to the SADHS one in five (21%) ever-partnered women had experienced physical violence, and 6% sexual violence, at the hands of an intimate partner.

The proportion of women ever experiencing IPV also varied across provinces with KwaZulu-Natal, at 13.7%, reporting the lowest rate. Women in the Eastern Cape, by contrast, reported the highest proportion of lifetime experiences of physical violence (31.6%) and women in the Northern Cape the fourth-lowest percentage (18.7%) (Statistics South Africa 2016: 55). In contrast to its rates of physical violence, Eastern Cape reported the fifth-lowest rate of sexual violence (6.7%) and Northern Cape the third-lowest (4.5%). In the Eastern Cape 2.3% of women reported 'often' experiencing physical violence in the 12 months preceding the survey, while 2.2% reported this in the Northern Cape.

Using these percentages rather than the 1% favoured by the Review produces different estimates of need.

If the SADHS 12-month figures for the Eastern Cape are applied then the number of women experiencing IPV in the province in 2016 would have been **48 283**, with violence occurring "often" for **8 804** women – more than double the 3 828 calculated by the Review. In the Northern Cape the number of women subjected to IPV in the previous 12 months may be calculated as **3 815**, with **1 646** experiencing violence 'often' – again, more than double the 748 calculated by the Review. In both provinces it is likely that some of these women would be able to find sheltering with family or friends, or have the resources to rent alternative accommodation, so the numbers calculated on the basis of the SADHS are likely too high to equate with actual need. But regardless of which estimate is used there do not seem to be an adequate number of shelters nationally. And if we take into account that shelters are intended to house all victims of crime and violence, not just women experiencing IPV, then these estimates are likely to be even more inadequate.

3.1 BUDGETING FOR THE VICTIM EMPOWERMENT PROGRAMME

Funding towards social welfare services such as shelters is distributed to the provinces via the Provincial Equitable Share (PES). The amounts allocated to each province are not identical but differentiated in accordance with a particular formula. While the extent of poverty in each province is taken into account when determining the quantum, population size is ultimately more decisive. Thus, due to the high degree of migration out of the province, the Eastern Cape does not receive the largest portion of the PES despite being the poorest province in the country. The Northern Cape receives the smallest portion of the PES as it is home to just 2.1% of the country's population.

But even if it receives the least, the Northern Cape DSD makes the highest per capita allocation towards welfare services for the poorest 40% of its population than the other provinces (Budlender and Francis 2014: 12-13). The Northern Cape spends R1 009 per person in this category per year, as opposed to the R299 spent per year by the least generous province, KwaZulu-Natal. The Eastern Cape had the fourth-lowest allocation – R452 per year – which was also below the national average of R463 per year *(ibid)*. The range in these amounts points to how provincial political priorities, along with the PES formula, also shape how the budget is distributed.

The provincial budgets for social welfare services are divided between a set of core services areas. Table 2, taken from an August 2018 presentation to parliament's Portfolio Committee on Social Development demonstrates how the combined national and provincial budget for social welfare services is broken down. At 3%, the allocation to the Victim Empowerment Programme (VEP) (focused on providing a range of services to people affected by crime and violence) is very small, with only the social relief of distress, at 1%, receiving less. Just as Figure 1 represented how care and support received half of the budget allocated to prevention, so this table enumerates how victim empowerment receives less than half of the budget allocated to crime prevention and support, which is focused on diversion programmes for children and adults in conflict with the law, as well as the implementation of the department's social crime prevention strategy. Indeed, by 2019/20 crime prevention and support is slated to receive three times the budget to victim empowerment. The budget for victim empowerment also grows very little over this period which, at 2.7%, is well below inflation. Again, at 2.3%, only social relief of distress shows lower growth.

Figures 3 and 4, derived from the same parliamentary presentation, set out how the social welfare services budget is distributed between programmes by the Eastern and Northern Cape DSD respectively. The VEP's location among the programmes receiving the least portion of the budget is again apparent. Eastern Cape allocates 4% of its budget to VEP, and the Northern Cape 2%.

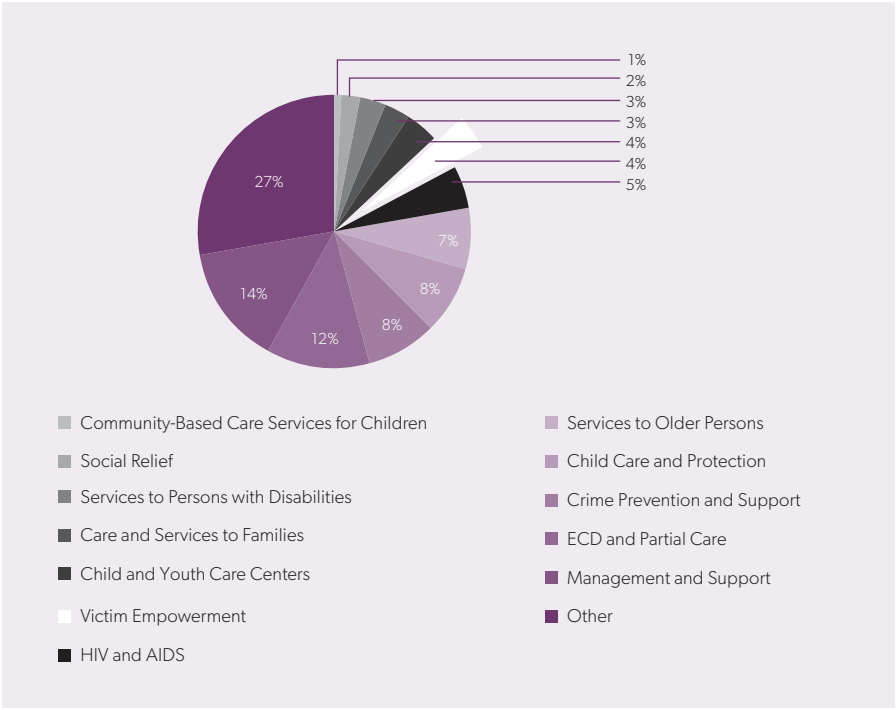
TABLE 2: NATIONAL AND PROVINCIAL BUDGET ALLOCATIONS TO SOCIAL WELFARE SERVICES FOR THE PERIOD 2017/18 TO 2019/20

SUB-PROGRAMME	2017/18 BUDGET	%	2018/19 MTEF	%	2019/20 MTEF	%	% INCREASE
Care and services to families	499 782	4%	530 644	4%	560 343	4%	7.3%
Child and Youth care centres	1 176 559	9%	1 813 897	13%	1 951 290	14%	5.5%
Child care and protection	1 813 897	14%	1 951 290	14%	1 300 736	14%	5.3%
Community-based Care services for children	770 738	6%	815 444	6%	865 466	6%	5.3%
ECD and partial care	2 711 571	22%	2 908 973	21%	3 030 922	22%	8.3%
Crime prevention and support	1 066 885	8%	1 126 772	8%	1 194 379	9%	4.2%
Substance abuse, prevention and rehabilitation	874 251	7%	1 020 279	7%	1095473	8%	11.8%
Victim empowerment	387 775	3%	410 837	3%	443 142	3%	2.7%
Services to old-er persons	1 312 934	10%	1 382 981	10%	1458857	10%	5.7%
HIV and AIDS	1 109 195	9%	1 102 226	8%	1 165 961	8%	10.1%
Services to persons with disabilities	777 103	6%	810 664	6%	851 859	6%	4.5%
Social relief of distress	98 107	1%	99 834	1%	105 229	1%	2.3%
	12 598 797		13 973 841		14 023 657		

(Source: DSD, 22 August 2018)

"At 3%, the allocation to the Victim Empowerment Programme is very small, with only the social relief of distress, at 1%, receiving less...The budget for victim empowerment also grows very little over this period which, at 2.7%, is well below inflation."

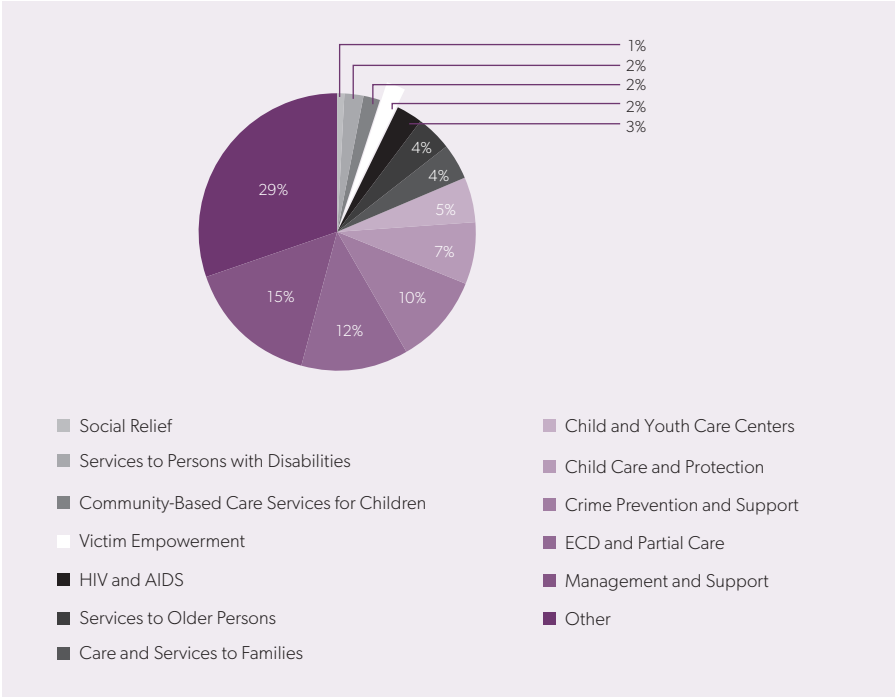
FIGURE 3: EASTERN CAPE PERCENTAGE SHARES OF TOTAL ALLOCATION



(Source: DSD presentation, 22 August 2018)

"Figures 3 and 4 set out how the social welfare services budget is distributed between programmes by the Eastern and Northern Cape DSD respectively. The VEP's location among the programmes receiving the least portion of the budget is again apparent. Eastern Cape allocates 4% of its budget to VEP, and the Northern Cape 2%."

FIGURE 4: NORTHERN CAPE PERCENTAGE SHARES OF TOTAL ALLOCATION



(Source: DSD presentation, 22 August 2018)

THE EASTERN CAPE VEP BUDGET

The VEP budget supports a range of different activities and services, in addition to the provision of shelters. Forms of shelter include White and Green Doors, crisis centres, one stop centres (or Khuseleka Centres) and shelters. A portion of the budget will be transferred to NPOs to subsidise the sheltering services they provide but some of it will also be retained to finance the DSD's staff and services. Figure 5 shows the total amounts budgeted and spent by the Eastern Cape DSD on the VEP from 2007 to 2016. Within all years shown, the total amounts budgeted and spent were nearly identical, i.e., in no year was there a significant overspending or underspending of the VEP budget.

From 2007 to 2012, the VEP budget was largely the same. From 2013 to 2016, the budget steadily and significantly increased, with this initially accounted for by the establishment of White Door Centres throughout the province. In 2015 and 2016, the increased budget appears to have been largely the result of a jump in

spending on employees (R2.8 million in 2014, R26.5 million in 2015, R59.5 million in 2016). Most of this jump is explained by changes to the way the DSD reported on personnel costs. Where all personnel were previously reflected under the administration sub-programme they are now reported on within their respective sub-programmes. As shown in Figure 5, over the period of time reviewed (2007-2016), the amount of money transferred to NPOs for sheltering services (white line) has not grown as significantly as transfers to other line items. Indeed, like transfers to VEP NPOs more broadly, the recent trend is a downward one.

FIGURE 5: EASTERN CAPE VEP EXPENDITURE 2007 - 2016

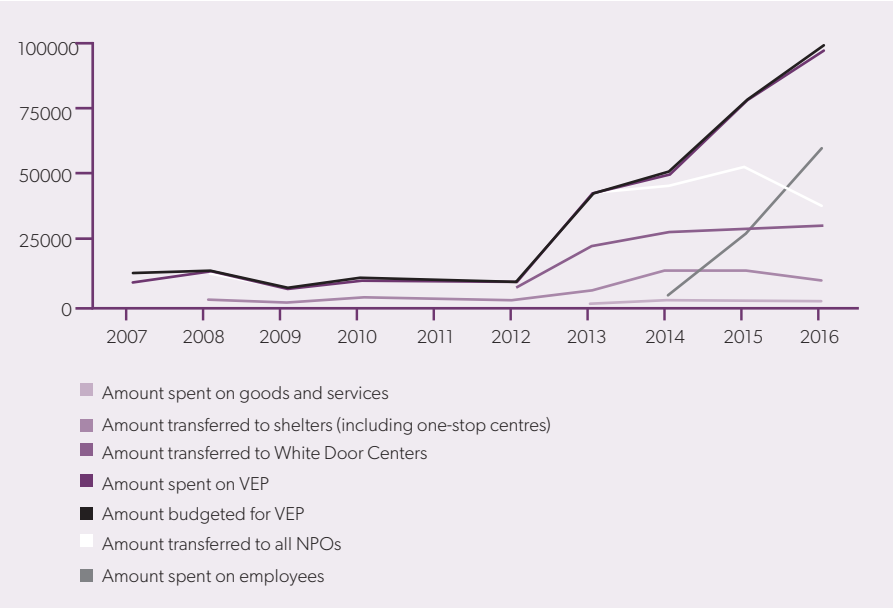
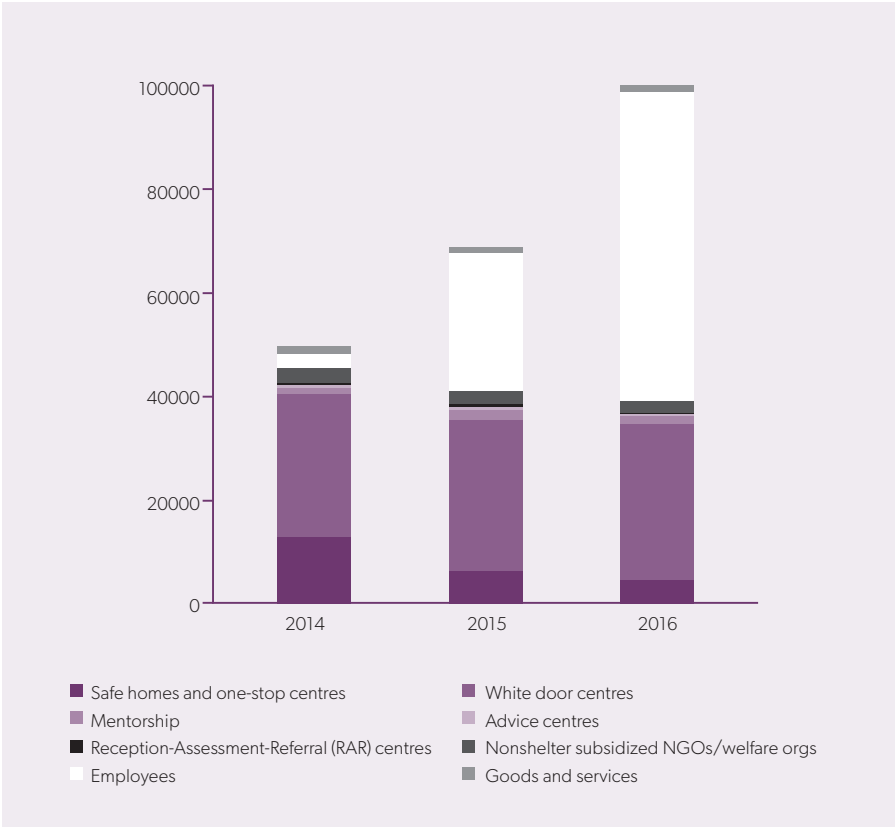


Figure 6 shows relative amounts of spending on various components of the VEP from 2014 to 2016, the years for which the most complete data on different areas of spending were available.

Because of the restricted time frame, Figure 6 demonstrates most strongly the increase in spending on employees but also shows the overwhelming emphasis on White Door Centres compared with other NPOs providing services, which included safe homes, advice centres, mentorship programs, and one stop centres. In 2011 there were no White Door Centres, with 40 established in 2012, 114 in 2014, 125 in 2015, and 134 in 2016.

FIGURE 6: EASTERN CAPE VEP BUDGET BREAKDOWN 2014 – 2016



THE NORTHERN CAPE VEP BUDGET

FIGURE 7: NORTHERN CAPE VEP BUDGETING AND SPENDING (2011-2016) AND ESTIMATES FOR 2017-2020

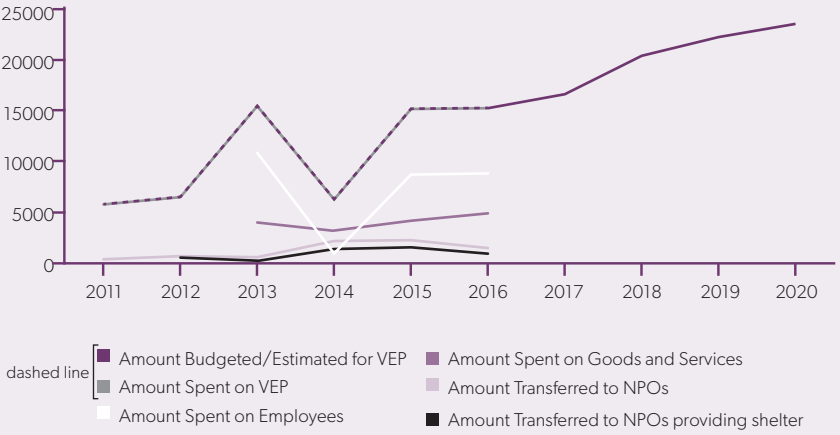


Figure 7 shows the total amounts budgeted and spent by the Northern Cape DSD on its VEP from 2011 to 2016 as well as medium term estimates made for 2017 to 2020 in the Northern Cape DSD Annual Performance Plan 2017/18 (p. 167).

Within all years for which actual spending is shown, the total amounts budgeted and spent were identical, i.e., in no year was there an overspending or underspending of the VEP budget. Over that same period, the budget has grown overall, with increases anticipated through 2020. However, amounts transferred to NPOs in general and to those who specifically provide shelter for victims of violence has remained largely static, thus becoming a smaller and smaller percentage of the overall Northern Cape DSD budget. Notably, the amounts spend on goods and services always exceeded the amounts transferred to NPOs in years where separate figures were reported.

The Northern Cape DSD's annual reports detail transfers to four NPOs providing shelter services during the period 2012 and 2017. Funding to two organisations ceased during this period while the other two organisations began receiving funding. The most any of the four organisations received was R849 877 in 2015/16 but this was to cover all the organisation's programmes – not just the shelter. This amount was also less than that allocated in 2014/15 (R921 939) when the shelter had-

not yet been established. The other shelter still receiving funding was allocated less in 2016/17 (R330 577) than in 2015/16 (R341 955).

Calculating what shelters, White Door centres and the like should be receiving is made difficult by the absence of a recent, normative framework around sheltering. But a costing exercise undertaken in 2018 with the NSM does provide some comparative contextualisation of these figures. Taking a longer-stay facility as its model, this provided a monthly variable cost of R2 574.48 per woman and R2 324.62 per child, producing a monthly cost of R7 223.72 for a woman with two children. Overhead costs amounted to R74 997.43 per month and allowed for a social and social auxiliary worker, three housemothers and a shelter mother. The ratio of social work staff was calculated as one social worker to 15 women and 30 children (Vetten, 2018). While this model will obviously require adaptation to different sheltering contexts, it does provide a benchmark against which to assess how the shelters in our sample were being subsidised.

"Calculating what shelters, White Door centres and the like should be receiving is made difficult by the absence of a recent, normative framework around sheltering. But a costing exercise undertaken in 2018 with the NSM does provide some comparative contextualisation of these figures...While this model will obviously require adaptation to different sheltering contexts, it does provide a benchmark against which to assess how the shelters in our sample were being subsidised."

(available at https://za.boell.org/sites/default/files/whatisrightlydue-costingdvshelters_fullreport.pdf)

4. STUDY FINDINGS

The study findings are presented in two parts: the first describing the shelters, their funding and staffing in more detail; and the second focuses on the women who sought shelter.

4.1 THE SHELTERS

FUNDING TO THE STUDY SAMPLE

When NPO services are funded by the DSD this is through a system of subsidisation based on the assumption that organisations will raise the balance of funds from donor organisations, trusts and foundations, corporate social responsibility programmes managed by the private business sector, and lottery. Obtaining these additional funds is neither easy nor guaranteed, and many organisations' services are now entirely dependent upon DSD subsidies. As part-payments, these are insufficient, with their limited value having been eroded further by inflation. In the absence of policy to guide and standardise their calculation, subsidies also bear little relation to the actual cost of services. Indeed, the courts have described these as "substantially inadequate."[6] Subsidies also vary considerably between provinces, as do payment practices (Budlender, 2018; Vetten, 2018).

The shelters in this study are an illustration of both observations.

6 *National Association of Welfare Organisations and Non-Governmental Organisations and Others v MEC of Social Development, Free State and Others (1719/2010) [2010] ZAFSHC 73 (5 August 2010) at 34 to 35*

DSD FUNDING TO THE NORTHERN CAPE SHELTER

The shelter in the Northern Cape is entirely dependent upon DSD funding as of the 2018/19 financial year. The shelter service does not, however, receive a separate subsidy but has its costs absorbed within the overall budget for the organisation's various services. Its funding therefore cannot be isolated and reported upon separately. This approach also ensures that all staff – but for the housemothers – are shared between the organisation's other programmes, including the cleaners and the social worker. Lunches for shelter residents are taken from the soup kitchen project that the organisation runs. These staffing constraints limit the range and depth of shelter programmes. While the organisation has submitted requests to DSD to employ a full-time social worker these have been rejected on each occasion as officials consider there to be sufficient social workers in the area. In this district it is DSD practice to appoint an organisation to provide social work services generally to a particular number of areas, including to the organisations based in those areas. Beyond this, relations between the organisation and DSD seem generally cordial – which cannot be said of Eastern Cape shelters and their DSD offices.

DSD FUNDING TO THE EASTERN CAPE SHELTERS

Three of the five shelters received subsidies from the DSD and table 3 reports the amounts received in 2017/18 and 2018/19. The line item 'Services and programmes' is intended to cover food, toiletries and other day-to-day necessities, while the amount allocated to 'Therapeutic services' may be utilised for psychological, or other clinical services. While Shelter 1 received the same amount of subsidy in both years, the line items this sum was distributed between were changed between the two years. Shelter 6 also received the same amount for both years but there was no change to how it was allocated. Only shelter 3 received an increase in its amount of subsidy between 2017/18 and 2018/19. Questioning these decisions is not always appreciated by officials, according to shelter staff. After having done so a shelter staff member reported being told: ***"remember we're funding you, you can't tell us who to pay" (Shelter manager, interview June 2018).***

Organisations also said that they could not rely on the DSD to uphold funding agreements and provided examples of being asked verbally, rather than in writing, to pay for food and other workshop costs incurred by DSD officials.

TABLE 3: SUBSIDIES TO EASTERN CAPE SHELTERS IN 2017/18 AND 2018/19

COST ITEM	SHELTER 1		SHELTER 3		SHELTER 6	
	17/18	18/19	17/18	18/19	17/18	18/19
Services and programmes	46,082	50,138	36,123	40,000	15,000	15,000
Therapeutic services	10,000	10,000	10,757	25,791	15,000	15,000
Social worker	128,140 or 10,678 p/m	128,140 or 10,678 p/m	106,783 or 8,899 p/m	128,140 or 10,678 p/m	128,140 or 10,678 p/m	128,140 or 10,678 p/m
Housemother(s)	49,692 or 2,050 p/m	60,600 or 2,500 p/m	49,692 or 2,050 p/m	60,600 or 2,500 p/m	26,400 or 2,200 p/m	26,400 or 2,200 p/m
Programme coordinator/manager	0	38,784 or 3,200 p/m	34,542 or 2,800 p/m	38,784 or 3,200		
Administrator	27,270 or 2,250 p/m	0	27,270 or 2,250	0		
Administrative support	40,000	0				
Administrative Expenses	39,478	48,000	33,333	45,000		
Security (x 2)						43,089 or 1,750 p/m
Capacity building	0	5,000	0	3,000		
Total subsidy to shelter	**340,662**	**340,662**	**300,000**	**341,315**	**227,629**	**227,629**

Their subsidies did not have funds allocated towards such costs. Said one interviewee: ***'[The problem] is that you never know when they'll ask for it back – there's [also] a tendency for DSD to come and take money." (Shelter manager, interview June 2018).***

The DSD in these districts also appeared to have particular ideas around the look and feel of the shelters. According to one shelter's staff member DSD officials referred to the shelter as the "bed and breakfast" – trivialising both the nature of staff's work and women's difficulties, as well as implying

that the shelter was insufficiently spartan in look and feel. A similar idea had been conveyed to a second shelter where observable effort had gone into making this shelter look and feel homely and comfortable. This individual had been questioned both about the type of toiletries she was purchasing for residents, as well as some of her furnishings (which the field workers did not observe to be especially luxurious).

Were they to find additional funds elsewhere then two of the shelters would not accept funding from the DSD. Indeed, one had previously refused DSD funding. And yet, after being begged by DSD to accept the money, when the organisation again complained of its treatment, the department responded with "you can't bite the hand that feeds you" (*Shelter staff member, interview June 2018*).

Limited funding (regardless of its source) also contributed to shelters' isolation from each other, diminishing opportunities for reciprocal support and learning:

Organisations were not getting [adequate] funding so it was difficult to travel to meetings. Our housemothers would also love more interaction with other housemothers, for debriefing, for peer support because you have to let it out... because it's hard! Your job doesn't end at work. It's not like you switch off at the end of the day. Having [peer support] would be so vital" (Shelter staff member, interview June 2018).

In the Eastern Cape subsidies were not only meagre; they were also late which further contributed to organisations' stress. Service Level Agreements (SLA) between organisations and the Eastern Cape DSD are typically signed in April at the start of each financial year and subsidies then disbursed in two tranches. With the first amount typically only being paid three to four months after the grant agreement is signed (i.e. July/August), organisations can be put in the position of "robbing Peter to pay Paul"[7], meaning that they are forced to use a different donor's funds to cover DSD-related costs while they await payment. Payment of the second tranche is equally delayed – being deposited in February on the expectation that all funds will have been spent by the end of the financial year (March 31).

But even when the money has been deposited into an organisation's bank account they still require the DSD's permission before they can purchase anything with it. This condition works as follows: the organisation must complete a requisition form – accompanied by comparative quotes for expenses exceeding R2,000 (applicable to variable costs such as food for shelter residents, catering and venue hire for workshops) – and then physically submit their request to the district official for approval. Only once this has been secured may they spend their money.

This cumbersome process has been made even more inefficient in relation to peri-ur-

7 *Shelter manager, interview June 2018.*

ban and rural organisations. One shelter, for example, must drive a significant distance to the local DSD office in order to submit their requisition. Five DSD officials of differing designations must then sign off the requisition before it is taken to a second DSD office for final approval by the DSD district manager. Once this has been obtained the form is returned to the first DSD office for collection by the organisation. The entire process takes between two weeks to a month – assuming none of the documents is misplaced, which then requires the process to start anew. The process is somewhat less onerous for a second shelter which is at least based in the same town as their local DSD office. In addition, their district office requires only five, rather than six, signatories to approve the purchase. Nonetheless, it too must travel between two offices. Only the shelter based in the same town as the district's regional office is spared the inefficiencies of this travel.

From the perspective of one of the shelters the two-stage signatory process not only reflected suspicion of the organisation, but also established relations of hierarchy:

"We have requested this money, they have approved this money; and yes [they] must have a way of monitoring [their] money, but the way in which this is done is very poor. Maybe [they think] we are working in their kitchen or in their garden?" (Shelter manager, interview June 2018).

STAFFING THE SHELTERS

Reinforcing this shelter manager's view that the DSD sees their work as menial is the fact that every post subsidy, with the exception of that for social workers, was below the proposed minimum wage of R20/hour (or R3 500/month) due to come into effect on 1 January 2019. The different amounts of subsidy allocated towards shelters also reflected different amounts of subsidy being towards the same type of post – even though an identical service was being offered by staff with the same qualifications.

Table 4 analyses shelter staffing more closely by contrasting the staff type and number available to each shelter, with use of an asterisk indicating the staff member to be working in other projects run by the organisation and thus not exclusively available on a full-time basis to the shelter.

The table also distinguishes between 'true' and 'stipend' volunteers, with true volunteers referring to those who undertake some activity on behalf of the shelter but are not remunerated for these activities. Shelter 5 is especially reliant on this category, having volunteers to provide administrative and other support and relying on students from the local university and college to publicise the shelter's work in local communities. Shelter 2 is unusual in having a psychologist volunteer her services weekly, while shelter 4's true volunteers include a self-defence instructor and a spiritual counsellor. Like shelter 5, shelters 2

and 4 also draw on students placed with the organisation to gain practical experience towards their qualification.

The stipend volunteers attached to shelters 2, 3 and 6 are not true volunteers and should, by rights be considered employees and receive subsidies in accordance with this status. The Directors of the organisations to which shelters 3 and 6 are attached receive stipends – R3 200 per month in the case of shelter 3 and R2 000 per month in the case of shelter 6. Non-management volunteers in shelter 3 assist with counselling and awareness-raising and are paid R700 per month when funds are available. Shelter 6's field workers who play an important role in identifying and referring women in the local community to the shelter receive R2 000 per month. Shelter 2's stipend volunteers perform a similar set of functions but are based at the courts and receive a stipend of R1 700 per month.

TABLE 4: STAFFING TYPE AND NUMBER BY SHELTER[8]

STAFF TYPE	SHELTER 1	SHELTER 2	SHELTER 3	SHELTER 4	SHELTER 5	SHELTER 6
Shelter/programme manager	1*		1*	1	1	1*
Social worker	1	1*	1*	1	0	1*
Social auxiliary worker	1*	0	0	0	0	0
Housemothers	2	2	2	4	0	2
Counsellor	1*	0	0	0	0	0
Creche teacher	1*	0	0	0	0	0
Cleaners/gardeners	2	4*	0	1	0	1
Security staff	0	0	0	0	0	1
True volunteers		2		5	4	
Stipend volunteers (excl. management)		6*	6*	0	1	2*

The next section briefly summarises the services offered by each of the six shelters.

8 *Asterisk indicates staff members working in other projects run by the organisation - thus not exclusively available on a full-time basis to the shelter.*

SHELTER 1

This shelter is a project run by an organisation that has been in existence for some six decades. The shelter itself has only been running since 2015 when it took over the service from another NPO. The shelter has eight rooms able to accommodate up to 20 women and children at any one time. Shelter services to residents include the provision of basic needs (toiletries and clothing when women cannot afford these), individual and group counselling, and other psychosocial and practical support services such as being transported and accompanied by staff to attend appointments or find work.

SHELTER 2

The organisation which the shelter is attached to was opened in 2004, originally to help street children. Its current projects range from a soup kitchen to court support, with the shelter opened in 2015. It is able to accommodate 13 women and children in three bedrooms. Shelter services include individual counselling, psychosocial and practical support (including referrals), skills development training and reunification services such as couple counselling. As will be illustrated later, the addition of the psychologist's services shapes the use of the shelter in distinctive ways.

SHELTER 3

Shelter 3 was opened in 2004, a decade after the organisation itself was established. The building houses up to 10 women and children in three rooms. The shelter provides individual counselling, court support and family reunification services, along with assisting women to obtain health care and apply for grants and protection orders. It refers women elsewhere for group counselling, family mediation and couples counselling.

SHELTER 4

Shelter 4 was established in 2015 as a further addition to the menu of services and programmes offered by the twenty-year old organisation. The shelter consists of five rooms able to accommodate some 15 women and children for up to three months. The shelter does not receive a subsidy from the DSD and raises funds elsewhere in order to employ one shelter manager, a social worker and four housemothers. At present it has one non-South African donor supporting the shelter.

Shelter services include paralegal support and other practical assistance, such as transporting and accompanying women to appointments, along with the provision of basic needs such as food and toiletries. Individual and group counselling is also available from the social worker and, when required, from a psychologist subcontracted at a reduced rate. The shelter currently runs a life-skills programme which some-

times incorporates recreational activities such as card-making, knitting and gardening.

SHELTER 5

Shelter 5, founded in 1988, is the only facility not attached to a broader organisational service. It contains four rooms able to accommodate up to 16 women and children. The shelter receives no funding from the DSD and is able to employ only one person in a supervisory capacity. In 2017/18 the shelter received an income of approximately R327 000, derived from individual donations, corporate sector donations and the sale of two vehicles. This left the shelter running on a deficit and reliant for the shortfall on a Trust which maintains the house and also holds funds that can be made available to the shelter.

Given its straitened financial circumstances and minimal staffing the shelter chiefly provides practical assistance, such as with assisting women to lay charges, apply for protection orders, and access health care. Length of stay is typically determined with women at intake. All residents are provided with a care pack, a towel and, when needed, clothing. They are also free to help themselves to groceries as meals are not cooked for them). Counselling is not available at the shelter and women and their children are referred to any one of six other facilities in the area. Three of these (which include two hospitals) are able to provide psychiatric and psychological services. Counselling services can also be provided by two members of the board who are social workers by profession.

SHELTER 6

Shelter 6 has three rooms and can accommodate 10 women and children for up to six months. The shelter was opened in 2006 but the organisation established almost a decade earlier. Individual and group counselling are routine while couple counselling is on request – typically when women do not wish to leave their homes but want the relationship to change. Other client services include practical support such as helping women to apply for child support grants and access medical care; legal support services (e.g. paralegal advice, court preparation, helping women to apply for protection orders, accompanying women to court) and referrals to other service providers. The shelter covers most of women's expenses in a bid to encourage those with some income to save their money and thus have at least some financial reserves to draw on once they start living independently.

This brief, descriptive sketch of the shelters does not do justice to the substance and depth of their work, which will become clearer from the analysis of case files which follows next.

4.2 THE WOMEN

WHY WOMEN CAME TO THE SHELTERS

Violence was interwoven into the fabric of most women's lives, whether this had been experienced historically or recently. While it directly accounted for 87% of all stays, violence also played a part in women's homelessness, their involvement in sex work and some of the other reasons that brought them to the shelter.

IPV was the type of violence women sought to escape most frequently (53% of the sample), almost always at the hands of an intimate male partner. There was however, one case of same-sex intimate partner abuse involving verbal and emotional abuse.

Almost the same percentage of women approached a shelter to escape family violence (14%), as did the group which had experienced sexual violence not committed by an intimate partner or family member (15%). But if the 10 cases of family violence and 16 cases of IPV also involving sexual violence are taken into account, then at least 70 (or 23%) women in the total sample experienced sexual violence.

Male family members predominated as perpetrators in the family violence category – fathers in particular (11 or 27%). At least two of these cases involved fathers raping daughters who suffered a degree of cognitive impairment. Sons, grandsons and brothers accounted for another 12 abusers and nephews, uncles and brothers-in-law another seven. There were single instances of a mother, grandmother, daughter and grand-daughter each behaving abusively, as well as a few aunts.[9]

There were a few additional assault cases in the sample where the assailant was unspecified, as well as another few cases where women were brought to the shelter following threats to their safety, either by members of the community or those involved in crime. The category of cases defined as involving trafficking or sex work was also small. Three of the cases in this category were referred to shelters by the Hawks and did appear to be fairly clear-cut examples of trafficking. The remaining cases were perhaps better described as sex work involving women whom officials did not seem to want to imprison but did not know how to help either.

None of the women categorised as homeless had experienced long-term destitution. Their homelessness was recent and

9 Two women had spent time in prison but it is not clear if the abuse they experienced was due to this.

often the result of being evicted or being released from the police cells and having nowhere to go. This group also included three family members whose shack had burnt down and who required temporary accommodation while they attempted to rebuild their home. Prior violence also emerged as being important in precipitating women's homelessness (a theme to be explored later in the report).

The remaining 'other' category included a few women who were being housed at the request of the Department of Home Affairs prior to their deportation, as well as women who had approached the shelter for practical help not related to violence, or who needed somewhere to stay while they settled legal and family matters. This category also included women with mental health difficulties and would have been larger had shelter 5 been able to accommodate 16 women who were experiencing psychological distress – which included suicidal ideation – and a further 11 who required help with problems of substance abuse.

TABLE 5: PRESENTING PROBLEM, FOR ALL SHELTER STAYS

PRESENTING PROBLEM	TOTAL (N=303)
IPV	162 (53%)
Family violence	43 (14%)
Non-partner attempted/rape	44 (15%)
Assault (perpetrator unspecified)	8 (3%)
Homelessness	19 (6%)
Crime/safety	5 (2%)
Trafficking/sex work	9 (3%)
Other	13 (4%)
Total	100%

SHELTER STAYS AND OCCUPANCY RATES

Table 6 summarises how the 307 women's 310 stays were distributed between the six shelters. Shelters 4 and 6 housed 25% and 20% respectively of the sample. The remaining four shelters housed smaller but fairly similar numbers of women ranging between 38 to 46 residents.

TABLE 6: NUMBER OF STAYS PER SHELTER

SHELTER	NUMBER (%)(N=310)
Shelter 1	45 (15%)
Shelter 2	46 (15%)
Shelter 3	38 (12%)
Shelter 4	79 (25%)
Shelter 5	40 (13%)
Shelter 6	62 (20%)
Total	100%

Table 7 breaks down these numbers further by capturing the proportion of women accommodated by each in relation to their presenting problem. Unlike the other facilities, shelter 3 housed a greater proportion of women subject to non-partner or family member rape, than those subject to IPV. At all other shelters, IPV predominated.

TABLE 7: PRESENTING PROBLEM, BY SHELTER

PRESENTING PROBLEM	SHELTER 1 (N=45)	SHELTER 2 (N=43)	SHELTER 3 (N=38)	SHELTER 4 (N=79)	SHELTER 5 (N=38)	SHELTER 6 (N=62)
IPV	18 (44%)	24 (54%)	7 (18%)	46 (58%)	35 (92%)	30 (48%)
Family violence	8 (20%)	6 (14%)	6 (16%)	9 (11%)	2 (5%)	12 (19%)
Non-partner attempted/rape	6 (15%)	10 (23%)	10 (26%)	5 (6%)		13 (21%)
Assault (perpetrator unspecified)	1 (2%)		3 (8%)			4 (7%)
Homelessness	2 (5%)	1 (2%)	4 (11%)	10 (13%)		2 (3%)
Crime/safety			1 (3%)	3 (4%)		1 (2%)
Trafficking/sex work	5 (12%)		3 (8%)	1 (1%)		
Other	1 (2%)	2 (5%)	4 (11%)	5 (6%)	1 (3%)	
Total	100%	100%	101%*	100%	100%	100%

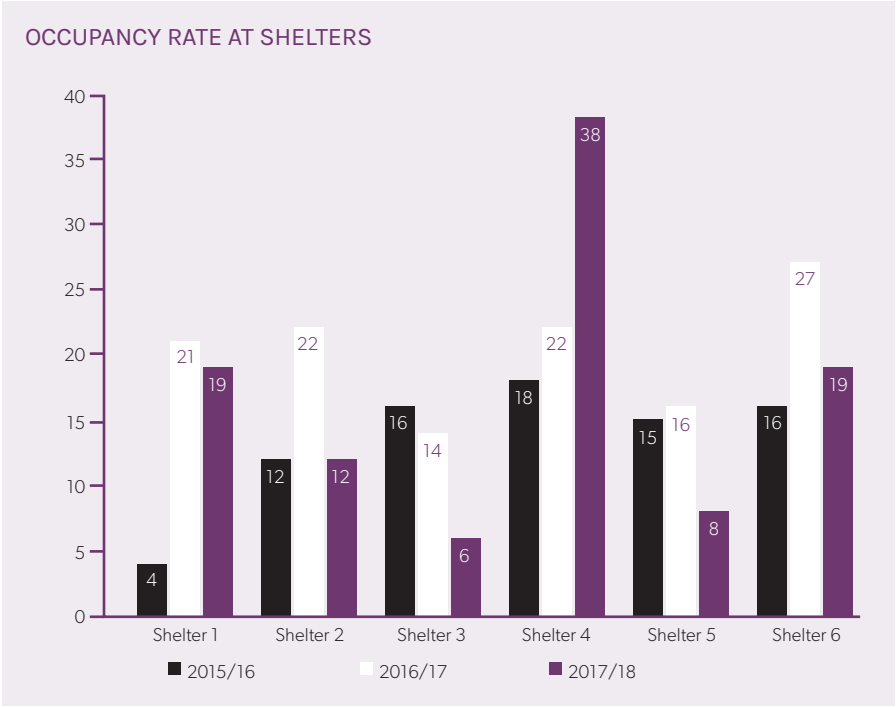
**The percentage does not add up to 100% due to rounding*

CHILDREN'S STAYS AND MULTIPLE STAYS

These numbers do not account for repeat stays, as well as those by children. Of the 17 women who had stayed at the shelter at least once before, nine had resided at shelter 6 and five at shelter 1. The remaining three shelters, with the exception of shelter 3 (which housed all its residents once only), each housed only one woman more than once.

In the Northern Cape, Shelter 2 housed an additional 22 children accompanied by adult care-givers while three Eastern Cape shelters accommodated 13 children. Taking account of these additional stays increases shelter occupancy rates, as figure 8 shows. These 353 stays still underestimate the number of stays, as dates for prior residency were not always recorded and therefore could not be allocated. Further, because shelters did not always keep complete records for the children accompanying their mothers to the shelter these figures are not reflected in the graph and nor is the number of adult care-givers when the child was the chief beneficiary of the service.

FIGURE 8: NUMBER OF WOMEN HOUSED ANNUALLY, BY SHELTER AND FINANCIAL YEAR



Shelter 1 was handed over to a different organisation in 2015 and, as a consequence housed no women in that year, explaining its few residents in 2015/16. Shelter 5 only accommodates women experiencing IPV and during the study period referred 37 women who did not fit this criterion elsewhere for assistance. Most staff suggested that staying at a shelter was stigmatising for women and, in rural areas, frowned upon as culturally inappropriate, it being preferred that women settle the violence through family structures. These perceptions were perceived as affecting both shelter occupancy rates, as well as women's length of stay. Indeed, only shelter 4 demonstrated increasing use over the three financial years. The remaining five shelters all housed fewer women in 2017/18 than they did in 2016/17, shelters 3 and 5 markedly so.

Occupancy rates also seemed to be affected by the time of year, with three shelters demonstrating very little use in the first three months of 2018. Shelter 2 admitted no women during this period and shelters 3 and 6 admitted just one woman each. For Shelter 6 the decision to limit their intake was a conscious choice based on the cumbersome funding requisition processes and practices described previously, pithily summarised by the programme manager as "no food, no client. No client, no food." He explained further:

How can you take someone in when you know there's no food? And then [DSD] will complain about numbers, they always want numbers. They keep asking 'why are you under-spending?', but they know the reason why (Shelter manager, interview June 2018).

Shelter 6 also faced staff constraints following the resignation of the social worker at the end of 2017. The DSD had asked the organisation not to fill the post until the start of the 2018/2019 financial year in April. The shelter manager (which the DSD had designated as a volunteer and paid a stipend towards) attempted to provide such services in the interim, with the position finally being filled in June 2018.

REPEAT AND CROSS STAYS

Ten of the 17 women who stayed more than once at a shelter did so at shelter 6 (and there were in fact an additional four women who returned to this shelter again after the conclusion of the study period). No information is available about these stays – which is unfortunate given how prominently this shelter features in repeat stays. There are two examples of the cross-use of facilities, or women staying in more than one shelter, with two women also returning to one shelter for a second time. Repeat and cross-use of shelters does not represent abuse of facilities (or 'shelter-hopping' as it is dismissively termed) but reflects the lengthy nature of processes required to put lives together again.

'Sandra', a white woman in her mid-40s, first resided at shelter 1 and exited in January 2017 to look after an elderly family member. She probably also returned to her boy-friend as two months later she ar-

rived at shelter 4 and stayed for two weeks to escape his violence. She subsequently absconded from the shelter (most probably to return to her boy-friend). At the beginning of 2018 she reappeared at shelter 1, stating that her boy-friend had abandoned her on an empty stretch of road between two towns and that she wanted to "clean up her act." She had by then voluntarily placed her three sons by a previous marriage in foster care and had supervised visitation rights.

Sandra faced a number of challenges in cleaning up her act. She was taking anti-depressants and was also severely underweight. Her one hand was disabled and she was also losing her sight. Sandra needed help obtaining the raft of documentation necessary to claim her sons' inheritance which she wanted to place in trust for their foster parents' use. She no longer had a bank account, having closed the one she had previously shared with her boy-friend because he spent whatever money went into it on methamphetamine (tik). Sandra was adamant that she was not going to return to her boy-friend and was planning to find a job to support herself. Her boy-friend was persistent in trying to pressurise her into returning to him, contacting her numerous times, following her to the clinic and leaving gifts at the shelter gate.

'Charlene's' two stays also highlight the need for extended support in some women's lives – particularly when mental health difficulties are prominent.

Charlene is a coloured woman in her late 30s who arrived at the shelter with two daughters following eviction from her eldest daughter's boy-friend's home. He was abusive to Charlene and all three of her daughters – especially when Charlene tried to intervene on behalf of her eldest daughter. She was able to move out of the shelter after the staff assisted her to find a job, as well as accommodation. But Charlene's new employer did not always pay her and she began falling behind on her rent payments. Her health started deteriorating and, at this point, she contacted the shelter again.

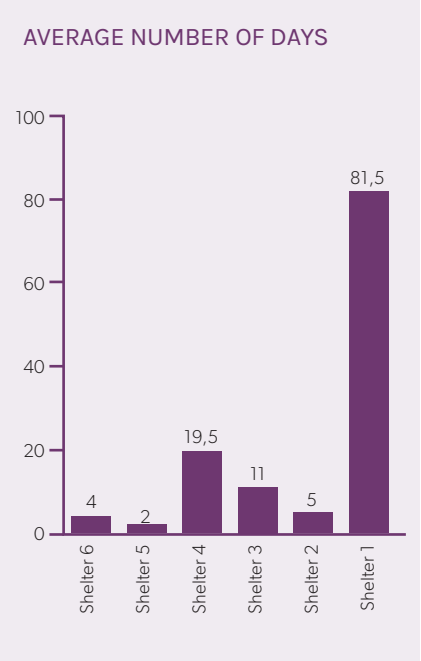
Charlene did indeed have significant health problems, being both HIV-positive and having multi-drug resistant tuberculosis. In addition, she had spent time in the psychiatric ward of a local hospital and had a history of depression and anxiety. She not only experienced panic attacks but was also self-harming – which extended to her having previously attempted suicide. It was on the basis of this history that the shelter, on her second stay, helped her to apply for and obtain a disability grant. Charlene was still resident in the shelter at the time of field work, with the social worker's process notes observing that her panic attacks worsened when discussion of her exit from the shelter was raised.

Charlene and Sandra's extended stays were unusual; most women in the sample left the shelters in under a month.

LENGTH OF STAY

Women's length of stay at the shelter ranged from a few hours to 244 days (or just over 8 months). The median stay was 8 days, with three-quarters of women (75%) having left within 29 days of their arrival. A minority of women thus stayed for longer than a month

FIGURE 9: MEDIAN AVERAGE LENGTH OF STAY, BY SHELTER



At a median of two days, shelter 5 recorded the shortest stays, with almost three-quarters (74%) of women having left within a week. Twenty-three days was the longest stay at this shelter. At shelter 6, some three-quarters of women (74%) had left by 8 days, with shelter records suggestive of how short stays at shelter 6 were being influenced by the cash flow challenges introduced by DSD's payment system. Case files indicated that in some instances women had been accepted by the shelter and then transferred to a different shelter when there was no money for food.

Shelter 2's stays were somewhat longer, 74% of women having left by day 11. Shelter 2's short stays may, to some extent, have been an artefact of the psychological services it offers – a factor we discuss in more detail later in the report. The shelter's social worker had also observed that women coming from particularly far-off areas tended to bring their younger children with them but leave the older children at home to prevent disruption of their schooling. Consequently, they did not remain at the shelter for very long.

At shelter 3, over three-quarters (83%) of women had left by day 29 of their stay while at shelter 4, approximately three-quarters (76%) stayed for just under two months (55 days).

Shelter 1 recorded the longest stays of all. Where the shortest stay at all the other shelters was one day (or less), five days was the shortest stay at shelter 1. Indeed, only a quarter of women (24%) had left the shelter within 30 days of their arrival. The median stay at shelter 1 was 81.5 days, with three-quarters (76%) having left by day 111.[10]

10 *There is also some indication in the shelter records of a few women cutting their stays short due to conflict with one of the housemothers.*

The next table compares the median length of stay by presenting problem and age category. It offers two calculations for IPV, the first including all shelters and the second excluding shelter 5 which almost only accepted women experiencing IPV and also actively determined women's stays. These calculations suggest that the nature of women's problems may not have been that important in influencing length of stay (especially if the second calculation is relied upon for IPV stays). In fact, age category would appear to exert a somewhat greater influence on the length of stay, with women aged 60 and over staying for the shortest period. Shelter 6, which serves a predominantly rural area, housed 12 of the 21 women in this age category and provided a possible explanation for these shorter stays. According to the programme manager this group of women were anxious about leaving their livestock and homesteads unattended for anything other than a brief period of time.

TABLE 8: MEDIAN LENGTH OF STAY BY PRESENTING PROBLEM AND AGE CATEGORY

	MEDIAN AVERAGE
IPV	7 days / 9 days
Family violence	8 days
Sexual violence	9 days
Other	8.5 days
18 – 24 years	9 days
25 – 29 years	8 days
30 – 39 years	9.5 days
40 – 49 years	8 days
50 – 59 years	6 days
60+	5.5 days

WHO THE WOMEN WERE

Almost two-thirds of the sample (63%) were black African women. Coloured women accounted for almost one quarter (24%) of shelter residents and white women about one in eight (12%). Only two women were of Indian descent.

Nine women (3%) came from outside the borders of South Africa, typically another African country but for the two women trafficked from Thailand. Eighteen women (6%) came from a province different to the one in which the shelter was located and arrived there for different reasons. For some the shelter provided accommodation while they testified in court or dealt with other legal and family matters. Others had come to the province for work, or in search of someone, and subsequently been stranded without the means to return home. Four women had relocated provinces in order to escape abuse, with two women being married to Western Cape gang leaders.

One woman in the sample defined as lesbian.

AGE

Women in the sample ranged in age from 16 to 85 years, with the average mean age of the sample overall being 36.1 years. Just over half (51%) of the sample were aged 33 and younger while about one in seven (14%) were 50 and older. Both young women under the age of 18 experienced IPV and stayed in Eastern Cape shelters.

TABLE 9: AGE CATEGORIES OVERALL

AGE RANGE	OVERALL SAMPLE (N=307)
Under 18	2 (1%)
18 – 25	63 (20%)
26 – 29	50 (16%)
30 – 39	89 (29%)
40 – 49	60 (20%)
50 – 59	23 (7%)
60+	21 (7%)
Total	100%

Greater variations in age appeared in relation to the reasons for women's stay at the shelters. Women experiencing family violence had the highest average mean age (40.84 years), followed by women who had experienced sexual violence (37.86 years). The average mean age of women experiencing IPV was 35.14 years. As these averages suggest, IPV was more frequent among younger women, with somewhat greater proportions of older women found in the groups which had experienced family violence or non-intimate/family member sexual violence. The greatest proportion of women aged 60 years and older had sought shelter following an experience of sexual violence which accounted for 46% of stays for women in this age group and more than one in five (23%) admissions overall for this form of violence.

TABLE 10: AGE CATEGORIES BY REASON FOR SHELTER STAY[11]

AGE RANGE	OVERALL SAMPLE (N=307)	IPV (N=160)	FAMILY VIOLENCE (N=43)	SEXUAL VIOLENCE (N=44)	OTHER (N=52)
Under 18	2 (1%)	2 (1%)			
18 – 25	63 (21%)	25 (16%)	10 (23%)	15 (34%)	11 (21%)
26 – 29	50 (16%)	25 (16%)	4 (9%)	8 (18%)	11 (21%)
30 – 39	89 (29%)	56 (35%)	9 (21%)	7 (16%)	12 (23%)
40 – 49	60 (20%)	39 (24%)	8 (19%)	2 (5%)	10 (19%)
50 – 59	23 (7%)	10 (6%)	5 (12%)	2 (5%)	6 (12%)
60+	21 (7%)	3 (2%)	7 (16%)	10 (23%)	2 (4%)
Total	101%	100%	100%	101%	100%

11 *Where percentages do not add up to 100% this is due to rounding*

INCOME AND EMPLOYMENT STATUS

The Eastern Cape is the poorest province in the country with 72.9% of people living below the poverty line in 2015. In the same year 54.3% of households in the province experienced poverty. Poverty in the Northern Cape is not as severe, the province being the sixth poorest in the country. In 2015 its poverty headcount was 59.0% while 45.6% of households experienced poverty (Statistics South Africa, 2017: 64-65). Shelters reflect some of the factors contributing to these rates of poverty.

Data on women's employment status were available for 87% of case files and showed two-thirds (68%) of the overall sample to be unemployed – which is comparable to the 64% found in other provinces (Vetten, 2018). Higher rates of unemployment were also found among women experiencing intimate partner and family violence than women who had experienced rape. This however is an artefact of the age of women seeking shelter following a rape. This group contained a higher percentage of scholars/students and pensioners than the intimate partner and family violence groups.

TABLE 11: EMPLOYMENT STATUS BY TYPE OF VIOLENCE[12]

	TOTAL (N=271)	IPV (N=144)	RAPE (N=37)	FAMILY VIOLENCE (N=37)	OTHER (N=46)
Unemployed	183 (68%)	100 (69%)	19 (51%)	27 (73%)	32 (70%)
Pensioner	12 (4%)	1 (1%)	8 (22%)	2 (5%)	2 (4%)
Scholar/student	11 (4%)	4 (3%)	5 (14%)	2 (5%)	
Full-time employee	41 (15%)	29 (20%)	4 (11%)	1 (3%)	6 (13%)
Temporary/part-time employee	4 (2%)	3 (2%)			
Self-employed	10 (4%)	2 (1%)	1 (3%)	3 (8%)	4 (9%)
Other	10 (4%)	5 (4%)		2 (5%)	2 (4%)
Total	101%	100%	101%	99%	100%

At least one in four case files (26%) reported the woman to have no access to any money. Information about women's access to state grants was available for 188 women and showed at least one-third (69 or 36%) to be in receipt of a grant. Of this number 42 (63%) received the child support grant, 16 (26%) received an old age pension and eight (13%) a disability grant. The percentage of those receiving a child support grant more or less reflects the percentage of the provincial population

12 Where percentages do not add up to 100% this is due to rounding.

receiving child support grants. Both the Eastern and Northern Cape have a higher share of the provincial population dependent on grants relative to the size of the population. In 2015 the Northern Cape had the third-highest percentage of poor households with children (64.1%) receiving the child support grant and the Eastern Cape the fifth-highest percentage (60.2%) (Statistics South Africa, 2017).

REFERRAL TO THE SHELTER

The greatest proportion of women were referred to the shelter by the SAPS – especially if sexual violence was involved and, to a lesser extent, IPV. NPOs as a group (including the organisation the shelter was attached to) were far more likely to refer women to shelters than other government departments. Others who referred women to shelters included family, friends and neighbours, religious leaders, the Department of Home Affairs and, in only one instance, a White Door Centre – which is low, given that White Door centres are short stay facilities intended to act as a point of referral to longer-stay shelters.

While the number of referrals from health facilities was low, some shelters had extensive contact with health facilities precisely because women's health needs required this. Shelter 2 worked diligently to establish relationships with health facilities in the region, which ensured that women from the shelter were prioritised for treatment at clinics and local hospitals (including private ambulance services). They were not required to queue and could be assisted even when they did not have their clinic cards with them.

TABLE 12: SOURCE OF REFERRAL BY PRESENTING PROBLEM[13]

SOURCE OF REFERRAL	TOTAL OVERALL (N=271)	IPV (N=138)	FAMILY (N=42)	SEXUAL (N=40)	OTHER (N=44)
SAPS	111 (41%)	61 (44%)	9 (21%)	23 (58%)	15 (34%)
Mother organisation	40 (15%)	23 (17%)	7 (17%)	3 (8%)	6 (14%)
Other NGO service	30 (11%)	13 (9%)	3 (7%)	4 (10%)	8 (18%)
Department of Social Development	23 (9%)	5 (4%)	5 (12%)	3 (8%)	10 (23%)
Court	16 (6%)	14 (10%)	2 (5%)		
Self-referral	8 (3%)	6 (4%)		1 (2%)	1 (2%)
Health facility	7 (3%)	5 (4%)	1 (2%)		
Other	36 (13%)	11 (8%)	15 (36%)	6 (15%)	4 (9%)
Total	101%	100%	100%	101%	100%

13 Where percentages do not add up to 100% this is due to rounding.

WOMEN'S HEALTH

The kind of ill-health noted in a number of women's files underscored the necessity of relationships with health facilities. The extent of their ill-health is likely to be under-represented, given the sparse notes kept by some shelters, coupled to the short stays.

There were few women in the peri-natal period (4%); more than double this proportion (10%) reported difficulties with substance use. At least four of the 31 women had previously attended rehabilitation services to address their substance abuse, suggesting that it was severe, while a few women's stays at the shelters had been terminated due to their drinking. Indeed, alcohol was far and away the substance women turned to most often, with a few women also using pain killers. Just one woman was recorded as using a combination of opiates (morphine, heroin and codeine).

Women who had experienced IPV or sexual violence were most likely to arrive at the shelter with injuries. While these often took the form of bruising associated with a beating, they also included stab wounds – particularly evident in the cases of women who had fought off attempted rape. At least one woman seemed to be in the process of being disabled by her intimate partner's abuse. The repeated blows to her ears were affecting her hearing.

Three women also presented with what seemed to be a moderate degree of cognitive impairment – but which was of a degree sufficient to place them at repeated risk of rape. A fourth woman in her late 60s was described as 'confused' and had been in the care of her daughter at the time she was raped.

Possibly as a result of the presence of older women in the sample, a fair number of the chronic conditions included hypertension and diabetes. Epilepsy was also included within this category. However, it is possible that some of the cases recorded as epilepsy may actually have belonged in the category we created of psychological distress. This captured a broad range of difficulties and disorders, including schizophrenia, psychosis, bipolar disorder, borderline personality disorder, PTSD, anxiety, and depression and suicidal ideation or attempts. Epilepsy was sometimes co-morbid with some of these conditions and in fact, what we recorded as epilepsy may have been bipolar disorder, given that drugs like Tegratol had been prescribed to women in combination with anti-depressants like Lexamil. There was also a woman like thirty-one-year old 'Zanele' who was being treated for epilepsy but whose other symptoms and difficulties strongly indicated the need for further assessment.

Zanele was HIV-positive and arrived at the shelter after having been gang-raped. She had a history of childhood sexual abuse, having first been raped by her uncle between the ages of 9 and 12. At 12 she ran away and lived on the streets for a number of years – again experiencing rape. At the time of the most recent rape she had been

squatting at a friend's house. Zanele was experiencing nightmares and flashbacks and suffered from other health-related difficulties. She spent a night vomiting and was then admitted to hospital for two days. On her return she had another epileptic fit and was again hospitalised for a few days. There was also a period during which her body went lame and she suffered headaches and backache. An altercation with another resident led to Zanele being kicked and one of her ribs being broken.

At least nine of the 44 women – just over one in five – had either previously been hospitalised or were hospitalised subsequent to their arrival at the shelter as a result of mental health difficulties such as depression, suicide attempts or panic attacks. Many of the women included in the psychological distress category had already been in contact with the mental health system and taking medication. Their psychological difficulties appeared to lie on the more severe end of the spectrum – raising questions around the extent to which more moderate or mild difficulties had been overlooked, including by the shelters. If the 31 women in substance abuse category are combined with the 44 women in the psychological distress category and the 11 women for whom these two difficulties co-occurred are excluded, then this results in 64 women – or 21% of our sample – presenting with any disorder. Rough as a calculation this may be, it is nonetheless higher than the 16.5% last year prevalence of neuropsychiatric disorders noted nationally by the SASH survey of 2004.

TABLE 13: HEALTH CONDITION, BY PRESENTING PROBLEM

CONDITION	N (%) (N=307)	IPV (N=160)	FAMILY VIOLENCE (N=43)	RAPE (N=44)	OTHER (N=53)
HIV/AIDS	42 (14%)	22 (14%)	5 (12%)	7 (16%)	8 (15%)
Pregnancy/ post-natal care	12 (4%)	9 (6%)			2 (4%)
Substance abuse	31 (10%)	13 (10%)		5 (11%)	7 (13%)
Psychological distress	44 (15%)	17 (11%)	9 (21%)	8 (18%)	12 (23%)
Chronic conditions	48 (16%)	17 (11%)	12 (28%)	10 (23%)	9 (17%)
Abuse-related injuries	43 (14%)	30 (19%)	2 (5%)	10 (23%)	
Other	41 (13%)	15 (9%)	4 (9%)	7 (16%)	6 (11%)

4.3 THE DIFFERENT ROLES SHELTERS PLAY IN WOMEN'S LIVES

Numbers cannot capture the singular complexity of individual women's circumstances – of which a shelter stay is but one moment. This section traces the various roles shelters play in women and children's lives, as well as how government departments utilise their services. (There will, of course, be some overlap between the different categories discussed here.)

WHEN CHILDREN ARE THE PRIMARY BENEFICIARIES OF SHELTER SERVICES

The Northern Cape shelter accommodated 22 children ranging in age from three to seventeen years over the three-year study period, while three Eastern Cape shelters housed 14 children between the ages of four and seventeen. In the Northern Cape half of the children were 12 years and older and at least three were boys. This was different to the Eastern Cape where only four children (all girls) were under 12. Most children arrived in the care of adults but there were six instances of children being unaccompanied. The Northern Cape cases included two families consisting only of children. The one group was waiting for their mother, who was working in the Western Cape, to fetch them after their father burnt the house down. The second group had stayed in the shelter for the week-end because their adult care-giver had been arrested for drinking in public and they were now alone at their home. Another 14-year old girl unaccompanied by adult care-takers was housed by the shelter for two days after she ran away following verbal abuse by her foster parents. The unsuitability of existing foster care arrangements was also central in the cases of the three unaccompanied adolescent girls in the Eastern Cape. They had been placed at shelters while DSD social workers sought to find them either adoptive homes or new foster families.

In both provinces rape featured prominently as the reason for children's stays, while precarious and unstable family circumstances were more likely to bring adolescent girls to shelters. Shelters were thus being used in two ways: as child and adolescent mental health services, and as temporary places of safety. The former use was particularly characteristic of the Northern Cape shelter due to the presence of the psychologist. Most children thus stayed at the shelter for short periods in order to receive psychological services, as well as assistance from the social worker who also has specialised skills in working with children. Sixteen-year old 'Grace', for example, arrived at the shelter following a suicide attempt made at her boarding school. Investigation revealed that she was being sexually abused by her step-father. When Grace was six she and her three sib-

lings had been placed in foster care after her parents were charged with neglecting them. Grace's mother re-instituted contact with her when she was 13 and she began staying with her mother during school holidays – the point at which her step-father began abusing her. Grace stayed for about a week in order to see the psychologist and then returned for a few follow-up appointments until her eating and sleeping had improved. Thereafter she was prescribed medication and plans made to return to her mother.

Eastern Cape shelters were more typically utilised as places of safety, often while alternative accommodation was sought for a child. For some of the adolescent girls a stay in the shelter often represented an attempt to resolve troubled family relationships. When 'Sinazo's' step-father was released from prison, he, her mother and younger sister, moved elsewhere. Sixteen-year old Sinazo was sent to live with her aunt and uncle. Her mother discouraged her from staying over, saying the family could not afford the additional food costs. Sinazo subsequently accused her uncle of rape and her aunt of physical abuse and was placed in the shelter. In the course of counselling she admitted to lying about the rape (for which no medical evidence had been found) and then left the shelter to live with her mother once more.

Three other equally complex and unrelated cases involved sexual exploitation. Fifteen-year old 'Yoliswa' reported that she and her friends had been stealing, as well as having sex with older men for money. Yoliswa had wanted help in changing her situation and reported the sexual exploitation to the police. She was subsequently placed in the shelter where worry about her future and concern over being separated from her family and friends – perhaps permanently – was causing her distress. While Yoliswa's family still seemed supportive of her, fifteen-year old 'Naledi's' family had called the police to remove her when she attempted to gain entry into the home late one night. This was following a period in which she'd been prostituted, gone to a shelter, returned to school, been located again by her pimp, and then joined a group of gangsters. In about the space of nine months she stayed at three different shelters.

ADULT WOMEN: WHEN SHELTERS FUNCTION AS A KIND OF HOSTEL

The sparseness of some shelters' records prevented a comprehensive view of how women and government departments utilised shelters. But what is available suggests a range of roles that shelters played in women's lives – one of which was the hostel.

Shelters could be described as functioning as a sort of hostel when they provided temporary accommodation for a brief period of time prior to women's being deported, or when they needed to testify in court, or settle other legal affairs (such as deceased estates). Government departments such as the police and the Department of Home Affairs, often relied on shelters in this way.

This utilisation was also evident in the placement at the shelter of the women whose shack had burnt down and needed somewhere to stay until they had built a house.

Brief stays were also associated with women who wanted specific legal and/or practical advice only (such as where to obtain adult nappies for a brother with disabilities) or counselling. 'Veronica', a 29-year old coloured woman, spent three days at shelter 2 in order to see the psychologist. She had been raped at knife point by three men who also attempted to strangle her with a pair of shoe laces. During the rape her mouth had been covered with a cloth – this act subsequently creating associations that made it very difficult for her to eat. In addition to the eating disorder she was experiencing nightmares and flashbacks.

SHELTERS AS REFUGES

In at least two other cases shelters provided a refuge from shame and humiliation – for a university student who felt stigmatised after being raped in her residence; and for a schoolgirl whose panties had been pulled down in front of the class by her teacher while she was menstruating. As refuges, they also provided women with the opportunity to renegotiate the terms of their relationships. 'Safiyya' had been married to her abusive husband for 16 years but took the decision to leave after he punished their adolescent daughter hard enough to leave injuries. Once at the shelter she contacted a family friend who was also a magistrate and who had previously mediated matters between the couple. He persuaded Safiyya's husband to leave, enabling her to return home with her daughter.

Shelters were sometimes also places for those whose actions placed them at odds with others – as was the case for 'Cawe' who had borrowed so extensively from her community to enable her gambling addiction that they had begun threatening her. In another example 'Siphokazi' arrived at the shelter complaining of abuse by her grandmother. However, none of her other family members was willing to have her live with them either. According to her grandmother, Siphokazi had a history of troublesome and manipulative conduct, which included accusing her grandmother of mistreatment.

Shelters were also places for women abandoned by men who either could not, or would not, support them economically. 'Deliwe's' husband had disappeared two years previously, taking his maintenance payments with him. Desperate, she took her three children and travelled to the town where her husband's last whereabouts had been recorded in order to search for him. Deliwe's stressed state and her destitute appearance, as well as that of her children, attracted attention and they were taken to one of the shelters. Like Deliwe, other women could also be said to have been 'found' hitch-hiking alone or with small children or wandering confusedly at a railway station. This was 43-year old 'Magda' who had not taken her medication and then

boarded a train in one province and disembarked in another.

For another group of women, especially those who had been raped, the shelter provided a place to recuperate from their injuries – which were extensive for the women who had fought off attempts at rape. The need to recover from injuries often overlapped with the need for safety. About a quarter of the women who were raped, especially those who were older, had had their homes broken into and were often robbed in addition to being raped, frequently by more than one perpetrator. None of these women felt safe enough to return to their homes, some of which required repairs and fortification. In other instances, women went to shelters in order to be safe from future attack, having been threatened by gang or community members. In 20-year old 'Ayanda's' case her neighbour, who had stabbed her 57 times, was threatening her with violence on his impending release.

SHELTERS AS SANCTUARIES

Safety was also a key issue for women affected by IPV. Indeed, three women had moved provinces to escape their abusive partners, one after her husband, a gang leader, orchestrated a gang rape of her and where the police had failed to act on numerous charges laid against him. Overall, almost one in five of the IPV case files (30 or 18%) reported women having been threatened with death by their abusive partners. There was little reason to doubt these threats. Three of the men had already killed others: the woman's 6-year old brother in one instance and in another, his mistress. (Who the third man, a former police officer, killed is not clear.) Two women had been hospitalised due to injuries sustained during some of their partners' attacks, while a third's intimate partner had already been convicted of the attempted murder, rape and assault of her. Two women had their homes set alight while others had been stabbed, choked and strangled, as well as whipped with cabling and other wires, hit with bricks or torches, threatened at gun point and stomped on. Women's injuries included stab wounds, broken ribs and wrist bones, head injuries and bruising.

The threats were not confined to the women but often extended to children, the women's mothers and siblings, as well as those who assisted the woman. 'Marie', a white woman in her early 40s who had sold her possessions in order to pay her transport costs from Johannesburg to the Eastern Cape, went to live with her mother. Her husband followed her and began threatening her mother and siblings, straining family relations. Marie went to the shelter to protect her mother. Pumeza, who was in her late twenties, was attempting to separate from her boy-friend who threatened everyone who attempted to assist her. After he successfully intimidated the woman who, up until then, had provided her with somewhere to stay, Pumeza was again left homeless. She arrived at the shelter having obtained more than one protection order against her boy-friend and having also opened a number of cases

of assault against him. The reasons for the police's inability to act were not available.

SHELTERS AS RETREATS

The toll inflicted by repeated violence was apparent from 40-year old 'Lenie's' case file. She too had been threatened with death and was trying to end the relationship. She told the social worker who assisted her that she "needs to rest and get help." Lenie was not the only woman to see the shelter as a place of retreat. Others did too and treated this as the opportunity to try and recraft their lives. In wanting to "clean up her act" Sandra (mentioned earlier) was wishing for this kind of starting over. Others saw shelters as serving this purpose too. Twenty-five -year old 'Limeez' had developed a drinking problem after the death of her first child. On the death of her second child the hospital's social worker recommended that she stay at the shelter "to sort herself out."

Rethinking her life was also one of the reasons bringing 'Ayanda' to the shelter. She had been doing badly at school and was lagging behind her peers. The disappointment of her wishes – studying at university in particular – had informed three suicide attempts. She came to the shelter in order to think about alternative futures. Taking a different path in life also featured among two of the sex workers (and was also the impetus behind one of the adolescent girls, Yoliswa, staying at the shelter). 'Fezekile' entered the shelter when she was 21, her life providing yet another illustration of the consequences of childhood sexual abuse. After her mother died she went to live with her aunt and uncle. Telling her that she needed to pay if she wanted her school fees and other expenses taken care of, the uncle began raping her. Unable to live like this, Fezekile went to live for a time with friends who were all engaging in sex work in order to have an income. Deciding that she did not wish to continue in this way, Fezekile travelled to another area where she then went to the police. They, in turn, referred her to the shelter for further assistance. What the outcome of her stay was is not clear from the records.

SHELTERS AS A FORM OF COMMUNITY-BASED MENTAL HEALTH FACILITY

Mental health featured particularly significantly in the experiences of 10 of the 31 women in the combined homeless and other category. Thirty-eight-year old 'Xoliwe' had been diagnosed with bipolar disorder which she managed with medication. After losing her job in another province she returned to the Eastern Cape. When her money ran out she resorted to living on the streets and was then referred to Shelter 3. Xoliwe was subsequently transferred to shelter 4 on the expectation that her family would soon collect her. By now she required repeats of her medication and went to the clinic to collect these. The clinic did not have her medication in stock and sent her to the hospital. But the dispensary had closed by the time she arrived so she was sent back to the shelter empty-handed. By this point, she had already become aggressive towards the fam-

ily members who had arrived to fetch her and refused to leave with them. She went back to the hospital four days later for her medication and was given a two-day supply only and told to return for further medication. On arriving back at the shelter she had a violent outburst and assaulted both the social worker and house mother. The shelter then took her to the hospital where she was admitted to the psychiatric ward.

There were also clear illustrations of how shelters had become part of the revolving door that circulated individuals between institutions. 'Sinah' was profoundly affected by her experience of being trafficked between two provinces and forced into drug-taking. She subsequently escaped and returned home where she was referred to the shelter for her safety. After her escape she had been hospitalised three times, following a suicide attempt on each occasion. She was experiencing auditory hallucinations and observed to argue with herself at times. The side effects of the psychotropic medications she had been prescribed made it difficult for her to hold down a job and so the shelter assisted her to obtain a disability grant.

Nineteen-year old 'Christine' had been sexually abused by her father for a number of years, with her mother's complicity. Her aunt gave her the money to leave so she caught a bus to an Eastern Cape city where nobody knew her. She first stayed at one shelter and, when she left, went to a second shelter for a time. She then returned to the second shelter two years later. By now she had been diagnosed with Borderline Personality Disorder, as well as PTSD. She had also had spells in psychiatric wards following her attempts at suicide and now required specialised psychiatric assistance and monitoring. The shelter attempted to admit her to one of the hospitals but was discouraged from doing so on the grounds that psychotic patients in the ward were not above attempting to have sex with other patients. (It is not clear if this was the admitting doctor's euphemism for rape.) Another hospital was finally found for her.

Turning to a shelter is, at heart, an act of hope and the delicate, reparative work it demands of shelters is one of their core functions.

4.4 SUPPORTING AND ASSISTING WOMEN

In addition to providing care and support – sometimes to an intensive degree – shelter staff also provided assistance with children, health care, legal and practical problems, as well as rehousing and job support.

LEGAL AND PRACTICAL SUPPORT

At least 50 of the 307 women (16%) arrived at the shelter already in possession of a protection order obtained in terms of the

Domestic Violence Act. Another 72 women were assisted to apply for the order, chiefly to deal with IPV or family violence. Obtaining a protection order is a requirement for residence at shelter 5, which may have inflated the number, as not all women may have wanted protection orders. But obtaining the order enabled some women to feel safe enough to return to their homes, even though the abusive party was sometimes still resident. Far smaller numbers of women sought to divorce (12) or obtain maintenance (8). More frequent was shelters' follow-up on the investigation of cases (especially in relation to rape), along with court preparation and support.

Shelters also spent time assisting women to navigate the bureaucracy of everyday life: obtaining identity documents, birth certificates, proof of residence, grants, and accessing banking services.

CHILDREN AND IPV

Information about children was not consistently documented – an indirect comment on the limited interventions available to children. (The number of older women in the study whose children would have been adults, also likely contributed to the lack of information about children.) Given the well-documented effects on children of witnessing IPV, this section focuses on that group of children specifically.

Information about children was available for 140 of the 160 IPV cases, showing that 85% of women had children. All six shelters focused on supporting children's schooling and ensuring they had access to health care. One shelter had started an on-site crèche close to its premises that was also open to children more broadly. While four of the shelters could provide play therapy if required, only shelter 2 appeared to have specialised skills for working with children. One shelter used some of its funding to pay external practitioners to provide more in-depth therapy, as some of the children had also been abused by the women's partner, with at least two children having been raped.

Concerns about continuing to expose children to violence or the children also being abused were sometimes the impetus for women leaving, as Safiyya's case (described earlier) illustrated. At the other extreme were women who struggled to look after their children because, as a social worker put it, "the abuse was so severe that she's no longer present in her life and doesn't know how to engage with and take care of her child."[14] This may have been the case for 'Serena' who was taking anti-depressants. Her husband abused tik, which she admitted to trying when with him (although there was no suggestion that she had become addicted to the drug). At the time she arrived at the shelter two of her children were living separately with other family members, while the third had been left behind with his father. The social worker fetched the two younger children and twice attempted to persuade the eldest

14 Social worker, interview June 2018.

child to come to the shelter. He, however, would not leave, angry at his mother for leaving him behind. However, when no food was left in the house he found his way to the shelter. Some weeks later the social worker placed all three children in foster care. It was the social worker's assessment that Serena had neglected the children by sending them to school for a number of days without breakfast and lunch, as well as by not fetching them from school.

Overall, at least 18 women requested help with parenting skills while foster care or adoption arrangements were made for at least eight women.

HOW THE SHELTERS ATTEMPTED TO ADDRESS WOMEN'S ECONOMIC DISADVANTAGE

Attempting to increase women's employability presents formidable challenges to shelters. Between 2014 and 2016, the Northern and Eastern Cape experienced the lowest and second-lowest economic growth rates respectively in South Africa (Eastern Cape Department of Economic Development, Environmental Affairs and Tourism, n.d.). Neither province has many large cities either, which also presents challenges for shelters in rural and peri-urban areas where few businesses exist and unemployment is high.

It is also difficult to address this degree of disadvantage in the context of a short stay. Shelters' efforts at helping women find work largely included helping women to develop their CVs, giving them access to shelter resources (use of telephone and a computer, for example), taking clients to drop their CV's off and/or to attend interviews and, where possible, directly engaging with prospective employers.

While one of the organisations managed a second-hand charity shop which provided some work experience for residents, no organisation was running any formal skills development programmes. Two were providing classes in arts and crafts – especially sewing and beading – as well as cooking classes. Occasionally, it was possible for a shelter to place women on courses providing computer skills. Two shelters were investigating the establishment of social enterprises that could support shelter residents while a third had recently entered into an agreement which would see a materials factory provide the shelter with material to make cushions which it would then market. None of the shelters had any form of relationship with the Sector Education and Training Authorities (SETA) so were not able to take advantage of any opportunities that they may have been offering.

LEAVING THE SHELTER

Information about women's exit from the shelters was missing for 119 (40%) of the 310 stays. Shelter 6's records were the most incomplete on this score with 77% of their files missing this information. To limit

the extent to which this skewed the data, we excluded their 62 records and analysed the remaining 248 records, of which 25% were missing information about women's departure from the shelter. Nine women were also still resident in the shelter at the time of the study's cut-off period. We thus present findings on the remaining 188.

When records were available, these showed at least 14 women to have requested an extension of their stay – typically because their new accommodation was not yet available or because they had not yet found a job enabling them to support themselves. These requests were usually granted.

TABLE 14: WHERE WOMEN WENT AFTER LEAVING THE SHELTER, BY PRESENTING PROBLEM[15]

	SAMPLE (N=188)	IPV (N=88)	FAMILY VIOLENCE (N=19)	SEXUAL VIOLENCE (N=20)	OTHER (N=38)
Returned to abuser	25 (13%)	19 (22%)	4		
Went to stay with family	88 (47%)	40 (45%)	7	11	10 (26%)
Found other accommodation	22 (12%)	15 (17%)	2		6 (16%)
Returned home after abuser evicted/ protection order obtained	14 (7%)	7 (8%)	3	1	
Absconded	10 (5%)	5 (6%)	2	2	1 (3%)
Returned to own home	13 (7%)	1 (1%)		5	11 (29%)
Other	16 (9%)	1 (1%)	1	1	10 (26%)
Totals	100%	100%			100%

Shelters helped women in different ways to find alternative accommodation. Most often this involved liaising with family members around providing somewhere to stay but also included providing advice about rentals, helping women find work with live-in accommodation, and assisting with the actual move.

One in five women (22%) returned to their abusive partners, while a further 8% returned to their homes following the es-

15 *Percentages are not provided for the family and sexual violence categories due to the small number of cases.*

tablishment of conditions for their return. This entailed securing a commitment from the perpetrator to address his drinking, or obtaining a protection order against their partner or having him evicted. Most women moved away from their partners however, either to a family member (45%) or to accommodation they shared with a friend or rented.

In the 'other' category were women who were deported or evicted from the shelter for breaking shelter rules (such as being drunk at the shelter or revealing its whereabouts). It also included the women who went to other institutions – such as shelters, older persons' homes or psychiatric wards.

Overall, the table underscores the importance of family assistance to women.

Follow-up with women once they had left the shelter was infrequent. Shelter 1 did provide follow-up services and also conducted home visits, especially where children were involved. At shelter 2 it was the social worker's impression that most of their residents preferred not to be contacted: "once they leave, they leave; it's almost as if they don't want to be reminded of it, or they feel ashamed if they have returned to their partners."[16] Shelter 6 also did not offer such services unless the woman lived in the immediate area.

"Shelters helped women in different ways to find alternative accommodation. Most often this involved liaising with family members around providing somewhere to stay but also included providing advice about rentals, helping women find work with live-in accommodation, and assisting with the actual move."

16 *Interview, June 2018.*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CONCLUDING REMARKS

This report set itself three objectives: investigating the budget allocated towards sheltering services, especially at provincial level; describing the circumstances of all women resident in the study shelters; and foregrounding women's mental health needs.

Shelters are situated at the nexus of a particular kind of political irrelevance, one that is informed by the low status of mental health generally and the low priority placed on the victim empowerment programme. The review of existing budgets and expenditure showed that, overall, care and support, was the activity least funded in relation to violence against women and children. This deprioritisation of care and support services was visibly evident in relation to the budget allocated nationally towards victim empowerment, the programme responsible for shelters. That victim empowerment receives the second-least portion of the budget is equally telling of its negligible status as a political priority. Thus, rather than being funded to fulfil what is clearly an essential role in addressing the needs of a highly vulnerable group of women, the shelters in this study were more often than not under-staffed and made less effective by limited, uncertain funding. It was not only the amounts that were cause for concern; the inefficient processes and procedures organisations were required to follow to access their funds imposed no less difficulty. These burdensome and bureaucratic constraints represent one of the ways in which shelters' ability to support women to recraft and repair their lives is limited.

A second is the absence of comprehensive recent policy. Not only have different forms of sheltering emerged since the issuing of the 2004 service standards but so have different populations of women come to be housed by shelters. It is appropriate for what were domestic violence shelters to also house women who have experienced family violence, as well as sexual violence not perpetrated by their intimate partner or a family member. It is also clear that histories of childhood sexual abuse are important factors contributing to women's later homelessness as adults, or their ambivalent engagement in sex work. Thus, in key respects, women are more alike than different. However, as a group they may not be typical of all women who have been subjected to violence. In addition to their complex life circumstances, women in this sample (like women in the other four shelter studies) were also very disadvantaged economically. They may well require far greater levels of support than other women. But as a group from whom much has been taken, much must be given. This is currently not the case – further underscoring the need for the comprehensive revision of existing policy. Indeed, the ways in which shelters have been unofficially drawn into revolving door patterns of mental health care in South Africa have largely gone unnoticed precisely because policy

has not kept up with the realities of sheltering. We conclude the report with a set of recommendations aimed at addressing some of the report's findings.

RECOMMENDATIONS

Violence is one of the determinants of mental health, making attention to women's mental health a vital and inescapable element of shelters' work. The recommendations that follow sets out how their victim empowerment function can be articulated with mental health policy, the ***National Mental Health Policy Framework and Strategic Plan 2013-2020*** specifically.

1. INCREASING ACCESS TO MENTAL HEALTH SERVICES

All shelters must have access to mental health services which include both a psychiatric as well as a psychological component. Detoxification facilities also need to be made available to women with substance abuse difficulties. Attention to women's children is also key, not only because a great deal of psychological difficulty begins in childhood and adolescence but also because of the children's exposure to violence. Strengthening the mental health component of shelter services could be accomplished by:

- Formalising specific agreements between the Department of Health and the DSD around the provision of mental health services to shelters, local clinics and hospitals. This may include making available nursing staff whose specific job it is to attend to shelter residents. This is in keeping with the principles of the Framework which include intersectoral collaboration and the mainstreaming of mental health into legislative, policy, planning, programming, budgeting and other activities in the public sector.
- Exploring the placement of clinical psychology master's students and interns at shelters.
- Exploring how psychological services specialising in children's mental health can be made accessible to shelters, including through shared posts.
- Clearly defining the roles and limits of shelters in providing mental health services. Shelters' chief purpose is to assist women who have experienced violence and they cannot be expected to function as mental health facilities. Where particular psychological difficulties are entrenched or severe shelters must form part of referral pathways to more specialised forms of assistance.

2. RECOGNISING THE ROLE OF NON-SPECIALIST WORKERS IN MENTAL HEALTH SYSTEMS

With not all women's distress being severe, shelter workers are well-placed to address mild and moderate difficulties. Indeed, the Framework affirms the place of non-specialist workers in mental health systems and recommends their training, as well as specialist supervision. This could also include some introductory training around psychotropic medications, including being able to assist women to adhere to their medication (when required).

The Framework also foresees a role for NPOs in the provision of information and education around mental health. Again, within limits, this is something organisations could be equipped to undertake specifically in relation to their work around intimate partner violence. This might include providing information to communities, families and friends around assisting someone to cope with PTSD; or providing basic information around how to recognise depressed and anxious thoughts and ways to prevent their taking hold.

3. RECOGNISING AND SUPPORTING THE IMPORTANT WORK OF SHELTERS

It should be clear from the research findings that shelter work is indeed "hard" (as one of the interviewees put it). Indeed, the 2008 Mental Health and Poverty Project singled out the need to recognise the economic, social and emotional impact upon women of being the chief providers of community-based care and recommended that they received appropriate support to do so. Yet some shelter staff are paid less than the minimum wage and others below market rates. They may also go without payment when their tranches are delayed and face the sort of stress that comes with knowing their services may not always be of the standard they ought to be. These are all preventable stressors.

IN CONCLUSION, WHAT IS REQUIRED IS CRITICAL REFLECTION ON POLICY AND PRACTICE OVER THE LAST TWENTY YEARS; THE CRAFTING OF FRESH AND COMPREHENSIVE SERVICES; COMMITMENT TO INTER-SECTORAL COOPERATION; AND THE POLITICAL WILL TO PRIORITISE AND INCREASE FUNDING TO THE VEP.

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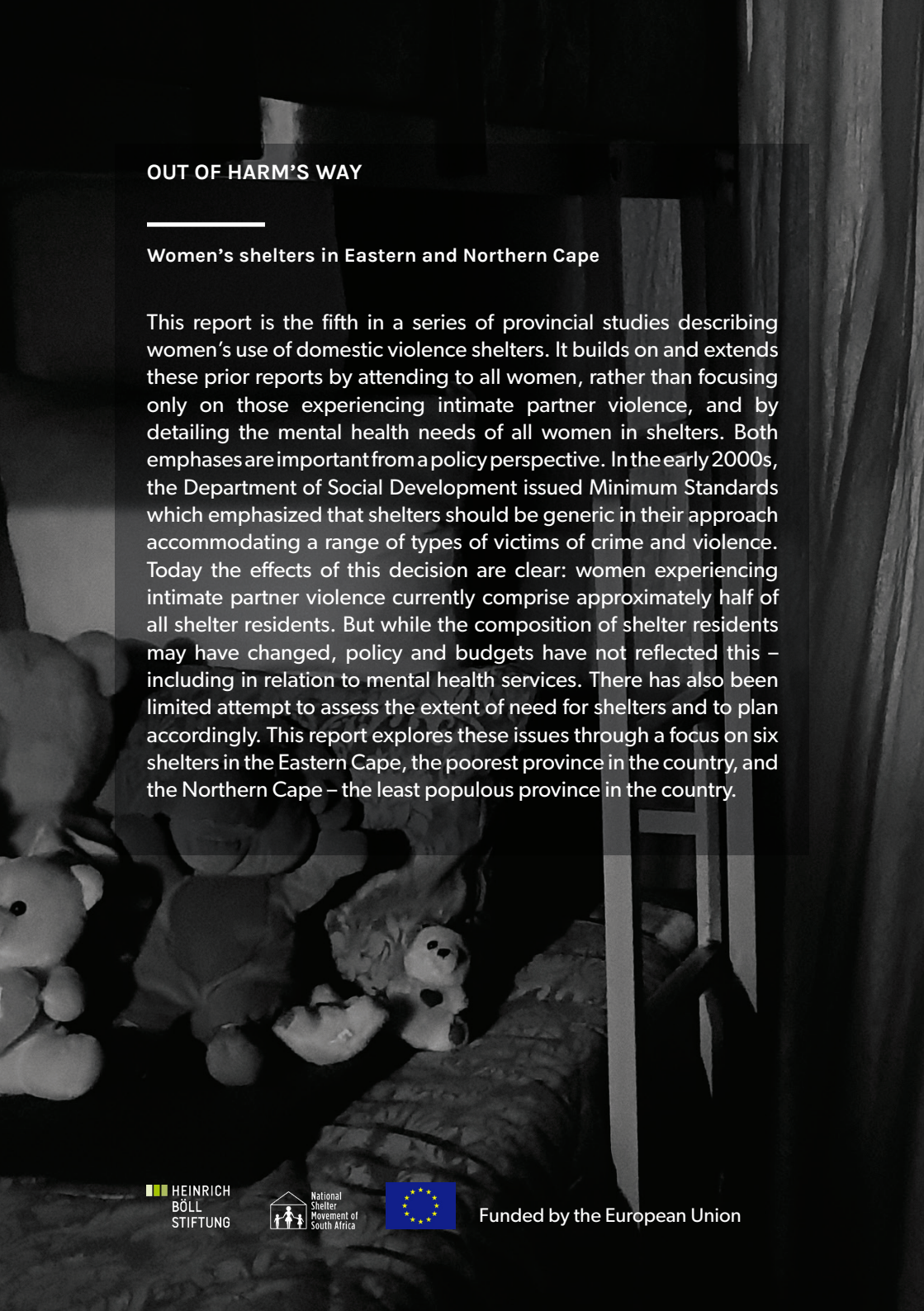

OUT OF HARM'S WAY

Women's shelters in Eastern and Northern Cape

This report is the fifth in a series of provincial studies describing women's use of domestic violence shelters. It builds on and extends these prior reports by attending to all women, rather than focusing only on those experiencing intimate partner violence, and by detailing the mental health needs of all women in shelters. Both emphases are important from a policy perspective. In the early 2000s, the Department of Social Development issued Minimum Standards which emphasized that shelters should be generic in their approach accommodating a range of types of victims of crime and violence. Today the effects of this decision are clear: women experiencing intimate partner violence currently comprise approximately half of all shelter residents. But while the composition of shelter residents may have changed, policy and budgets have not reflected this – including in relation to mental health services. There has also been limited attempt to assess the extent of need for shelters and to plan accordingly. This report explores these issues through a focus on six shelters in the Eastern Cape, the poorest province in the country, and the Northern Cape – the least populous province in the country.

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