A Rapid Assessment of Violence Crisis Services during COVID-19 Lockdowns in South Africa

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Abstract: Government and civil society have made significant efforts to keep gender-based violence (GBV) services available during the COVID-19 lockdown, a time which may exacerbate challenges for those at risk of GBV. Despite this commitment, a rapid assessment of violence services in South Africa finds that a quarter of Thuthuzela Care Centers – government-run, one-stop sexual assault resource centers – and 40% of violence shelters were unreachable during a week of twice-daily calling. Additionally, only 25 shelters nationwide stated they were able to take in new clients and not all individuals seeking services would likely meet the criteria for admission. These troubling barriers to accessibility are likely indicative of COVID-19 lockdown challenges as well as existing pre-COVID-19 deficiencies in South African GBV service capacity. Further government action and resources must be directed to ensure that reliable access to GBV services during the duration of COVID-19 and beyond.

Introduction

The state of gender-based violence in South Africa

Prior to COVID-19, South Africa faced a well-documented epidemic of gender-based violence (GBV). The most recent South African Demographic and Health Survey (DHS) reports that more than a quarter (26%) of ever-partnered South African women have experienced any type of physical, sexual, or emotional violence by a partner. The DHS also reported that the proportion of women reporting violence by a partner in the last year varied significantly by province, which was as low as 7% in Limpopo and as high as 18% in North West.[1] The South Africa GBV crisis has received attention at the international and national level, prompting government and civil society responses. The recent R1.6 billion Emergency Response Action Plan on Gender-based Violence and Femicide represents the latest example of government efforts to invest in expanding GBV service access.[2] Non-governmental organizations (NGOs) also play a significant role in the GBV response, in terms of advocacy, prevention, and response.[3] Accordingly, GBV services in South Africa are diverse in terms of both the entities providing them and available services. For the purpose of this analysis, we focus specifically on two types of services, Thuthuzela Care Centers (TCCs) and domestic violence shelters given their importance in the immediate response to GBV survivors. However, we acknowledge this is not the sum of GBV services in South Africa, and in fact, globally, many GBV survivors rely on informal social support rather than accessing formal services. [4,5]

TCCs are one-stop sexual assault centers that aim both to aid in conviction of sexual offenses but also to expand physical, psychological and social care for survivors of rape, sexual assault and domestic violence.[6] While the primary route through which individuals access TCCs is via police referrals and transport, TCCs also receive referrals from hospitals and other health care providers as well as individuals coming by themselves directly to the centers.[7] While few-peer reviewed evaluations of TCCs exist, the grey literature suggests that individuals seeking care at TCCs have faced documented delays in care and other issues including inadequate privacy.[8,9] Critiques of the TCCs have also found a lack of resources for sufficient follow-up and comprehensive service delivery, noting that while acute medical needs may be met, emotional support services are often not provided due to insufficient funds, space, and social workers.[10]

Violence shelters are another vital aspect of the GBV response, including the National Shelter Movement of South Africa (NSMSA), which serves as a collective voice for the majority of South

Africa GBV shelters.[11] Similar to TCCs, the grey literature suggests there are insufficient violence shelters in South Africa, many of which have overburdened staff serving in multiple roles, and rely heavily on volunteers. Many shelters have had to cut program provision as expenditures exceed Department of Social Development funding.[12] In addition to limited capacity, needs also may not be met for some survivors of GBV because of various criteria required for being housed within a shelter; review of shelter criteria includes examples such as some shelters cannot take women with children, cannot take women with male children over a certain age, cannot take individuals with mental health challenges, and cannot take men.[13] Attention has also been called to the specific challenges individuals with disabilities face in accessing GBV services, including lack of accommodations for physical disabilities and communication challenges.[14] Additionally, shelters may not be able to provide appropriate resources to survivors of same-sex intimate partner violence.[15] In short challenges to finding GBV services existed for many in South Africa, even prior to COVID-19 crisis.

GBV and COVID-19

COVID-19 related lockdowns and layoffs can increase risk of GBV by simultaneously isolating people with their violent partners during times of economic and social stress and cutting them off from available resources.[16] Past global health crises have demonstrated these risks; quarantines and school closures during the 2014 Ebola outbreak resulted in documented harms, including sexual coercion and abuse, to young women.[17] Moreover, in addition to direct harms sustained by individuals during such public health crises, GBV service delivery is often disrupted when personnel and resources are redirected for emergency response.[18] Cognizant of the lockdown's potential exacerbation of the existing GBV crisis, South African government and civil society have moved quickly to adapt GBV resources to better serve survivors during these unprecedented times. In particular, measures to mobilize virtual resources have been vital to the response, including bolstering 24-hour hotlines for domestic violence and rape crisis and providing virtual support via Skype, "Please call me" SMS message services, telephone counseling, and other safety-planning services and shelter referrals for survivors.[19, 20] Additionally, the government classified TCCs and shelter services as essential services during the COVID-19 pandemic to allow continued provision of care.[21, 22] In the initial period after lockdown began, the national GBV Command Center saw a small increase in calls, but other GBV related services including cases reported to TCCs decreased.[21] Decreased reporting is likely not indicative of decreases in GBV, but often reflective of decreased ability to access services,[23] further emphasizing the importance of ensuring accessibility to services during lockdown. This rapid assessment aims to assess the extent to which these GBV services remained operational during COVID- related lockdowns in South Africa.

Methods

A rapid assessment of GBV crisis services was conducted by amfAR, The Foundation for AIDS Research, to record whether services remained open and providers were answering the phone during COVID-related lockdowns. Data collection spanned one month (April 30–May 29) during which South Africa was in lockdown level 5 (enforced restrictions on all non-essential movement) or level 4 (slightly eased regulations on movement with strict restrictions on most travel).[24] During the assessment, a team of six data collectors called all gender-based violence shelters publicly listed, using the primary phone number listed for each shelter in the National Shelter Movement of South Africa (NSMSA) shelter directory (n=86)[25] and all TCCs listed by the National Prosecuting Authority of South Africa (n=55).[26] Seven additional known shelters

through researcher contacts were added to the initial list (2 shelters in Gauteng province, 1 shelter in KwaZulu Natal, and 2 in Mpumalanga province). Total shelter count n=93.

Data collectors called every GBV service twice a day until a person was reached for up to seven days, or a maximum of 14 calls per service.[1] Calls were all made during South African business hours and from a local South African phone number. Callers identified themselves as researchers based in the United States when asked, otherwise the questions were asked without the researchers providing additional background information on themselves. Of primary interest were whether publicly available numbers for GBV crisis services were working and whether these services continued to field incoming calls during COVID lockdowns. GBV shelters with intake capacity were asked if they had space available to house new clients. If staff described any criteria for admittance to the shelter, that was also noted but was not specifically asked by data collectors. Survivors who are seeking shelter may not always be contacting shelters directly, but rather through referral from a social worker, police, NSMSA representative, hotline etc. who may help them navigate the shelter system. This is particularly true given the specific referral system set up for shelters during COVID-19,[19,20] however, we chose to call the main numbers listed for each shelter listed on the NSMSA directory[25] for a number of reasons: first, we wanted information specific to each shelter and second with the directory remaining prominently listed on the NSMSA we assumed this was a place survivors seeking support might still visit. We acknowledge that some GBV survivors seeking care may have been able to find the appropriate instructions to reach the shelter representative for each province, and thus our efforts are not meant to exactly replicate what their search may be like but instead to capture information regarding the state of services during COVID-19 and note the challenges some might face in reaching a shelter. The difficulties that data collectors experienced in trying to find current publicly available contact information for crisis may be felt by survivors as well.

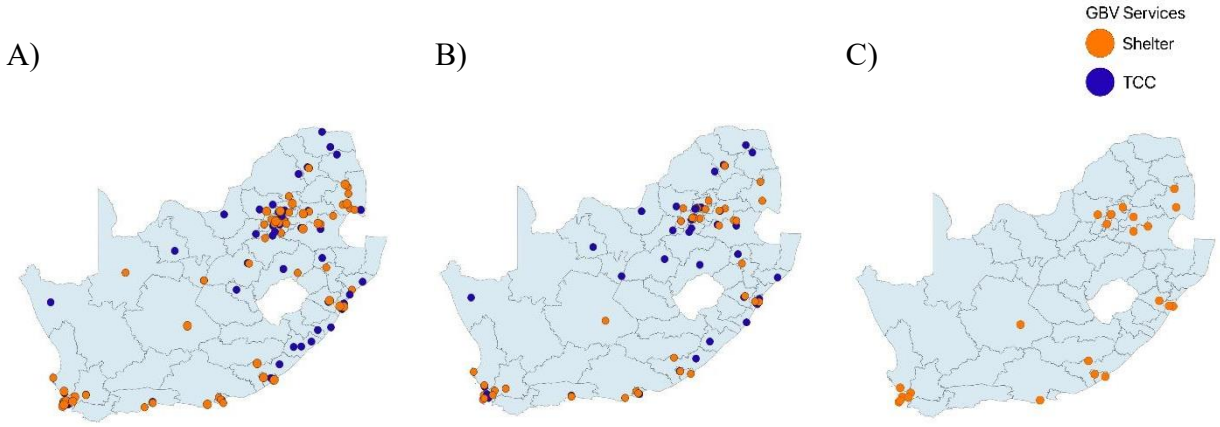
Other limitations to this assessment are that TCCs and shelters do not make up the totality of South Africa's GBV response, and we did not attempt to contact hotlines or social workers specifically. For ethical reasons we chose not to add call volumes to hotlines or individuals involved in case management, however acknowledge that we missed key pieces of the GBV response system in South Africa. Accordingly, the results should be interpreted only as an initial indication of service availability through the method of contact we selected. Further investigation is needed to assess the accessibility of GBV services in the unique setting of the COVID-19 lockdowns.

Results

Overall, the assessment found that 63% of TCCs and shelters were reachable during the assessment, requiring an average of 3 calls per service. Of the known and reachable GBV shelters, 25 confirmed that they had space to accommodate new clients for intake [Figure 1].

[1] Five of the 19 shelters who were deemed non-responders were only contacted 4 times instead of the full 14 calls due to timing constraints.

Figure 1. GBV services by type and availability, May 2020[2]



A) All known GBV services

B) All reachable GBV services

C) All shelters taking new clients for intake

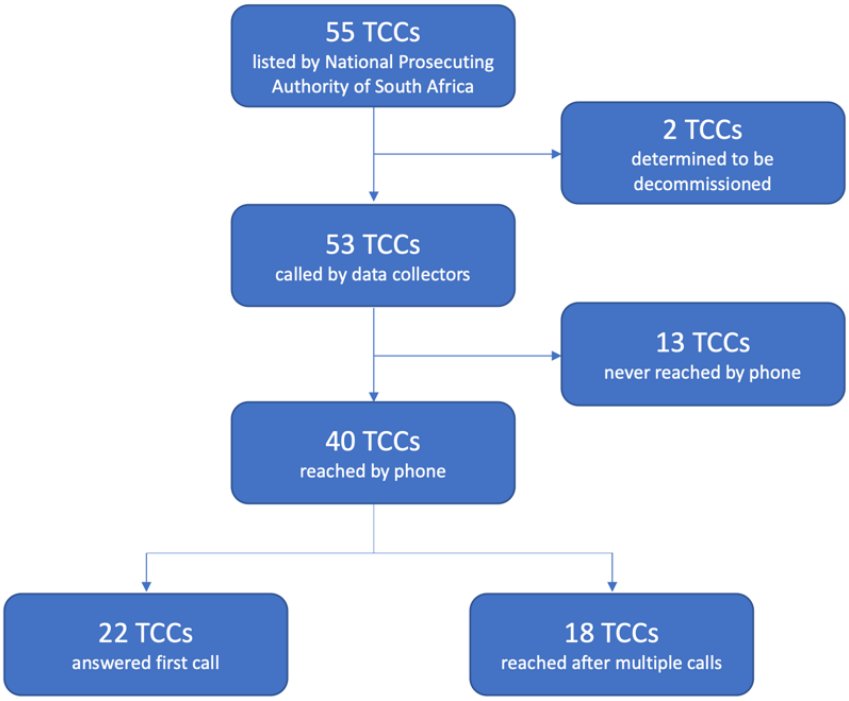
Thuthuzela Care Centers (TCCs)

TCCs are located in each province, with four in each Free State and Northern Cape, five in Mpumalanga and Northwest, seven each in Gauteng, Limpopo, and Western Cape, and eight in KwaZulu-Natal and Eastern Cape. During the data collection process, two TCCs of the original 55 were determined to have been decommissioned. Of the remaining 53, the majority (40, 75%) were reachable by phone during the week of calling. Thirteen TCCs were not reachable by phone. Twenty-two TCCs answered the phone on the first attempt. On average, it required 2.5 calls to a facility to reach a live person (range 1-12 calls) [Figure 2]. In general, data collectors found TCC staff to be friendly and informative when reached. Many TCCs had phone numbers that routed through the larger hospital facility number, and occasionally main hospital staff were unsure about the existence of TCCs. Given that TCC services do rely significantly on referrals from police rather than individuals seeking the services by themselves, it is not unexpected that directly calling the TCCs was sometimes a challenge. However, in the event that a survivor or patient reaches the TCC directly, phone calls should still be fielded accordingly.

Of the reachable TCCs, 26 (65%) confirmed that they were open 24 hours a day to serve clients – although not all services would be available at all times. Several TCCs noted that while services were not available 24 hours a day on-site that they partnered with other NGOs who could provide more specialized services during non-business hours like nights, weekends, and holidays. These TCCs were still counted as operating 24 hours a day.

[2] Exact shelter location unavailable for safety reasons. Locations represent approximations based on available information in the National Shelter Movement directory

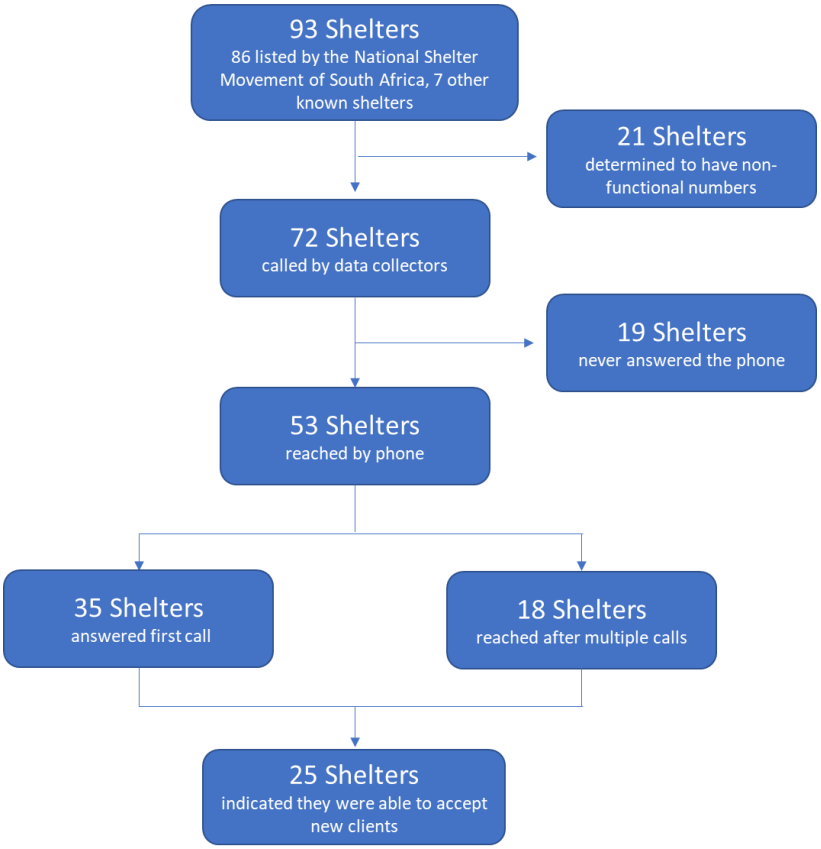
Figure 2. TCC Accessibility



Shelters

The number of shelters varied by province: one in North West, two in Limpopo and Northern Cape, four in Free State, seven in Eastern Cape, nine Kwa-Zulu Natal, 16 in Mpumlanga, 18 in Western Cape and 28 in Gauteng province. Nearly a quarter (23%) of the shelter's listed telephone numbers were nonfunctional (i.e., number was immediately disconnected or call could not be completed). Among unreachable shelters, data collectors were not able to distinguish between those with outdated phone numbers, those shelters that may have no longer been functioning prior to COVID-19, and those closed due to COVID related issues. Fifty-three shelters (57%) were ultimately reachable during the assessment, and 35 shelters answered on the first attempt. Of the shelters with working numbers, it took data collectors an average of 4 calls to reach a live person (range 2-7 calls) [Figure 3]. At the time of data collection, 25 shelters across the country reported having room for new clients who met the shelter's client criteria. Similar to the TCCs, data collectors found that when they were able to reach staff, they were friendly and informative; however, few shelter staff were able to confirm that they could accommodate new clients for intake, though some were able to provide the contact information of social workers with that information.

Figure 3. Shelter Accessibility



The specific criteria required for shelter entry varied. Most shelters required a client to be a woman and any accompanying children to be under a certain age. Entry into one shelter in Gauteng was contingent on proof of a negative COVID-19 test and another in Eastern Cape required clients provide their own personal protective equipment – requirements that could make the shelter inaccessible for many. Two shelters indicated they could only accept intake clients with a referral from the Department of Social Development (DSD) but were open 24 hours a day given their government designation as first responders. Both of these shelters were located in Western Cape, where a specific two-tier referral system had been put into place in which several shelters have been identified as Stage One, where survivors spend two weeks to monitor for COVID symptoms before moving on to Stage Two shelters.[27] This assessment documented only a small snapshot of the barriers that a survivor may need to overcome to access shelter. Additional barriers may include lack of transportation, financial barriers, citizenship requirements to enter shelter, other restriction of number of age of accompanying children. Together, these barriers have the potential to exclude survivors from shelter even if there is space available for intake.

Of note, the assessment also found that shelters were adapting to the challenges of COVID-19 by providing additional virtual support, phone-based counseling, and safety planning. Some shelters were maintaining limited vital functions, such as handing out food and clothing, despite the

inability to accommodate new clients for intake. Those that were not accepting new clients during lockdown planned to be fully operational after lockdowns eased, though the actual ability of these shelters to accommodate new clients post-lockdown is not guaranteed. Indeed, many of the challenges noted during this rapid assessment, including limited shelter space and staff capacity to field calls, may be indicative of pre-existing issues that will not be addressed as lockdowns ease.

Conclusions

While there have been noteworthy adaptations to service delivery by South African GBV service providers during COVID-19, this assessment finds that actual availability of services during lockdown may be more limited than what's publicly listed due to non-working numbers and non-answered phone calls during these difficult times. Unlike the well-resourced, non-traumatized individuals who made hundreds of calls to service providers across South Africa during this rapid assessment, an actual survivor may live in a province with only one shelter and only have the time for one call. A non-answered call or incorrect published phone number should not join the countless other social, cultural, and economic barriers that survivors of violence need to overcome in order to secure their safety.

COVID infection does pose a serious risk to clients and staff of GBV services that cannot be ignored. Many shelters in this assessment have taken steps to reduce COVID risk for their clients and staff such as requiring a negative COVID-19 test prior to admittance, requiring individuals bring their own PPE, reducing shelter capacity, or the two-tier system implemented in Western Cape. Given that some of these requirements may be prohibitive for those seeking services, government support to ensure availability and accessibility of needed COVID-19 testing or PPE is vital for the GBV response in order to keep both clients and staff safe.

Even as lockdowns ease, COVID-19 related food-insecurity and economic instability, both of which have been associated with GBV, [30-31] will remain prevalent. A significant increase in governmental and donor resources for social workers, case management, intake services, and active outreach and dissemination of GBV information will be required to combat the GBV pandemic in the face of COVID-19. In President Ramaphosa's May 13th (2020) speech, he stressed that lockdown measures were designed to ensure that survivors of violence would continue to receive assistance.[32] This promise needs to be backed up by the resources necessary to ensure that a survivor's call for help is answered the first time, every time.

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