

From Policy to Practice: Frontline Staff Insights on Gender-based Violence and the Built Environment at a South African University

Inge Newport
Tshwane University of Technology

Abstract

Gender-based violence (GBV) persists as a pervasive challenge within South African universities, undermining student safety, well-being, and equity. Although the Department of Higher Education and Training (DHET) has established a national policy framework mandating institutional responses to GBV, implementation has been inconsistent and uneven. This paper examines the gap between policy intent and practice through a built environment and user-needs perspective, highlighting how spatial and infrastructural conditions shape the capacity of frontline staff to deliver GBV-related services. The study engaged 60 staff members across nine campuses of a South African university, including security, health, and wellness personnel. Using participatory methods such as walking interviews and campus mapping, systemic spatial and infrastructural barriers that hinder the effective implementation of GBV policy mandates were identified. A policy-based interview checklist revealed discrepancies between policy requirements and the environmental conditions necessary for service delivery, pointing to the need to develop implementation standards. The findings highlight how spatial features, such as inadequate lighting, proximity to taverns, and insufficient surveillance, can increase vulnerability to GBV. The results indicate a need to develop targeted interventions, including GBV-focused safety audits and purpose-designed prevention and response infrastructure. The study demonstrates how policy-derived spatial enquiry tools can elucidate environmental factors impacting service delivery outcomes versus expectations. It further advocates the development of policy implementation and monitoring standards to promote consistency in policy adoption. The paper contributes to identifying built environment features associated with GBV within university campus settings and the necessary infrastructure needed to address it.

Keywords

Gender-based violence; South African universities; Built environment perspective; Participatory research.

Introduction

Despite South Africa's progressive constitution aimed at protecting human rights, its society carries forward remnants of oppressive historical and traditional gender norms that contribute to it having one of the highest rates of gender-based violence (GBV) globally (Department of Justice and Constitutional Development [DoJ & CD], 2012, p. 14; Department of Women, Youth and Persons with Disabilities [DWYPD], 2020, pp. 21–24; Govender, 2023; Zungu et al., 2024, p. 2). As microcosms of society, universities reflect the broader challenges of gender inequality and violence (Commission for Gender Equality [CGE], 2024a, pp. 3–6; Department of Higher Education and Training [DHET], 2020, pp. 1–2). Various publications indicate that GBV is a common occurrence in South African universities, with female and LGBTQIA+ students disproportionately affected (Brink et al., 2022; CGE, 2024b; Fielding-Miller et al., 2021; Gender Dynamix [GDX], 2023; Hamlall & Jagath, 2024; Mutinta, 2022; Mutongoza, 2023; Sekgobela et al., 2024). The inclusion of female students under the age of 25 as a sexually vulnerable group in the *Criminal Law (Sexual Offences and Related Matters) Act* (SORMA) highlights the ongoing risks that female students encounter in educational settings (*Criminal Law (Sexual Offences and Related Matters) Amendment Act 13 of 2021* (S Afr) p. 14).

In 2020, the South African government took a strong stance against GBV by releasing the South African *National Strategic Plan on Gender-Based Violence and Femicide* (DWYPD, 2020; the

NSP on GBVF) and the Department of Higher Education and Training (DHET) *Policy Framework to Address Gender-Based Violence in the Post-School Education and Training (PSET) System* (DHET, 2020). The DHET GBV policy framework is the mandate from which universities must develop their own internal GBV response strategies. The framework requires institutions to create a supportive legislative and administrative environment that fosters prevention, awareness, support, and assistance in addressing GBV (DHET, 2020, p. 14). The framework does not explicitly detail the infrastructure requirements; however, these needs are implied through the expected actions described in the document. For instance, establishing reporting and monitoring systems, as well as offering support and assistance services (DHET, 2020, p. 21), requires sufficient facilities and resources.

Supporting DHET is Higher Health (n.d.-a), a national, government-funded nonprofit organisation responsible for driving health and wellness initiatives in the higher education sector. Since the release of the DHET policy framework, Higher Health has addressed GBV in institutions through the provision of awareness and advocacy materials, support services for GBV, and training opportunities. Additionally, they facilitate a peer education programme focused on student-to-student guidance on GBV prevention and service availability at universities (Higher Health, n.d.-b).

Following the release of the DHET GBV policy framework, Higher Health developed several guidelines and protocols to assist institutions in adopting aspects of the policy framework. These guidelines and protocols include spatial references to safety infrastructure minimum standards, accessibility of reporting and response service spaces, and the right to privacy in areas such as ablutions (Higher Health, 2021, 2023a, 2023b). The recommendations demonstrate a clear understanding of the built environment's impact on safety, inclusivity, and service delivery; however, they are not accompanied by an audit checklist for compliance purposes.

Despite these policy tools, studies conducted by the Commission for Gender Equality (CGE) (2024a, pp. 18–22) and the Ministerial Task Team (MTT), which advises the Minister of Higher Education, Science, and Innovation on matters related to GBV (DHET, 2024), have identified significant gaps in how institutions translate policy intent into practice (CGE, 2024a, pp. 13–15; DHET, 2024, pp. 5–6). The inconsistency of interventions and the persistence of GBV, as noted by the CGE and MTT, underscore the need to strengthen response strategies, implementation standards, and monitoring tools employed by institutions (DHET, 2024, pp. 8–9; Zungu et al., 2024, p. 19).

This paper aims to better understand the gap between policy expectation and implementation by examining the conditions that affect GBV service delivery at a university in South Africa. The study employs participatory spatial methods, such as walking interviews and campus mapping, to investigate how environmental and infrastructural factors impact the capacity of frontline staff to deliver prevention and response services. The interview questions focus on the infrastructure requirements implied within the DHET policy framework and Higher Health guidelines, offering a practical approach to bridge the divide between policy expectations and the staff's requirements to deliver a service effectively. The research emphasises the importance of incorporating user insights into service infrastructure planning to promote the equitable implementation of policies, and advocates for the development of implementation and audit standards to enhance policy implementation and monitoring.

Literature review

Research shows that policy gaps often have a spatial component. For instance, the CGE and MTT studies on the implementation of the DHET GBV policy framework identify that spatial and infrastructural issues, such as inadequate lighting and inaccessible clinics, hinder staff's ability to

effectively implement GBV mandates (CGE, 2024a; DHET, 2024). Similar findings are reflected in academic studies, which indicate that the quality and accessibility of service infrastructure can impact campus safety, reporting rates, and the perception and experience of support services (Fielding-Miller et al., 2021; Mahlangu et al., 2022; Randa et al., 2023).

Studies by Machisa et al. (2021) and Sepadi and Chadyiwa (2025) demonstrate that environmental factors, such as lighting, building placement, and surveillance patterns, directly affect exposure to GBV. Surveys on campus safety conducted by Mkhize (2022, p. 8) and Mdlungu et al. (2020, p. 543) highlight the importance of functional environmental factors, such as adequate lighting, clear walkways, and effective access control, in creating safe spaces. In contrast, infrastructure deficits, such as poor visibility of reporting offices and a lack of secure and soundproofed consultation rooms, compromise accessibility and trust, deterring individuals from reporting incidents or engaging support services (Gwiza & Hendricks, 2024, pp. 61–62; Mahlangu et al., 2022; Munro-Kramer et al., 2025, pp. 2–3).

Additionally, the CGE (2023, pp. 13–15) identifies systemic challenges related to fragmented service environments, indicating that GBV offices, counselling units, and campus protection services typically operate in isolation. These siloes are spatially represented through the disconnected service spaces across campus. This fragmentation contradicts the NSP on GBVF (DWYPD, 2020, pp. 47, 70, 94), which promotes co-created, inclusive environments that foster social connectedness and communal healing.

Literature suggests that an effective response to GBV requires trauma-informed and confidential service spaces (DoJ & CD, 2012, pp. 18–19; Foundation for Professional Development [FPD], 2016, pp. 38–39; Higher Health, 2021, pp. 5, 15). Randa et al. (2023) and Holton et al. (2018) document how the physical environment of clinics and reporting spaces impacts survivor comfort and acceptance of care. Olson et al. (2020) identify one-stop GBV service models as effective frameworks for post-assault support. The one-stop model opposes siloed service systems by combining reporting and immediate access to a comprehensive suite of support services. Such models align with the recommendations of DHET (2020, p. 16) and the CGE (2024a, pp. 21–24), which advocate for integrated, survivor-centred service spaces on campus.

Mathews et al. (2024, p. 2) argue that effective GBV interventions must also address intersectional inclusion in response to differences in gender and accessibility. Research by von Meullen and van der Walldt (2022) and Seidu et al. (2024, p. 149) indicates that a lack of attention to LGBTQIA+ visibility and universal accessibility contributes to the marginalisation of individuals within campus environments. Applying a gendered and intersectional perspective to the built environment (Baldwin, 2023; Navarrete-Hernandez et al., 2021) reveals how spatial layouts, accessibility, and signage practices can have different impacts on users, requiring careful consideration to promote inclusion and equitable access to reporting and support services.

These insights represent the built environment as a potential promoter or inhibitor of GBV policy implementation. Despite a well-intentioned policy framework, universities have only demonstrated partial compliance, resulting in limited national reform (CGE, 2024a, 2024b; DHET, 2024). This study addresses this gap between policy and practice by engaging frontline staff in an analysis of their campus environment using the policy framework as a lens.

Method

The data collection consisted of semi-structured group interviews and a mapping activity conducted at the institution's nine campuses, which are spread across three provinces. The study focused on three departments within the institution that typically respond to cases of GBV. The three

departments formed two sample sets per campus, based on their field of expertise. Sample set one comprised Campus Protective Services (CPS), responsible for campus security. Sample set two comprised Student Development and Support (SDS) and the Department of Health and Wellness, which are responsible for students' psychological and medical well-being. The enquiry aimed to tap into the experiential and latent knowledge of these frontline staff to identify environmental inhibitors and promoters of GBV, as well as service delivery approaches for addressing GBV on campuses.

Snowball sampling was used to formulate the participant groups for each campus. By the end of the data collection, a total of 60 frontline staff members had participated in the study. First, the directors of the three departments were contacted to initiate the snowball sampling process, which filtered down to the heads of department and practitioners of each campus. Participant inclusion criteria required members to be actively employed within the relevant department at the institution and have experience of GBV case handling or familiarity with standard operating procedures and familiarity with the campus grounds and facilities. Additionally, CPS participants required experience with GBV interventions, first response, reporting systems, support service referrals, safety audits, or day and night patrol. For SDS and Health and Wellness participants, the requirements were the same, except that safety auditing and patrols were replaced with GBV-related clinical experience in the field of counselling, therapy, or medical services.

The snowball sampling process was very effective in regulating the inclusion criteria, as either the director or head of department knew which members had the most experience or training in GBV prevention and case handling. At only one campus, the sample expanded to another department recognised for its contributions to developing GBV interventions and making referrals on that campus.

There were two split activities conducted on each campus with both sample sets: (1) a semi-structured group interview with a policy-based checklist, and (2) a walking interview with mapping using an open-ended interview guide.

The checklist used during the group interview outlined the needs for infrastructure, services, and systems identified through a thematic analysis of the DHET GBV policy framework and Higher Health protocols and guidelines with which institutions must comply. The checklist took the form of a needs analysis questionnaire, prompting staff to respond to a list of infrastructure components identified as necessary to action policy and protocol statements. For instance, the requirement to offer psychological support to survivors was associated with a checklist prompt, asking, Is there a need for a psychological support office on campus? Participants could respond with a simple yes or no, indicate whether they had the facility or not, confirm whether the facility was suitable or not, and provide open-ended comments as part of a group discussion regarding the facility in question.

Interviewing against the listed features provided an opportunity to assess the degree of alignment between the DHET and Higher Health recommendations and what was available on the campuses. The checklist tool facilitated discussions and helped identify gaps and needs within the service environments concerning the recommendations from DHET and Higher Health. Additionally, it enabled the assessment of agreement with policy statements and created a narrative dataset regarding the implementation of policies at both the institutional and departmental levels.

The walking interview and mapping activity enabled participants to engage directly with their immediate environment, sharing more detailed information on the existing infrastructure and its shortfalls while indicating on-site examples. During the walkthrough, participants were encouraged to identify specific safety concerns and environmental aspects that hindered safety and service delivery. These concerns were marked up on a corresponding campus map. Likewise, they could point out aspects that they felt contributed to a more secure, inclusive, and responsive environment.

During the identification of shortfalls, participants were also prompted to provide preferred solutions, further establishing features that they believed promoted a safer and more conducive service environment.

The feedback from the checklist and walking interviews was combined and thematically analysed to group similar points together. The analysis led to the identification of more than just environmental factors impacting safety and service delivery. Within the narrative, vulnerable groups within the institution could be identified along with the types of GBV being reported. In terms of infrastructure, the participants associated the presence and condition of specific areas and infrastructure with GBV occurrences. Additionally, the narrative produced a considerable number of suggestions for environmental inclusions and improvements to enhance how GBV is addressed on campus. In doing so, the participants identified what was needed to implement the DHET and Higher Health recommendations more effectively.

These methods generated a richly contextual qualitative dataset that reveals valuable information on the institution's response to GBV and aspects needed to align with policy recommendations. Following the completion of data collection, it became evident that the checklist tool and interview guide could be adapted to immediately categorise responses into thematic sets using a standardised menu or scaling system. The potential for data to also be empirically categorised became evident during the thematic analysis. This would better support the summarisation of data and allow for more transparent result communication, as well as improved compatibility for comparative analysis.

Results

The feedback from the interview and mapping process enabled the identification of vulnerable groups within the campus community and the associated risks in specific areas and infrastructure. This feedback highlighted the spatial dimension of GBV impacting university students. The checklist results specifically indicated that staff fully supported the DHET and Higher Health recommendations while also affirming the necessary environmental considerations for their implementation. These results suggest that policy-derived spatial enquiry tools can elucidate environmental factors that impact service delivery and serve to bridge the gap between policy intent and implementation.

Identification of vulnerable groups

The interview results highlight the vulnerability of female students, mirroring societal risks. First-year female students were considered particularly vulnerable due to their inexperience with university life and their susceptibility to being sexually exploited in manipulative relationships. LGBTQIA+ students were identified as being at risk for specific forms of GBV that target their sexual orientation, negatively impacting their sense of inclusion.

Additionally, former survivors of GBV, for instance, childhood survivors, were flagged as vulnerable due to post-traumatic stress disorder (PTSD) that could negatively impact their well-being and academic success. It was felt that this group required tailored reporting and support services.

The vulnerability of financially disadvantaged students was emphasised as a significant contributing factor to GBV. Thus, the need to consider intersectionality emerged from the compounding of these challenges. For instance, a financially disadvantaged female first-year student faces a significant risk of feeling pressured or manipulated into transactional relationships to meet basic needs, such as housing or funds for food and other necessities.

The vulnerability of students with disabilities and the occurrence of GBV between staff members were mentioned in the interviews. However, far fewer cases were reported in comparison to the other vulnerable groups identified. Lastly, perpetrators were also less mentioned but were highlighted as needing specific rehabilitative interventions to address the underlying causes of their actions and promote prevention.

Examples of GBV highlighted within the vulnerable groups included verbal and sexual harassment, physical assault, intimate partner violence (IPV), transactional sex, cyber-GBV, rape, and exclusion from gendered spaces like ablution facilities. Table 1 presents the five most vulnerable groups identified through the interviews.

Table 1

Five Vulnerable Groups Emphasised by Participants in the Interviews

Vulnerable Group	Specific Safety Risk or Contributing Factor
Female students	Female students were consistently identified as one of the most susceptible groups to GBV. Most cases reportedly occurred off campus, around taverns, and in off-campus residences.
First-year students	First-year students, and females in particular, were considered vulnerable due to their inexperience with university life and relationships, which perpetrators exploited.
LGBTQIA+ students	LGBTQIA+ students faced intolerance related to their gender identity. They also experienced shortfalls in access to gender-neutral ablution facilities and safe spaces like gender desks.
Financially disadvantaged students	Financial dependence on others to meet basic needs made female students particularly susceptible to abusive and transactional relationships. Transactional relationships with “blessers”, older men who provide goods and experiences, typically for sex, were a concern. Blesser relationships could involve controlling and isolating behaviours, and an insistence on unprotected sex, which heightens risks of unplanned pregnancies and sexually transmitted infections (STIs).
Former survivors of GBV	Former survivors of GBV were considered vulnerable to re-traumatisation, and PTSD. Concerns were raised regarding the cycle of violence and use of unhealthy coping mechanisms that could occur within this group.

Although the identification of vulnerable groups was not explicitly part of the interviews, it naturally emerged during discussions across all campuses. The identification of vulnerable groups has spatial relevance as it informs the development of interventions and spaces that address the factors contributing to vulnerability, thereby mitigating its impact.

Identification of environmental risk factors

The role of security infrastructure in maintaining a safe campus was highlighted as critical for preventing GBV and fostering a sense of safety across campuses. All campuses had walls or fencing and implemented gate access controls. However, there was a lack of consistency in the availability and use of technology, such as digital scanners.

The quality of lighting and closed-circuit television (CCTV) coverage varied between campuses, with each campus having blind spots in certain areas. The control room, which serves as a communications hub and CCTV monitoring centre, was frequently identified as needing upgrades. Twenty-four-hour security patrols were standard across all campuses and were regarded as one of the most reliable ways to promote a secure environment. However, the condition of the gatehouse

interiors varied, and the availability of basic services for guards on shift, such as restroom facilities and heating, was limited.

Alcohol and drugs were considered contraband and not allowed on campuses or in residences. Several of the campuses had residences on premises that posed additional risks related to night activity and visitation, though all residences had private access controls in place. Access to bus transportation was standard across all campuses, though the limited night service and location of off-campus bus stops at some locations were considered safety risks.

Overall, the campus grounds were considered safe spaces. Factors negatively impacting safety were mainly related to the surrounding area, which fell outside CPS jurisdiction. The inner city and settlement location of some of the campuses increased the risks of violence and harassment for students waiting for transport or walking to and from the campus. Undesirable activities around campus, such as the presence of taverns, drug addicts, and thieves, directly impacted reports of GBV, including verbal harassment and muggings.

Taverns near some campuses created consistent challenges, such as patrons catcalling female students passing by and male students entering campus intoxicated, occasionally provoking fights. Interviews consistently highlighted alcohol as a trigger for GBV, particularly in social, sporting, or promotional work settings off campus. Off-campus and private residences were considered to carry a higher risk of GBV compared to those on campus.

Table 2 outlines the key factors contributing to GBV identified by participants, along with their recommended strategies for prevention.

Table 2

Staff Interview Results on GBV Occurrences Involving University Students and Suggested Response Strategies

GBV Occurrences Involving University Students In and Around Campus	Suggested Response Strategies
GBV, including physical and sexual assault against vulnerable groups • Gender norms, bias, intolerance, and predatory behaviours directed at female, LGBTQIA+, and first-year students. • Physical and sexual assaults or potential for physical and sexual assaults to occur.	• Develop and disseminate GBV policy and protocols. • Establish a digitally integrated reporting and referral system linked to an immediate response. • Develop GBV-focused safety audit standards, conduct regular audits, and align environments to the audit standards (e.g., access controls, lighting, CCTV). • Provide a GBV orientation and kit with policy, protocol, and reporting system information. • Continuous GBV and gender-related awareness campaigns and media displays. • Permanent emergency number and reporting systems displays (quick access when needed). • Install panic buttons on campus and in SDS and Health and Wellness offices that provide an immediate CPS response. • Establish a gender desk for reporting and building a diverse gender community. • Facilitate the establishment of GBV survivor and gender-related support groups.
Transactional GBV • Sex for basic needs, luxury goods, and entering or progressing in an academic programme. • Blessers soliciting students near residences.	• Food or necessities bank for needy students. • Student work or entrepreneurial opportunities. • Awareness campaign on risky relationships. • Audit lifted blocks and upgraded marks.
GBV at social events • Older men at campus sporting events harassing female students. • Harassment or fights at freshers' balls.	• Contraband checks at the entrance gate/s. • Increased security and monitoring at events. • Make security more visible.
Alcohol-based GBV • Harassment and fights instigated by intoxicated students entering campus from social events or taverns.	• Removal of taverns directly outside campuses. • GBV awareness campaign involving tavern owners. • Alcohol awareness campaign.
Cyber-GBV • Cyber-GBV including derogatory WhatsApp groups, online bullying, harassment, threats, receiving ghost messages or explicit media, and the abusive use of personal information.	• Establish a cyber-GBV unit for immediate response to online cases of GBV. • Awareness and educational campaigns for online safety and privacy settings.
Perimeter-based GBV • Verbal harassment or muggings while walking or waiting for the bus outside of campus. • Predatory or voyeuristic gaze into campus residences.	• Perimeter security features (CCTV, lighting, patrols). • Secure bus stops. • Scheduled transport for extra-curricular activities. • Safe grocery shopping options. • Educational campaigns on situational awareness. • Install privacy and security features at residences.

These suggestions align with DHET and Higher Health recommendations but reflect specific contextual challenges related to the campus location. This highlights the impact of campus

surroundings in contributing to GBV. It also emphasises the need to broaden our understanding that GBV in the university context is not only an issue within the campus environment but also extends to students' overall experience. Therefore, prevention and response strategies should take into account the various settings where students may be vulnerable to GBV and require support.

Support service provision

In addition to the campus safety infrastructure, participants emphasised the importance of three essential service spaces that align with the recommendations from DHET and Higher Health. These spaces were considered crucial for providing comprehensive prevention and support: (1) a campus clinic, (2) psychological support spaces, and (3) a gender desk.

Campus clinic with GBV-focused emergency response service

Seven out of the nine campuses had a clinic on premises. The remaining two campuses shared the clinic at their neighbouring campus, which was a bus ride away. The campus clinics all had similar facilities, including a reception area, waiting area, consultation rooms, an emergency bed, an ambulance pick-up point, and a medicine dispensary. However, the space available in some clinics and the privacy of the entrance, waiting area, and ambulance pick-up point were flagged as problematic at some locations.

Despite the challenges faced by some clinics, they all played a vital role as safe spaces for students, offering a range of free services. These services included sexual health care, family planning, emergency medical assistance, and hospital transfers. While these clinics provided essential services like vaccinations and HIV testing, staff identified a significant need to enhance the availability and delivery of services focused on GBV.

Recommendations for enhancements included:

- Establishing a 24-hour medical unit to respond to incidents that typically occur at night and on weekends.
- Providing daily in-house access to STI and HIV testing, moving beyond visiting service units and public mobile units with limited privacy.
- Establishing a permanent office for a clinical trauma counsellor focused specifically on aspects like GBV cases and receiving positive HIV test results.

Participants emphasised that clinic design should prioritise privacy and confidentiality, from the reception area to consultation rooms, and comply with Department of Health (DoH) standards for facilitating medical care. A private ambulance pick-up point at the clinic was considered essential to maintain patient confidentiality during transfers to hospitals or a Thuthuzela Care Centre (TCC), in the case of a physical, sexual, or rape assault.

Additionally, it was deemed essential for the clinic to be well equipped and adequately maintained to ensure reliable and consistent service standards that would encourage word-of-mouth referrals. Alongside enhancing infrastructure and human resources, participants emphasised the necessity of ongoing training to ensure trauma-centred service delivery.

Psychological support spaces offering diverse, trauma-informed therapies

Participants highlighted the essential role of psychological support spaces as havens for survivors of GBV. Campus facilities included one-on-one psychotherapy and academic counselling. The size and appearance of these facilities varied significantly from campus to campus, with some counselling offices facing severe limitations regarding space, seating, privacy, and acoustics.

Although a gender desk and GBV trauma counselling were available, access to sessions was limited, sometimes to one day a week, resulting in low uptake of the service. The staff identified a need to make more accessible and private service options available to comprehensively address GBV, build trust in service systems, and encourage reporting.

Key recommendations included:

- Establishing a 24-hour campus counselling service or hotline to address after-hours emergencies and assist with referrals.
- Diversifying services to include trauma-informed counselling for survivors, different therapies, support groups, and prevention-focused therapy for perpetrators.

Participants considered the design of these spaces to be crucial, emphasising privacy of entrances, reception areas, waiting rooms, and counselling rooms. Soundproofing in counselling rooms was considered essential for maintaining confidentiality and ensuring complete immersion during therapy sessions. Comfortable and appropriately sized furniture for deep relaxation was also highlighted as important for the client's comfort and focus during sessions.

There was also a desire for facilities that support various therapies, including group, outdoor, and activity-based approaches. This would necessitate more flexible, multifunctional spaces and adequate storage for a range of therapy tools. Furthermore, a bright, inviting, and serene environment, incorporating natural elements such as gardens or outdoor spaces, was believed to alleviate stress and enhance healing.

Gender desk as a central hub for advocacy, reporting, and support

Although all the campuses included inclusive gender practices in their current services, none had a permanent, dedicated gender desk or a GBV reporting hub. Participants highlighted the importance of establishing a central and easily identifiable gender desk both on campus and in residences. Participants indicated that the lack of such services hampers reporting and engagement among vulnerable groups, including LGBTQIA+ students. However, a well-implemented gender desk could be a safe space for marginalised gender groups to connect and build community.

Staff envisioned a gender desk as a space that enhances gender awareness, advocates for inclusivity, encourages the reporting of GBV incidents, and ensures immediate access to assistance when needed. Additionally, staff believed that a well-resourced gender desk could proactively encourage a community of practice for gender-focused campaigns, GBV awareness, and research initiatives.

The following aspects were deemed essential for the design of a gender desk:

- The desk should handle inquiries, make referrals, and provide opportunities for individuals to sign up for campaigns and support groups.
- The space should be securely managed to ensure confidentiality when reporting and connecting to GBV referral services.
- The reporting system should seamlessly integrate referral and tracking across all relevant service providers, ensuring an immediate and streamlined response.
- The gender desk should incorporate the Higher Health peer educator programme to support the running of interventions and offer an accessible peer-to-peer service option.

Participants expressed that the gender desk should ideally be integrated into a larger GBV Responsible Offices (RO) network across campuses and residences that takes responsibility for all GBV-related interventions and reporting functions. The participants from the SDS and Health and

Wellness sample groups strongly felt that this would help limit any potential conflict of interest that could arise between their role as practitioners and the need to assist with case follow-up.

The idea of establishing a GBV RO originated from the Higher Health guidelines, which recommend allocating a GBV RO within each institution to enable independent and focused management of the GBV strategy.

The results of the data collection suggest a shift toward a more proactive, integrated, and survivor-centred approach to how institutions address GBV. They demonstrate that creating a genuinely safe campus involves more than just security patrols and cameras; it also requires building a community of practice and a compassionate support system. The results emphasise the value attributed to spaces and infrastructure to mechanise the delivery of impactful interventions and services.

Discussion

The findings from this study reveal that the built environment plays a far greater role in GBV policy implementation than is often acknowledged. While the DHET policy framework and Higher Health guidelines provide comprehensive policy direction, they fall short of defining the environmental and infrastructural conditions necessary to make these directives workable on the ground. The insights of frontline staff across nine campuses make this gap tangible, showing that poor lighting, fragmented service locations, limited privacy, and inconsistent surveillance systems hinder the very policies designed to protect students. In this sense, the physical campus becomes a determinant of whether survivor-centred policy ideals can be achieved in practice. This indicates a need to standardise infrastructure and monitoring requirements as part of policy and protocol frameworks to bridge the gap between policy and practice.

Through the participatory mapping and checklist processes, frontline staff gave clear and practical insight into how policy is lived and enacted in day-to-day service delivery. Their experiential knowledge highlighted the challenges they face as well as the feasible ways forward, which included regular GBV-focused safety audits and improved reporting and referral systems. The establishment of gender desks as visible and confidential hubs for advocacy and assistance was also considered essential to service delivery and strengthening departmental collaboration.

These suggestions illustrate the valuable contribution frontline staff can make as co-creators of policy and implementation practices. Their user-based insights help translate abstract policy into a grounded directive for operational practice.

The study also highlights the importance of intersectionality in shaping campus experiences of safety and support. Female, first-year, LGBTQIA+, financially disadvantaged students, past survivors, and students with disabilities were all identified as vulnerable to experiencing compounded challenges that increase their risk of GBV. Environmental barriers such as inaccessible counselling offices, the absence of gender-neutral ablution facilities, or unsafe transportation routes amplify these vulnerabilities. Therefore, designing for inclusion means thinking diversely about spatial belonging, considering all experiences of spatial perception and use.

A recurring concern across campuses was the fragmentation of services related to GBV. CPS, SDS, and Health and Wellness often operated in isolation, with limited spatial or procedural integration. This separation creates a functional disconnection, weakening their ability to offer a trauma-centred service, and track cases or make follow-ups. The participants' call for an integrated service model, anchored by a gender desk or RO, mirrors one-stop models like TCCs. The one-stop system could

serve as a practical model for South African universities, facilitating a more user-centred approach to access and continuity of care while fostering inter-departmental collaboration.

Finally, the checklist developed for this study offers a promising framework for aligning policy intent with environmental readiness. By linking spatial features to specific policy and protocol requirements, the tool provides a measurable way to assess how campus environments support or hinder the implementation of these requirements. If refined and standardised across the sector, it could help DHET and Higher Health monitor progress more consistently and support institutions in setting spatial priorities for GBV prevention and response.

Ultimately, this study demonstrates that effective GBV policy implementation depends not only on institutional commitment but also on the physical conditions through which policy is enacted. Aligning infrastructure and service planning with the lived realities of staff and students can serve as a valuable springboard to creating campuses that are policy compliant.

Limitations

While this study focuses on frontline staff, it is critical to consider the valuable contribution students can make to identifying campus safety and service shortfalls and recommendations. Additionally, it is essential to note that while the results presented in this paper reflect themes arising from a collection of campuses, a campus's unique context and features must be considered to address site-specific concerns related to GBV and develop targeted interventions.

Recommendations

In addition to the recommended measures for campus safety and GBV service inclusions presented in the results, institutions need to conduct regular safety and service audits to address site-specific needs. Conducting audits requires a standard measurement tool, and recommending that such tools be integrated as part of national and institutional GBV policy is critical to enforce monitoring practices.

These audits should ideally employ participatory methods, such as those used in the data collection of this study, to gather diverse perspectives and insights. Importantly, students should be included to ensure that the needs related to safety and service delivery are user-centred and will be easily adopted.

Furthermore, such environmental audits should be designed with a GBV and intersectional lens, rather than focusing solely on safety from a general perspective. After the interviews, several participants remarked on the value of analysing their everyday environment through this lens, as it helped them articulate the features that could contribute to GBV. This feedback highlights how the methods effectively drew out insights rooted in the participants' daily work experiences and surroundings.

Conclusion

This study highlights the essential role of frontline staff in recognising and addressing GBV in South African universities. By employing participatory methods, the research reveals the relationship between environmental factors and GBV. The findings indicate that while national policies establish a well-intentioned framework for preventing and responding to GBV, significant implementation gaps remain at the institutional level. The study advocates for a holistic, survivor-centred approach to incorporating trauma-informed services, inclusive infrastructure, and collaborative interventions. By highlighting the perspectives of frontline staff, this research

contributes to creating safer and more responsive campus environments and advocates for the implementation of enhanced monitoring systems to ensure compliance.

Ethics statement

This study received ethical clearance in accordance with the Institutional Review Board (IRB 00005968), registered with the South African National Health Research Ethics Council (REC-160509-21). The clearance (REC2022/07/011) included approval to contact staff participants through their relevant head offices and work contact details, as well as authorisation for the collection of data on-site, including built environment information and photographs, as part of the mapping activity. The study adheres to the requirements of informed consent and participant confidentiality in the dissemination of data.

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The author may be contacted via:

Inge Newport — newporti@tut.ac.za

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