Rapid assessment and gap analysis:
Post-violence care services at public health facilities in the
City of Johannesburg (Regions D, E and G)





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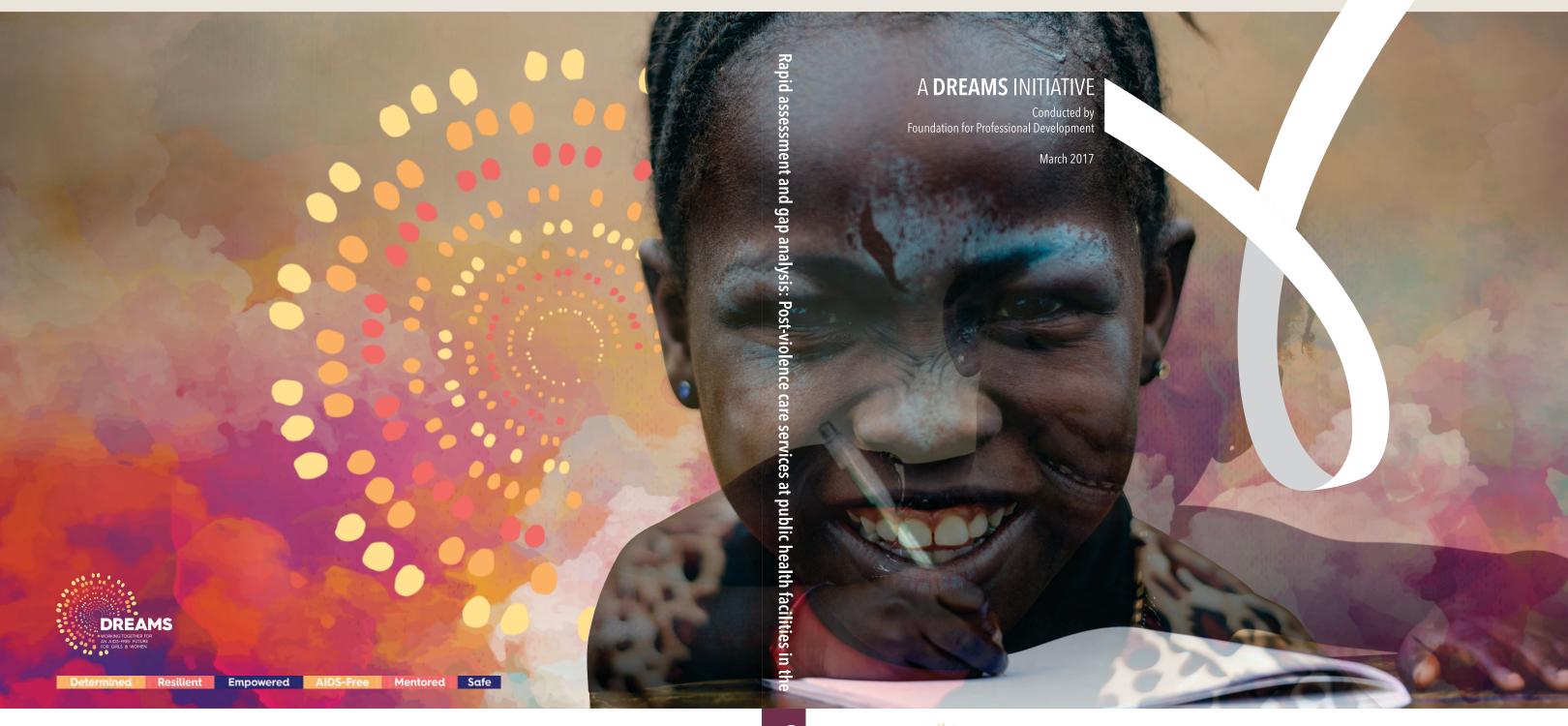




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City of Johannesburg (Region D, E and G)





















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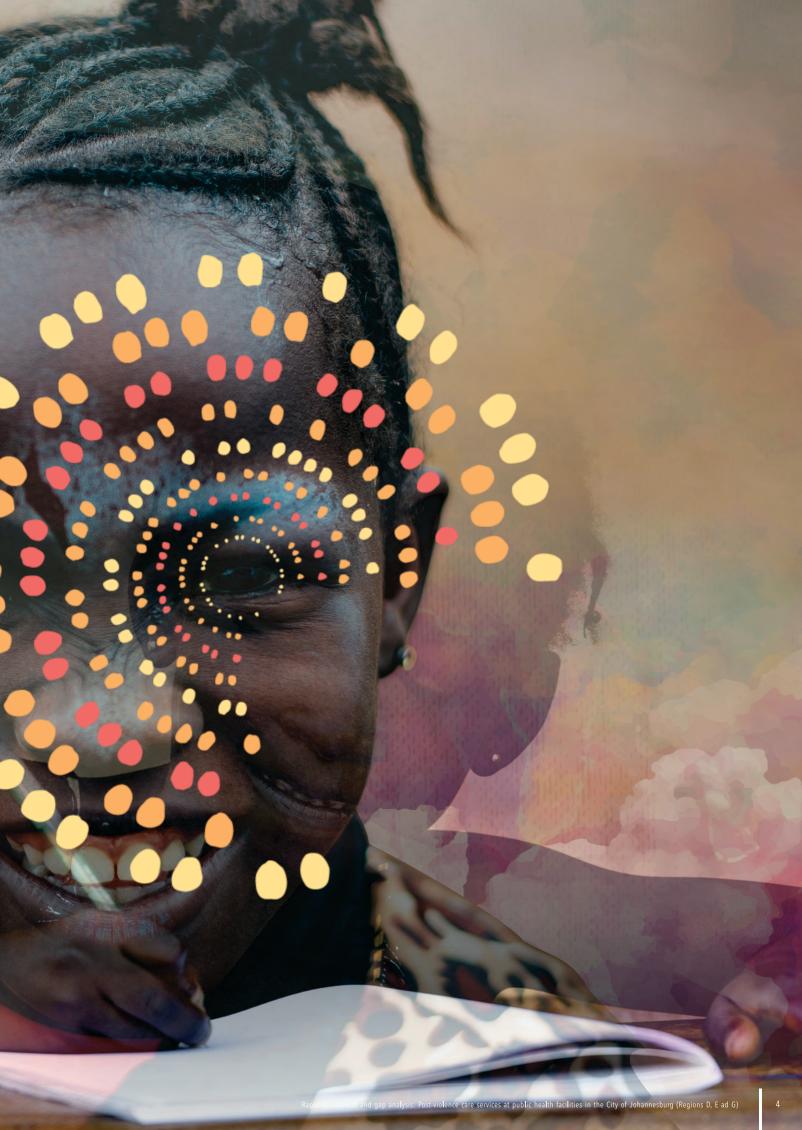






#### **Disclaimer**

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### **ACRONYMS**

AIDS	Acquired immunodeficiency syndrome
ACRWC	African Charter on the Rights and Welfare of the Child
ART	Antiretroviral therapy ————————————————————————————————————
ARV	Antiretroviral
СВО	Community-based organisation
CDC	Centers for Disease Control
CEDAW	Convention for the Elimination of all forms of Discrimination Against Women
CGE	Commission for Gender Equality 2
СНС	Community Health Centre
CoJ	City of Johannesburg
CPD	Continuing professional development
CSO	Civil Society Organisation
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DoH	Department of Health
DoJ	Department of Justice and Constitutional Development
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, Safe
DSD	Department of Social Development
DVA	Domestic Violence Act
EMS	Emergency medical services
EU	European Union Company of the Compan
FBO	Faith-based organisation
FCS	Family Violence, Child Protection and Sexual Offences Investigation Unit
FHI360	Family Health International 360
FPD	Foundation for Professional Development
GBV	Gender-based violence
GNP	Gross National Product
НСР	Healthcare practitioner
НСТ	HIV counselling and testing
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
IDMT	Interdepartmental management team
IDP	Integrated Development Plan
IEC	Information and education communication
IMC	Inter-ministerial committee
iMMR	Institutional Maternal Mortality Ratio
ISS	Institute for Security Studies
ISSSASA	Increasing services for survivors of sexual assault in South Africa
KZN	KwaZulu-Natal
LA	Local authority
LGBTI	Lesbian, gay, bisexual, trans and intersex persons

MRC	Medical Research Council
MSF	Médicins Sans Frontièrs/Doctors without Borders
NACOSA	Networking HIV & AIDS Community of South Africa
NGO	Non-governmental organisation
NPA	National Prosecuting Authority
ОСНА	UN Office of the Coordination of Humanitarian Affairs
PEP	Post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PEPUDA	Promotion of Equality and Prevention of Unfair Discrimination Act
PFA	Psychological first aid Psychological first aid
PHC	Primary Healthcare centre
POA:VAWC	Programme of action to address violence against women
PwC	PricewaterhouseCoopers
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RTI	Research Triangle Institute
SADC	Southern African Development Community
SAECK	Sexual assault evidence crime kit
SAHRC	South African Human Rights Commission
SAPS	South African Police Service
SDG	Sustainable Development Goals
SOA	Sexual Offences and Related Matters Amendment Act
SOC	Sexual offences court
Stats SA	Statistics South Africa
STI	Sexually transmitted infection
SWEAT	Sex Worker Education and Advocacy Task Force
ТВ	Tuberculosis
TCC	Thuthuzela Care Centre
ТОР	Termination of pregnancy
VAWC	Violence against women and children
VEC	Victim Empowerment Centre Cent
VEP	Victim Empowerment Programme
VSC	Victim Support Centre Contraction of the Contractio
UN	United Nations
UNICEF	United Nations Children's Fund
UNCRC	United Nations convention on the rights of the child
UNODC	United Nations Office on Drugs and Crime
UNPF	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

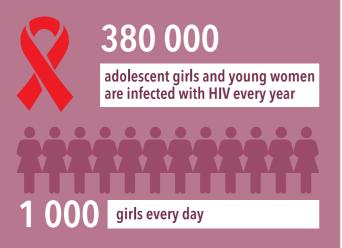


# **EXECUTIVE SUMMARY**



#### **Background**

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, Safe) initiative aims at reducing HIV infections among adolescent girls and young women in ten sub-Saharan African countries, of which South Africa is one<sup>1</sup>. The target group is adolescent girls and young women because, despite the considerable progress in the global HIV/AIDS response, gender and age disparities in the high-HIV burden DREAMS countries remain almost unchanged - approximately 380 000 adolescent girls and young women are infected with HIV every year (i.e. around 1 000 girls every day)<sup>2</sup>. Many adolescent girls and young women lack a full range of opportunities and are too often devalued because of gender bias, leading them to be seen as unworthy of investment or protection. Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence (GBV), and school drop-out all contribute to girls' vulnerability to HIV. Keeping adolescent girls and young women HIV free also positively impacts their overall health, education, development, and wellbeing<sup>3</sup>.



The Foundation for Professional Development (FPD) was contracted by USAID to be the technical assistance partner to:

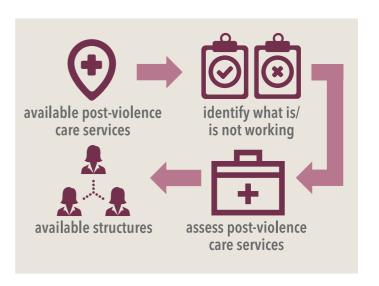
- MatCH Systems (in eThekwini: North, South & West;
   Umkhanyakude: Hlabisa and Matubatuba)
- Anova Health Institute (Anova) (in City of Johannesburg Regions D, E & G)
- Right to Care (in City of Johannesburg Region A).

As a component of the technical assistance provided, FPD conducted a rapid assessment and gap analysis of public healthcare facilities in the City of Johannesburg (CoJ) Regions A, D, E and G.



#### **Purpose**

The purpose of this rapid assessment and gap analysis was to identify where post-violence care services are available (mapping), identify what is/is not working, identify available structures, and assess services against a comprehensive package of post-violence care services. The rapid assessment and gap analysis focussed on all the components related to the functioning of post-violence care services at health facilities in City of Johannesburg (Regions A, D, E & G). It assessed the quality of services provided, assessed the equipment at facilities, assessed the staffing and training of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working with/within the facility.



The results of this rapid assessment and gap analysis will contribute to improving services delivered at facilities. It will contribute to better informed decision-making around how healthcare facilities work, foster an environment of excellence at service delivery level and promote greater accountability for performance of facilities. The ultimate goal is to keep young women and girls HIV free, increasing secondary school enrolment, attendance and completion and to decrease HIV risk.

<sup>1</sup>DREAMS innovation challenge brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect <sup>2</sup>lbid.

3Strategic Plan: DREAMS.



#### Methodology







situational analysis desk review

field work and data collection

reporting

The rapid assessment and gap analysis was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two, field work and data collection, and phase three, reporting. The data collection team used a concurrent triangulation mixed methods design. Quantitative and qualitative data of equal weight were collected simultaneously and integrated during the interpretation of the findings. Sampling was not necessary, as all public health facilities in CoJ (Regions A, D, E and G) were part of the study. A total of 25 facilities were not surveyed (for various reasons) and were therefore excluded from the study. The final number of facilities surveyed was 73 across the four regions.

facilities surveyed
across 4 regions
facilities
were not surveyed



There were two populations in this rapid assessment and gap analysis – the facility staff and the NGO staff. The exact number of facility and NGO staff across all facilities was unknown. The NGO informants were conveniently sampled based on who was available at the time of data collection. The team also interviewed NGOs who are directly involved in the DREAMS initiative in the regions, NGOs working in the field of gender-based violence (GBV), and South African experts in GBV. In spite of numerous attempts, the team could not interview CoJ health managers.

The team conducted a situational analysis using a literature review, using international and local reports, articles and standards to develop this. This also informed the data collection tools that were developed, as well as the interview schedules. They considered the South African legislative and policy frameworks. National and international policy guidelines, and norms and standards on the delivery of GBV support services were consulted.

An application (ODK App) and survey tool was developed in collaboration with Medical Practice Consulting, which uses TRISCOMS cloud hosting technology, to allow the team to collect data electronically using tablets.

The quantitative data were exported from the cloud database into MS Excel™, where it was cleaned, coded and descriptively analysed. No inferential analyses were conducted. The audio recordings were transcribed verbatim and analysed through a combination of deductive and inductive thematic coding. Themes were drawn from the semi-structured interview schedules and added to the coding frame.



#### **Major findings**

This rapid assessment and gap analysis was conducted between August 2016 and March 2017 using a mixed methods approach. Key informants were interviewed and an application-based survey was carried out using tablets. Interviews and data collection took place between November 2016 and March 2017.

facilities in the four regions provide forensic investigations



2

facilities in CoJ (Regions A, D, E & G) provide full package of post-violence care



very few facilities in CoJ (Regions A, D, E & G) are ready to *upscale* their post-violence care services



no proper record of the number of *sexual* assault cases reported at facilities who do not deliver post-violence care services



There are only three facilities in the four regions that provide forensic investigations, and only two facilities in CoJ (Regions A, D, E and G) provide the full package of post-violence care as defined by the TCC Blueprint. There are differences in post-violence care available between regions, with regions D and G being able to provide more of the right facilities, equipment and services. The findings suggest that the very few facilities in CoJ (Regions A, D, E and G) are ready to upscale their post-violence care services, based on the current opening hours, equipment and ability to provide psychosocial support. There is no proper record of the number of sexual assault cases reported at facilities who do not deliver post-violence care services, as these cases are referred to other facilities.



There is a great concern regarding the referral pathways within CoJ (Regions A, D, E and G). Fifty-five facilities refer to three TCCs (Nthabiseng TCC in Region D, Lenasia TCC in Region G and Masakhane TCC in Ekhurhuleni) and one medico-legal clinic. The remainder refer to 16 other facilities (inside and outside the surveyed regions). Many of the facilities within the region, which were part of this study, reported that they do not provide post-violence care services. Some of the facilities outside the regions might provide the required services. There is also concern about transport to the referral facilities, as many of them are quite a distance from where the victims present. This is a major issue in Region A and E.

Most facilities have facilities such as ablution facilities, examination rooms, and a wheelchair ramp, and most of the equipment required to upscale their delivery of post-violence care services. However, post-violence care specific equipment (according to the TCC Blueprint) such as anatomically correct dolls, comfort packs and clean clothes, colposcopes and examination lights needs to be procured. There are still facilities that need additional space. Many key informants highlighted the lack of adequate, private counselling space as well as private, separate examination rooms for victims of sexual assault. The majority of facilities self-reported that their clients wait less than 45 minutes for service. Many victims struggle to access post-violence care services due to wrong referral pathways and lacking access to transport. Almost half of facilities reported that they can provide psychosocial support to victims of sexual violence, but they have limited personnel. There is only one trauma counsellor across the 73 facilities surveyed, and there are limited numbers of psychologists available.



There are a number of factors that influence the quality of services delivered:



#### **Human resources**

Most facilities are well staffed, although more trauma counsellors and psychologists are needed. Facilities reported that they receive debriefing on a regular basis, but key informants highlighted that this is not adequate in this very stressful and emotional work environment.



#### **Training**

Only four facilities reported that they have received refresher training on managing sexual assault. There is a clear need to expand the training, and to include auxiliary workers and other stakeholders. If the provision of post-violence care is upscaled to more facilities, additional training will be needed on the management of sexual assault and how to conduct a medical investigation.



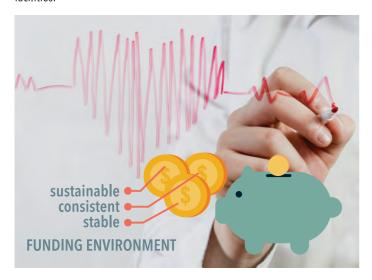
#### Victim friendliness

Victim friendliness in the facilities is still a major problem. There is still a lot of secondary victimisation because sites are not victim friendly, EMS and SAPS staff are insensitive and counselling rooms and privacy within the facilities is inadequate. Victims often have to wait in line with other outpatients and also experience secondary victimisation when they are referred.

There are 25 NGOs who deliver services in 46.58% of the facilities in CoJ (Regions A, D, E and G). There are some problems with regards to the relationships between the NGO and DoH staff. It is important to note that the NGOs are contributing to the continuum of care for victims of sexual assault. The research team also found that although only 25 NGOs were identified working within the facilities, there are many more in all the regions who are providing additional support to victims of GBV.



There are problems within the funding environment that need to be addressed. A sustainable, consistent and stable funding environment is required to ensure that the necessary services can be delivered at all facilities.





#### Recommendations

The evaluation team made a number of recommendations to improve service delivery, functioning of the facilities as well as the potential upscaling of post-violence care. The recommendations can be summarised as follows:



#### Post-violence care service delivery recommendations

Facilities need to record all victims of sexual assault who present, even if they are referred to other facilities. This will ensure that follow-up care can be provided.

There are a number of facilities who are open 24/7, and they are ideally situated to upscale their post-violence care services. This should be piloted first before roll-out to other facilities.

Stakeholders need to investigate how access to transport can be improved when victims are referred to other facilities.



#### Referral pathways recommendations

A referral directory needs to be developed for facilities who cannot provide post-violence care services.

All stakeholders, including SAPS, NGOs and CBOs need to be trained in the use of such a referral directory.



#### **Facility and site recommendations**

Facilities need a dedicated telephone line linking them to units that deliver post-violence care services.

Additional medical equipment will be needed when upscaling post-violence care services.

Facility managers should investigate the possibility of a dedicated examination room and counselling room for victims of sexual assault.

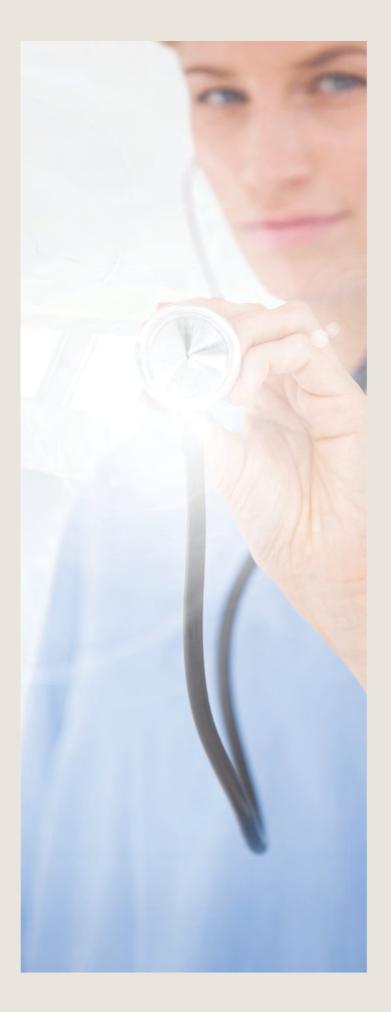
Short-term and long-term psychosocial support to victims needs to be improved and the DoH, DSD and the NGOs need to investigate ways to do this.



#### Improvement of service delivery recommendations

Refresher training, training on the management of sexual assault and how to conduct a forensic investigation is needed.

All stakeholders must be involved in training (DoH staff, DSD, SAPS as well as NGOs and CBOs working in the regions).





#### **NGO** recommendations

Stakeholders must conduct a community mapping exercise to understand what other post-violence care services are delivered in the area and widen the support for victims.

NGOs need to be recognised for the services they provide and should be adequately remunerated.

Communication channels between NGOs and facilities need to be improved.



#### Other recommendations

New, inclusive guidelines for the management of sexual assault in South Africa need to be developed.

All stakeholders should investigate how GBV services can be upscaled. This should include upscale of GBV services within existing health facilities. In addition to this the model should be linked with the other existing rape crisis centres and Kgomotso Care Centres.

Post-violence care services clearly need to be upscaled in CoJ. It is clear that some facilities have the potential for upscaling, and where this is not possible, proper referral is required. The team believes that if the recommendations are implemented, all post-violence care services in the CoJ will be strengthened.





### **CHAPTER 1:** INTRODUCTION **AND OBJECTIVES**

#### Contextual background to the rapid assessment and gap analysis

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, Safe) initiative aims at reducing HIV infections among adolescent girls and young women in ten sub-Saharan African countries, of which South Africa is one. <sup>4</sup>The target group is adolescent girls and young women because despite the considerable progress in the global HIV/AIDS response, gender and age disparities in the high-HIV burden DREAMS countries remain almost unchanged – approximately 380 000 adolescent girls and young women are infected with HIV every year (i.e. around 1 000 girls every day).<sup>5</sup> Many adolescent girls and young women lack a full range of opportunities and are too often devalued because of gender bias, leading them to be seen as unworthy of investment or protection. Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, GBV, and school drop-out all contribute to girls' vulnerability to HIV. Keeping adolescent girls and young women HIV free also positively impacts their overall health, education, development, and wellbeing.6

The Foundation for Professional Development (FPD) was contracted by USAID to be the technical assistance partner to:

- MatCH Systems (in eThekwini: North, South & West; Umkhanyakude: Hlabisa and Matubatuba)
- Anova Health Institute (Anova) (in City of Johannesburg Regions D, E & G)
- Right to Care (in City of Johannesburg Region A).



As a component of the technical assistance provided, FPD conducted a rapid assessment and gap analysis of public healthcare facilities in the City of Johannesburg (CoJ) Regions A, D, E and G.

The Thuthuzela Care Centre (TCC) Blueprint was key to determining the package of post-violence care services that should be available at public health facilities as well as the core competencies of staff. TCCs provide a comprehensive set of services for victims of sexual assault and for this reason they are often called one-stop service centres. The TCC Blueprint was read together with the 2015 Guidelines and Standards on supporting survivors of  $sexual \, violence \, published \, by \, the \, Networking \, HIV/AIDS \, Community \, of \, South \,$ Africa (NACOSA),8 the 2010 PEPFAR Toolkit on Sexual and Gender-based Violence, as well as any other minimum standards of care that the might already be used in provincial health facilities. TCCs are not the only support centres for survivors of sexual violence and the NACOSA guidelines provides more general norms and standards on the provision of post-violence support that could also apply to health facilities.

This assessment of the post-violence care services also took cognizance of service providers who work in, or with, these health centres in the provision of care, such as non-governmental organisations (NGOs). Their role in the

provision or care and how this complements the services that the healthcare facilities provide will form part of this assessment.

Part of the rapid assessment and gap analysis involved mapping the centres that do provide these services.

## Contextual background

South Africa has some of the highest levels of sexual violence and related offences in the world. Experts in GBV and sexual offences think that many rapes and other sexual offences are still underreported. Women and children who are subjected to rape and other sexual offences are also more vulnerable to other sexual and reproductive health problems. This can have implications for HIV status, pregnancy, contracting sexually transmitted infections (STIs) and physical injuries.









DREAMS innovation challenge brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect

Total Strategic Plan: DREAMS.

Strategic Plan: DREAMS.

Strategic Plan: DREAMS.

Strategic Plan: DREAMS.

This includes basic care at primary healthcare facilities, as well as care at community health centres and hospitals; and the referral system between health facilities.

Guidelines & Standards for the Provision of Support to Rape Survivors in the Acute State of Trauma. 2015. Published by NACOSA with support from the Global Fund to Fight AIDS, Tuberculosis & Malaria.

Keesbury, J., and Thompson, J. 2010. A step-by-step guide to strengthen sexual violence services in public health facilities: Lessons and tools from sexual violence services in Africa. Lusaka: Population Council.

# 3. Donor and government response

DREAMS is a holistic response to HIV/AIDS because the DREAMS core package brings together evidence-based approaches that go beyond the health sector, addressing the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education.<sup>10</sup> The core interventions are linking post violence care services to clients, and training professionals working with GBV clients.<sup>11</sup>

The South African government, in conjunction with various international development agencies, civil society organisations and bilateral funding agreements responded to the GBV situation in South Africa in various ways. A number of acts were promulgated and legislative changes made. Various government departments were given the task of addressing GBV either via services, policies or campaigns. This includes the Departments of Social Development, Health, Justice and Constitutional Development and Basic Education. There are also various awareness programmes (such as the Sixteen Days of Activism for violence against women and children from 25 November to 10 December each year and Women's month in August) and other projects managed by NGOs.

# Purpose of the rapid assessment and gap analysis

The purpose of this rapid assessment and gap analysis was to identify where post-violence care services are available (mapping), identify what is/is not working, identify available structures, and assess services against a comprehensive package of post-violence care services. The rapid assessment and gap analysis focussed on all the components related to the functioning of post-violence care services at health facilities in the City of Johannesburg (Regions A, D, E & G). It assessed the quality of services provided, assessed the equipment at facilities, assessed the staffing and training of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working with/withinthefacility.

The rapid assessment and gap analysis results will contribute to improving the services delivered at facilities. It will contribute to better informed decision-making around the functioning of healthcare facilities, foster an environment of excellence at service delivery level and promote greater accountability for performance of facilities. The ultimate goal is to keep young women and girls HIV free, increasing secondary school enrolment, attendance and completion and to decrease HIV risk.

# 5 Objectives of the rapid assessment and gap analysis

The rapid assessment and gap analysis had the following major objectives:



The rapid assessment and gap analysis was conducted between August 2016 and March 2017 and included a survey of public health facilities (clinics, community health centres (CHCs) and hospitals) in City of Johannesburg (Regions A, D, E & G).

# 6. Intended users of the rapid assessment and gap analysis

This rapid assessment and gap analysis is conducted to serve the needs of specific stakeholders and primary intended users of the findings and recommendations. Stakeholder participation is an integral component of the evaluation design and planning and is fundamental to the validity of this.

10Ibid

Key stakeholders and use of the rapid assessment and gap analysis

#### CITY OF JOHANNESBURG METROPOLITAN MUNICIPALITY

- Promote accountability and transparency
- Improved management of post-violence care services in health facilities



#### DREAMS implementing partners (Anova and Right to Care)

Improved oversight and better service delivery, better management of the DREAMS programme and adequate information for up-scaling



### PROVINCIAL DEPARTMENT OF HEALTH AS WELL AS SPECIFIC SECTORS: (I) HIV & TB (II) YOUTH, GENDER AND TRANSFORMATION

- Promote accountability and transparency
- Improved management of post-violence care in health facilities.



#### **DEPARTMENT OF SOCIAL DEVELOPMENT**

Improved services and support for victims of gender-based violence and sexual assault



#### **SOUTH AFRICAN POLICE SERVICE (SAPS)**

Improved oversight and increased conviction rates



#### **DEPARTMENT OF BASIC EDUCATION**

Improved support to children who are victims of sexual assault



USAID

#### **FUNDER: USAID**

Decisions on future funding of GBV initiatives in South Africa



#### **NGOs WORKING WITH HEALTH FACILITIES**

Assurance that the health facilities are functioning as required and that improvement plans are in place for the facilities that are not functioning on the required standards



#### **NGOs WORKING WITHIN HEALTH FACILITIES**

Improved engagement between NGOs and the health facilities.





### CHAPTER 2: DESK REVIEW AND SITUATIONAL ANALYSIS

This desk review and situational analysis will focus on the definition of key terms and a discussion on GBV in South Africa. It will then highlight the international standards for managing sexual assaults and highlight the South African legislative and policy frameworks as well as policy guidelines, norms and standards. It will discuss the functioning of PHCs, other responses and identify still existing gaps. The desk review and situational analysis provide a broad background on the current environment in South Africa in which the PHCs function, taking into account all reports, reviews and assessments done on TCCs, as well as other GBV-related services in South Africa.

# Defining gender-based violence and sexual violence

#### 1.1. Gender based violence and human rights

GBV is a recognised violation of basic human rights (WHO, 2002a). The violence can, therefore, be directed at women, girls, men, boys and the lesbian, gay, bisexual, trans and intersex (LGBTI) community. The majority of affected individuals are women (and by extension their children) because of the unequal distribution of power and resources in society, as illustrated in Bloom's (2008:14) definition:



"[Gender-based violence is] violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society."

That GBV is a violation of women's human rights is evident in the human rights focussed definition in the Declaration on the Elimination of Violence Against Women adopted by the United Nations General Assembly in 1993, and the 1995 Platform for Action from the United Nations Fourth World Conference on Women in Beijing, which defines GBV as:



"the violation of women's human rights and a form of discrimination that prevents women from participating fully in society and fulfilling their potential as human beings." (WHO, 2002a:28).

#### 1.2. Gender-based violence as a broad spectrum

Understanding that GBV constitutes a broad spectrum of acts or forms of discrimination is important for informing the types of preventative and care measures that are designed. The comprehensive definition of GBV used by the United Nations Population Fund (UNPF) illustrates the wide spectrum:



"Gender-based violence is violence involving men and women, in which the female is usually the victim and which is derived from the unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual and psychological harm, including intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community. It includes that violence which is perpetuated or condoned by the State."

(WHO, 2002a:15).

The broad range of activities that constitute GBV is captured in the literature which at different times refers to various definitional subtypes including: (1) the type of violence (e.g. emotional/psychological, physical, sexual, economic abuse); (2) who it is directed at (e.g. children, women, the LGBTI community); and (3) the setting in which it is perpetrated or the relationship between the perpetrator and victim (e.g. domestic violence, intimate partner violence, strangers etc.).



For Wekerle and Wolfe (1999) the relational aspect to GBV is very important as it signifies the need for control or dominance. They argue that elements of GBV are often overlooked or deemed to be less significant because the parties are adults in a close relationship.

The different dimensions or elements to GBV are, of course, not mutually exclusive, but this discussion serves to illustrate that it is a broad concept and defining and describing its different elements is important for identifying appropriate responses and care.

#### 1.3. Defining sexual violence

As mentioned above, sexual violence is a subtype of GBV. Similar to the discussions on the definition of GBV, some of the literature on sexual violence point out the range of possible victims (not exclusively women):



"[Sexual violence] refers to all forms of assault and abuse of women, men, adolescents, and children (girls and boys), including rape, incest, indecent assault and defilement [child sexual abuse]. Sexual violence occurs when a person uses psychological pressure, abuse or authority, threats or physical force against another person for sexual purposes, whether or not the act constitutes a criminal offence under domestic law." (Keesbury and Thompson, 2010:4)

Other definitions, such as that by the WHO (2002b:149) explicitly refer to sexual violence as perpetrated against women:



"[sexual violence is] any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work."

Understanding the different dimensions to sexual violence – who is affected, in what way, and in which context – is important to ensure that post-violence care is comprehensive, sensitive and inclusive of the diverse needs and realities of those affected. Such sensitivity also includes consideration of the language used to address those affected and the literature reflects the debates about words such as 'victim', 'survivor', 'complainant', 'person in need of care'. (Western Cape Government, 2014).

#### 1.4. Risk factors and drivers of gender-based violence

Various authors have commented on separate but inter-related factors that might facilitate or perpetuate the existence of GBV by increasing the likelihood of individuals perpetrating, or becoming victims (Machisa et al., 2011; Mpani and Nsibande, 2015). Although these contextual factors are quite diverse, for the purposes of this review they have been grouped into factors at the level of the community/society and the individual, and are summarised below.

Community- or societal-level factors that relate to the existence of GBV include:



#### Inappropriate societal norms and standards

The range of current societal norms and standards (globally and in South Africa) that contribute to and sometimes justify violence against women, children, and other vulnerable groups and that prevent victims of sexual violence from accessing appropriate care is vast. It includes: patriarchal cultures, religion and State institutions; so-called 'benevolent' sexism; disregard for the equality and status of women; the mainstreaming of pornography; the sexual objectification of women and girls; continued sexist stereotyping in the media/advertising; prostitution/sale of women (Krug et al., 2002; Weideman, 2011). Widespread tendencies to blame victims or to normalise violence prevent victims from seeking care or leaving abusive relationships (Krug et al., 2002; Weideman, 2011).



#### **Destructive masculine identities**

A number of authors argue that elements pertaining to the social construction of male identity, such as ideas around aggression, dominance, rigid gender roles and patriarchal family structures, and encouragement to engage in risk (e.g. sexual behaviour) can be destructive and result in violence directed at women and children (Bennett, 2010; Peacock and Levack, 2004; Department of Women et al., 2013; Mpani and Nsibande, 2015). This is illustrated by research among South African youth conducted in 2008 that illustrated masculine entitlement. The results showed that 62% of boys over 11 believed that forcing someone to have sex is not an act of violence (MRC, 2010).





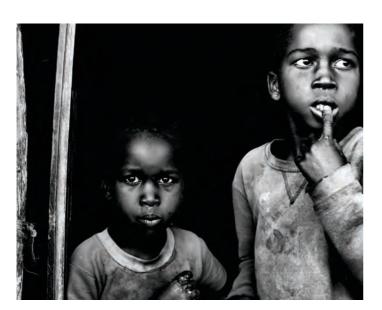
#### **Gender inequality**

Many authors and institutions, including the WHO, have presented evidence in support of the argument that there is a relationship between the extent of gender inequality and the extent of GBV (WHO, 2002a; WHO, 2002b). Gender inequality is evident in the spheres of political and civil-society decision-making as well.



### Ineffective legislative and policy contexts and ineffective interventions

The inconsistent implementation of policies can undermine initiatives aimed at preventing or reducing GBV (Vetten, 2014). Lack of implementation, resultant slow legal processes, and low levels of prosecution and conviction of perpetrators all contribute to the perpetuation of GBV (Department of Women, 2013). Furthermore, although short-term interventions such as shelters are necessary, steps are not always taken to address the home environment where the abuse is taking place, resulting in women and children returning to these situations (RAPCAN and MRC, n.d.).





#### **Poverty**

The link between poverty and GBV is multi-faceted, for example: poverty increases powerlessness and vulnerability to domestic violence because having fewer resources makes women more dependent on abusive partners and might put their children at risk as a result of access to substandard childcare facilities (RAPCAN and MRC, n.d.; Western Cape Government, 2014). Poverty increases exposure to certain high risk situations, for example inequitable access to basic services such as private toilets and inadequately lit streets compromises the safety of poorer women (Davis, 2013; Narayan cited in WHO, 2002a); and poverty exacerbates the negative consequences of GBV as access to quality medical and psychological support services are diminished (Narayan cited in WHO, 2002a). Poverty not only increases women's vulnerability to GBV, but could also be a factor influencing perpetrators. For example poverty can result in men feeling emasculated which can result in violence (Sonke Gender Justice, 2013).

poverty can result in men feeling emasculated which can result in VIOLENCE

Individual-level factors that relate to the existence of gender-based violence include:



### Childhood exposure to violence (either directly or witnessed) /child abuse:

Several studies nationally and internationally demonstrate that children who witnessed violence or were subjected to any form of violence are at a higher risk of experiencing or perpetrating violence in later life (Krug et al., 2002; RAPCAN and MRC, n.d.; Jewkes, n.d.; Coie et al., 1993; WHO, 2002a; WHO 2002b). This link also relates to the subjection of children to harsh physical and other punishment as a link has been shown between these disciplinary practices and the likelihood of children and adults tolerating or engaging in GBV (RAPCAN and MRC, n.d.).



#### Use of drugs and alcohol

Many empirical studies in diverse contexts and on a global scale have demonstrated a relationship between the use of alcohol and/or drugs and violence – this link can take many forms, such as aggression as a result of alcohol abuse, using drugs or alcohol to render the victim submissive or incapacitated, etc. (Krug et al., 2002, Jewkes n.d.; RAPCAN and MRC, n.d.; Weideman, 2011; WHO, 2002a; WHO, 2002b; WHO 2003). Research by Gender Links in Gauteng found that men's alcohol consumption was closely associated with perpetration of all forms of violence, including rape. It also found that 4.2% of women had been raped while drunk/drugged and that of the men surveyed, 14.2% had admitted to forcing a women to have sex when she was unable to refuse on account of being drunk/drugged (Machisa et al., 2011). Research has also shown that there is a causal relationship between GBV and HIV infection in women and that alcohol use is part of the explanation of this link (Jewkes et al., 2010).

forcing a women to have sex when

she was drunk/drugged

of women had been raped while



#### Access to firearms

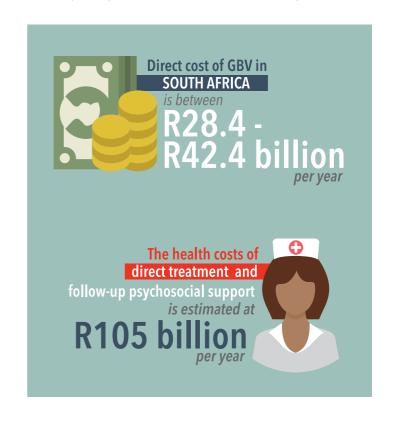
A number of research initiatives (Krug et al., 2002; RAPCAN and MRC, n.d.; Weideman, 2011) have demonstrated a relationship between access to firearms (and other weapons) and GBV.

#### Impact of gender-based violence

Individuals who have experienced sexual violence may as a consequence suffer from a range of psychological and behavioural problems and physical injuries, many of which can be long-lasting. These individuals are furthermore at an increased risk of a number of reproductive health-related

complications. These have been widely documented in the literature and include anxiety, depression, post-traumatic stress disorder, secondary victimisation, suicidal behaviour, risk of substance abuse, death, risks from unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV/AIDS, infertility, etc. (Kruger et al., 2002; WHO, 2002a; WHO, 2002b; WHO, 2003; NACOSA, 2015). In addition, "rape and domestic violence [could] account for 5 - 16% of healthy years of life lost to women of reproductive age" (Murray and Lopez cited in WHO 2003: 18).

In addition to the impact of sexual violence on the health and wellbeing of survivors, some authors comment on the social and economic costs for society (Morrison and Orlando, 2004). This includes the erosion of social trust (WHO, 2002a) as well as economic costs for the country. The WHO (2002a) claims that for many countries the losses due to interpersonal violence are worth more than one percentage point of their annual gross national product (GNP). Two large-scale studies by the World Bank (1994 and 1996) provide empirical evidence of the costs (social, economic and personal) of sexual violence (WHO, 2002a). It influences the social and economic development of the country as it reduces victims' contribution to the economy. KPMG estimated that the direct cost of GBV in South Africa is between R28.4 and R42.4 billion per year (Watson, 2015). There are also other costs to consider. The health costs of direct treatment as well as followup psychosocial support is estimated at R105 billion per year (Hwenha, 2014). The costs related to the prosecution and rehabilitation of perpetrators is not included in this amount and relates to the government services from SAPS, the justice system as well as the correctional services system.



# **2** Gender-based violence internationally – prevalence and policy frameworks

2.1. International policy framework (policies, legislation and conventions)

In light of the prevalence of gender-based and sexual violence described above there are a number of policy frameworks and other international instruments that have been put in place to promote gender equality, mainstream gender in development, and try and protect women against discrimination and violence.



OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS

International policies, legislation and conventions relating to the rights of women and girls to which South African is a signatory/beholden

#### INTERNATIONAL INSTRUMENT

#### **CEDAW**

Convention on the Elimination of All Forms of Discrimination Against Women, 1979



South Africa is a State Party to this treaty which it ratified in 1995 and is therefore obliged to take action on a number of fronts, such as: acting against discrimination against women, which includes implementing legislation that promotes gender equality, and eliminating customary or traditional practices that may be harmful to women and prevent them from realising their human rights. (SAHRC, 2015)

The United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 1985



The needs and rights of victims of domestic crime are recognised internationally and the Declaration sets out principles (for example compassion and dignity) relating to the treatment of victims within the framework of a responsive legal system. South Africa is signatory to this Declaration. (Western Cape Government, 2014)

UNCRC United Nations Convention on the Rights of the Child, 1989



The Convention articulates a number of rights that children have, including the right to be protected against abuse and exploitation. South Africa ratified the UNCRC in 1995 and it has influenced domestic legislation around child protection and child justice. (Western Cape Government, 2014)

The Declaration on the Elimination of Violence against Women, 1993



Article 1 of the Declaration provides a definition of violence against women, while article 2 provides a non-exhaustive list of acts of violence against women occurring at the level of the family, community and State. South Africa ratified this Declaration in 1995. (Western Cape Government, 2014)

Beijing Declaration and Platform for Action, 1995



In 1995 South Africa became a signatory to the Beijing Declaration and Platform for Action which contains 12 thematically organised strategic objectives aimed at the empowerment of women. It recognises the importance of such empowerment for world peace and development. The Declaration and Platform for Action is meant to accompany the provisions of CEDAW. (SAHRC, 2015)

The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, 2000



The Protocol is a supplement to the United Nations Convention against Transnational Organized Crime. It is aimed at lessening and preventing human trafficking in participating States as well as ensuring laws and policies are in place in these States to provide for the security and recovery of victims. (Western Cape Government, 2014)

United Nations World Conference on Racism, Racial Discrimination, Xenophobia and Related Intolerances in Durban in 2001, culminating in the Durban Declaration and Programme of Action



The Declaration was signed by the South African government and recognises that racism and racial intolerance affect women and girls differently to men and can be contributing factors towards the deteriorating wellbeing and status of women leading to violence and other forms of discrimination. It therefore recommends the integration of a gender perspective into policies aimed at eradicating racial and other discrimination. (SAHRC, 2015)

In addition to these international instruments South Africa is also signatory, or beholden to, a number of regional (African) and sub-regional policies, legislation and conventions. Again, this is not an exhaustive list, but aims to illustrate the existing framework to which South African laws and policies are aligned.



**OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS** 

Regional policies, legislation and conventions relating to the rights of women and girls to which South African is a signatory/beholden

#### **REGIONAL INSTRUMENT**

#### **ACRWC**

African Charter on the Rights and Welfare of the Child, 1990



Similar to the UNCRC, the ARCWC is a regional instrument to protect the rights of children, including their right to safety and security. It was ratified by South Africa in 2000. (Western Cape Government, 2014)

Southern African Development Community (SADC) Declaration on Gender and Development,



South Africa signed the Declaration in 1997 and the Addendum in 2008. Among other things, the signatories are required to initiate legal reform and to change social practices that discriminate against women. Furthermore, States are obligated to protect the sexual and reproductive rights of women and address and prevent violence against them. (Western Cape Government, 2014)

(Addendum on Prevention and Eradication of Violence against Women and Children, 2008)

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol), 2003



South Africa ratified the Protocol at the end of 2004. It protects a broad range of women's rights including the right to dignity (Article 3), the right to life, integrity and security of person (Article 4), the elimination of harmful cultural practices (Article 5), the right to peace (Article 9), and a comprehensive list of reproductive rights in Article 14 including medical abortion and access to adequate and affordable health services. In Articles 22(b) and 23(b) sexual violence in respect of elderly women and women with disabilities are specifically recognised and States have the obligation to ensure their freedom from violence. (Western Cape Government, 2014; SAHRC, 2015)

SADC Protocol on Women and Development, 2008



South Africa is not only a signatory, put participated in the drafting of this Protocol in 2008. It is wideranging, making provision for women's access to information, to the rights of widows, etc. and acknowledges that gender equality is essential to development. (SAHRC, 2015)

This section has illustrated the international and regional (African) policy context against which South African legislation preventing and treating gender-based and sexual violence is framed. It has also illustrated the variable, and in many cases high rates of sexual violence, indicating the international scale of the problem. In the section that follows the focus shifts to the nature and extent of gender-based and sexual violence in South Africa and the institutional and legislative frameworks set out to address it.

Gender-based violence in South Africa – trends, institutional frameworks and quality of care

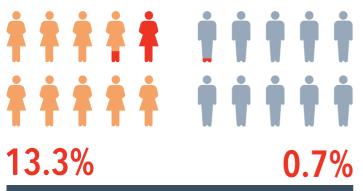
3.1. The socio-economic and political status of women in South

Although great strides have been made as far as women's inclusion in the political and economic sphere in South Africa, statistics indicate that there are many women's rights that remain unattained and that women often still hold a vulnerable position in society. The following description and statistics

are not meant to be comprehensive and all inclusive, but rather illustrative of women's socio-economic status in relation to some indicators that expose them to vulnerability.

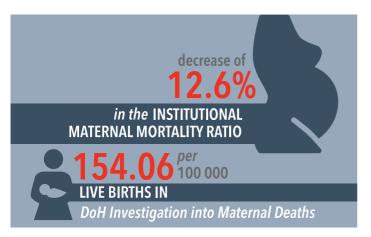
A contributing factor to the higher poverty rate among female-headed households is that women continue to earn less than men do (Stats SA, 2013). An audit conducted by PricewaterhouseCoopers (PwC) showed that on average women earn 28.1% less than their male counterparts and that black women are most likely to be unemployed (PwC, 2013). When considering female representation at more senior levels of employment the Commission on Employment Equity found that only one-fifth of top management positions are held by women, despite women make up more than 46% of the economically active population in South Africa (Commission on Employment Equity, 2014). Other studies confirm the underrepresentation of women in senior management positions – female representation on the Johannesburg Stock Exchange (JSE) is only 10% (PwC, 2013), while only 18% of managers in South Africa are women (National Planning Commission, 2010).

Women's access to education affects their ability to enter the formal economy. Data collected by Stats SA show that South African women are less likely to be able to read, and less likely to have a tertiary education than men (Stats SA, 2013). School drop-out rates for women are higher probably as a result of increased family commitments, pregnancies and higher prevalence of HIV infections (Stats SA, 2011). For example, in 2012, a noticeably larger percentage of females (13.3%) than males (0.7%) cited 'family commitment' as a reason for dropping out of school (Stats SA, 2012).



cited 'FAMILY COMMITMENT' as a reason for dropping out of school

With regards to healthcare, improvements have been made in maternal mortality rates in South Africa as reflected in an investigation by the Department of Health into maternal deaths for the period 2011 to 2013. This investigation showed a decrease of 12.6% in the Institutional Maternal Mortality Ratio (iMMR) reflected in an iMMR of 176.22 per 100 000 live births in 2008-2010 to 154.06 per 100 000 live births in 2011 - 2013. This decrease was attributed to an overall decrease in deaths resulting from pregnancy-related infections and an increased willingness of mothers to test and get treated for HIV (Department of Health, 2014). However, avoidable factors that contributed to sub-optimal care included poor clinical assessment, delays in referrals, and lack of appropriately trained doctors and nurses which was thought to have significantly contributed (15.6% and 8.8% respectively – an increase from 9.3% and 4.5% in 2008-2010) to assessable maternal deaths (Department of Health, 2014).



In South Africa (as elsewhere) continued inequity in employment practices, salaries, access to infrastructure and healthcare reduce female autonomy and contribute to the inappropriate societal norms and values discussed elsewhere in this report, in turn increasing women's vulnerability to gender-based violence. (SAHRC, 2015)

#### 3.2. The prevalence of gender-based violence in South Africa

When interpreting statistics and other empirical evidence on the prevalence of GBV authors caution that careful interpretation is necessary. Under-reporting is likely for a variety of reasons that include shame, familiarity with the perpetrator, internalisation, inappropriate societal norms that blame the victim, etc. (Kim and Motsei, 2002; Parliamentary Research Unit, 2013a; NACOSA, 2015; SAHRC, 2015). When information is collected on sexual offences and domestic violence the information is often not disaggregated and information is difficult to compare across sources (Parliamentary Research Unit, 2013a).

In understanding statistics on gender-based and sexual violence it is important to understand that vulnerability to violence spans the entire life cycle, in other words most victims will repeatedly be subjected to (or perpetuate) GBV (Weideman, 2008). This relates to earlier discussions in this report about factors such as inappropriate social norms, gender inequality, and poverty that creates vulnerability to violence. Surveys conducted in four South African provinces in 2008 and 2010 show, for example, that over 80% of respondents thought that "women should obey their husbands", or that "women need their husbands' permission" to engage in various daily activities. Only about half of respondents thought that "men should share the work around the house with women" (Jewkes, n.d.). Further, more than 60% of female respondents said that they could not "refuse to have sex with their husbands", and as many as 40% thought "beating was a sign of love" (Jewkes, n.d.). Unequal power relationships resulting from patriarchal systems, and the favouring of heterosexuality as sexual orientation also has implications for the prevalence, type and responses to violence (NACOSA, 2015).



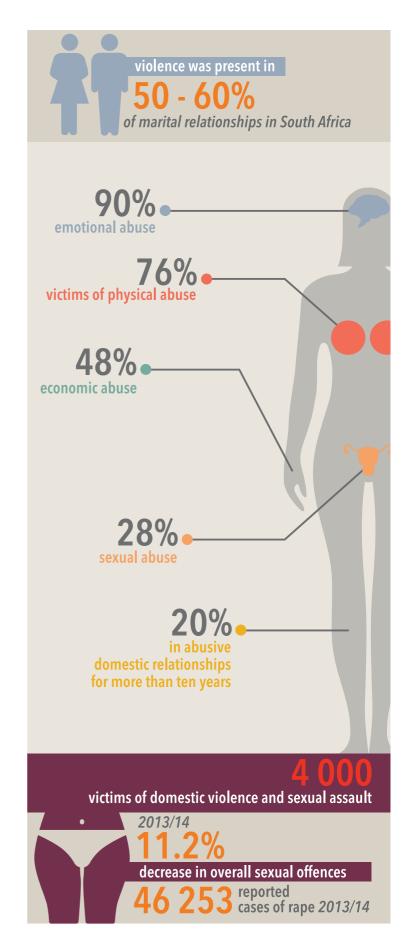
#### 3.2.1 Intimate partner and domestic violence

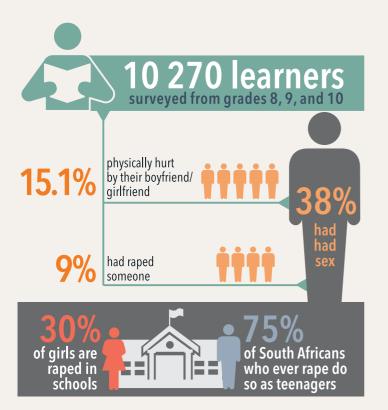
Literature on the prevalence of violence against women over time present a bleak picture of consistently high rates. A 1991 study reported that violence was present in 50 - 60% of marital relationships in South Africa (Vogelman and Eagle, 1991). A 2002 community-based study of violence against women in three provinces estimated that between 19% and 28% of women had been subjected to physical violence from a current or ex-partner, while 41% of men in Cape Town reported having physically abused a female partner in the ten years before the study (Abrahams et al., 1999). Research in 2008 among approximately 4 000 victims of domestic violence and sexual assault showed that 76% of respondents had been victims of physical abuse, 90% of emotional abuse, 48% of economic abuse, and 28% of sexual abuse. Approximately 20% of the victims interviewed had been in abusive domestic relationships for more than ten years when they were interviewed (Weideman, 2008). Similarly, Rasool et al. (2003) in a national survey of violence against women also found that much of the abuse suffered by survivors took place over a longer period of time. The Sonke Change Trail (2016) report that 32% of South African men used violence towards their partners, and 28% have raped.

Another indication of the prevalence of violence against women is use of the legal system to obtain protection orders. For example, in 2011, 217 987 new protection orders were granted against domestic violence, a further 87 711 protection orders were finalised, and 31 397 warrants of arrest were issued for breach (Parliamentary Research Unit, 2013a). In 2011, 13 748 new criminal prosecutions for domestic violence were initiated (Parliamentary Research Unit, 2013a) which was an increase from 3 954 in 2009. This could indicate an increase in domestic violence, or it could indicate (more positively) that increasing numbers of victims are taking protective action. Despite increased protection measures, 57% of the women murdered in South Africa are killed by intimate partners (Matthews, 2013), or according to Abrahams et al. (2012), every 8 hours a woman in South Africa is killed by an intimate partner.

#### 3.2.2 Rape and sexual violence

A brief overview of some of the empirical data available illustrates the extremely high rates of rape and sexual violence in South Africa. A 2015 report by the SAHRC states that "sexual violence has reached 'epidemic' proportions" in the country (SARHC, 2015:29). Between 2008/09 and 2013/14 there had been an 11.2% decrease in overall sexual offences (from 70 514 recorded cases to 62 649). During the same period reported cases of rape had stabilised with 47 588 cases reported in 2008/09 to 46 253 in 2013/14) (ISS, 2014). Actual numbers are likely to be higher than those reported to police and the MRC estimate that only one in nine rapes are reported (ISS Crime Hub, 2014). Figures across different sources (e.g. National Planning Commission, 2010; Kim and Motsei, 2002; ISS, 2011; Rape Crisis, 2013) reportsimilarly high numbers.





Studies that focus particularly on young and adolescent women also find a high incidence of rape and sexual violence among these groups. For example, 10% of sexually experienced females aged 15 - 24 reported that they had had sex because someone physically forced them, and another 28% reported that they did not want to have their first sexual encounter, indicating that they were coerced into it (Pettifor et al., 2004). The second South African National Youth Risk Behaviour Study conducted in 2008 reported that 38% of the 10 270 learners surveyed from grades 8, 9, and 10 had had sex, of which 9% reported that they had raped someone, and 15.1% that they been physically hurt by their boyfriend/girlfriend. A 2011 study by the South African Council of Educators claimed that 30% of girls are raped in schools and incidents of rape, sexual bullying and harassment are perpetrated by teachers and learners (Parliamentary Research Unit, 2013a). These indications of rape being conducted at a young age echo the findings of a 2012 study on perpetrators/rapists, which found that many commit their first rapes while still in their teens (Jewkes, 2012). Jewkes (n.d.) indicate that an estimated 75% of South Africans who ever rape do so as teenagers, and most women who experience intimate-partner violence do so as teenagers, which provides strong empirical motivation for interventions directed at preteens and teens.

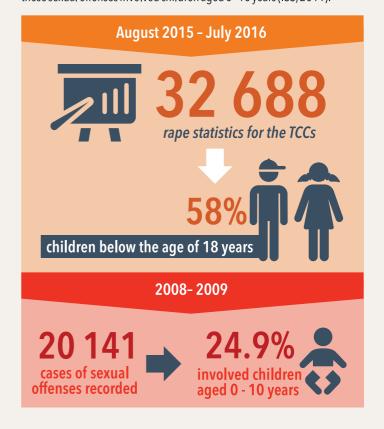
In many countries, including South Africa, Botswana and Namibia, both men and women are often targeted because of sexual identity (being gay or lesbian), (NACOSA, 2015). This is often called "corrective rape". Koraan and Geduld (2015) report that "corrective rape" refers to an instance when a woman is raped in order to "heal" her of her lesbianism. According to them, there have been 31 known cases of murders linked to the victim being openly lesbian in the past 5 years. They also report that there are at least 10 rapes a week linked to this in South Africa.

#### 3.2.3 Violence against sex workers

Sexual violence against sex workers is also under-reported due to the nature and legality of their work. The data that exist indicate that both clients and police officers are perpetrators (WHO, n.d.; Curran et al., 2013; NACOSA, 2015;). During a survey of 1 136 sex workers in South Africa more than half (54%) had experience physical violence in the last year (SWEAT, 2012). The Sex Worker Education and Advocacy Task Force (SWEAT) has also made resources and educational material available to sex workers in order to help reduce violence and raise awareness about their rights if incidences of violence occur(SWEAT, 2004).

#### 3.2.4 Violence against children

Children are also victims of crime and a 2002 report by the SAHRC into sexual offences against children noted the overlap between gender-based violence and the rights of children. It noted in particular the vulnerability of the girl child to violence and argued for concerted efforts to address secondary victimisation (SAHRC, 2015). Among the dominantly social contact crimes committed against children in 2011, 51.9% were sexual offences (ISS, 2011). The National Prosecuting Authority's (FPD, 2016) rape statistics for the TCCs for the year August 2015 – July 2016 are 32 688. Of these 58% are children below the age of 18 years. The Institute for Security Studies (ISS) notes the disturbing finding that in the case of the most prevalent crime against children, namely the 20 141 cases of sexual offences recorded during 2008/9, 60.5% were committed against children below the age of 15 years. Even more disturbing is the fact that 24.9% of these sexual offenses involved children aged 0-10 years (ISS, 2011).



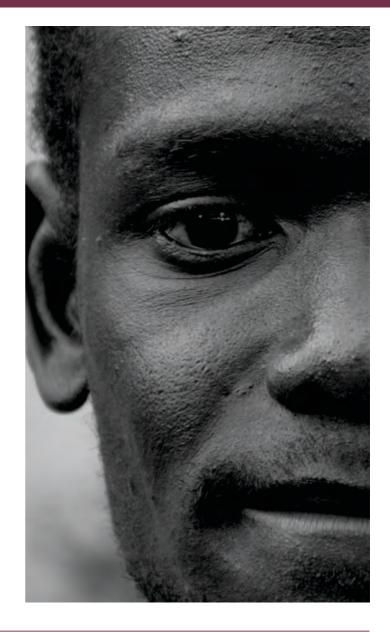
### 3.3. Legislative and institutional framework aimed at addressing gender-based violence in SA

#### 3.3.1 Legislative and policy framework

The 1996 Constitution of the Republic of South Africa and the Bill of Rights contained therein sets the tone for the protection of women's rights and any legislation enacted in this regard. Section 9 states that discrimination on the grounds of, *inter alia*, gender, sex, pregnancy and sexual orientation is prohibited. Other rights that are consistently violated in the lives of women in the context of a discussion on gender-based violence are the right to freedom and security of the person (Section 12); the right to be free from subjugation in the forms of slavery, servitude or forced labour (Section 13); the right to privacy (Section 14); the right to freedom of movement and residence (Section 21); and the right to access to healthcare services, including reproductive healthcare (Section 27).

It is the responsibility of governments to create and implement laws to protect their citizens from sexual violence (Kilonzo, 2013) and there have been profound legislative and policy changes with regard to violence against women in South Africa since 1998 (Weideman, 2014; SAHRC 2015).<sup>12</sup>

The graphic below summarises some of the laws and policies relating to GBV. Some of the main legislation and policies are briefly explained, while a more detailed discussion on policies and guidelines related to the provision of medical care are discussed later in this report.





#### Domestic Violence Act, No. 116 of 1998:

The purpose of this Act is to provide maximum protection under law for victims of domestic abuse. It has broadened the definition of domestic violence thereby affording greater protection to victims and also allows for issuing of protection orders.



#### Service Charter for Victims of Crime in South Africa (referred to as the Victims' Charter), 2004:

The Victims' Charter contains seven key rights that victims have when interacting with services provided to them. It is aligned with both the victim-centred approach of the National Crime Prevention Strategy of the Department of Safety and Security, as well as the 1985 United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. (Western Cape Government, 2014)



#### The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007:

The Act aims to incorporate all sexual crimes into one law and clearly defines sexual crimes and related matters. It also tries to ensure that victims receive adequate and appropriate services and assigns roles and responsibilities to different departments for the implementation of the Act. (NACOSA, 2015)



#### National Management Guidelines for Sexual Assault, 2003:

These guidelines were compiled against the backdrop of increasing incidence of sexual violence and lack of standardisation of healthcare. It contains detailed guidelines around investigations, treatment, referrals and follow-up (DoH, 2003). The guidelines prescribe the comprehensive support that should be provided to rape survivors and as well the administering of PEP. (Herstad, 2009)

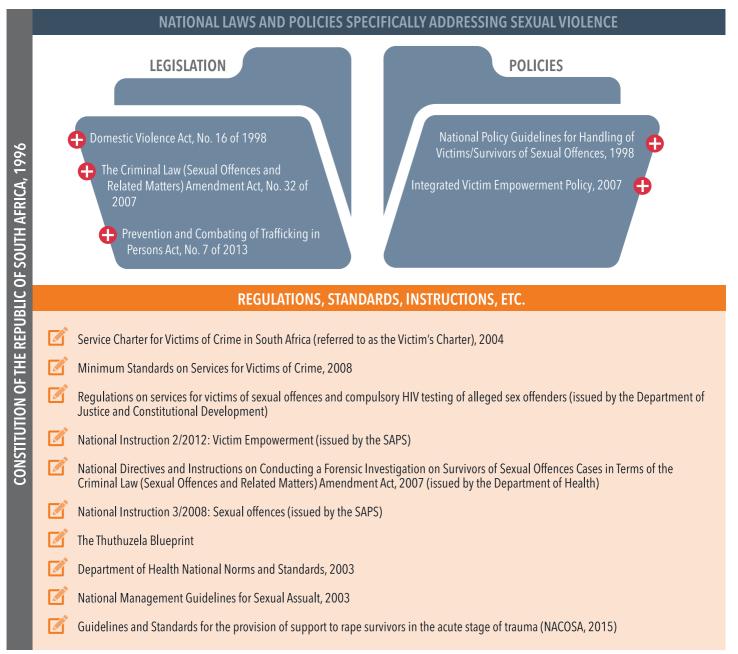


#### Prevention and Combating of Trafficking in Persons Act, No. 7 of 2013:

This Act gives effect to South Africa's obligations under international agreements to combat trafficking of persons. (Western Cape Government, 2014)

There have also been many legislative enactments to advance or protect the position of women that does not directly relate to sexual violence and is therefore not included in this review. These include: Promotion of Equality and Prevention of Unfair Discrimination Act, No. 4 of 2000 (PEPUDA); Recognition of Customary Marriages Act, No. 20 of 1998; Basic Conditions of Employment Act, No. 75 of 1997; The Employment Equity Amendment Act, No. 47 of 2013 (the EEAA); National Health Act, No. 61 of 2003; etc.

It is worth noting that while there might be various laws, policies and frameworks in place, enforcement of these is often inadequate (WHO, 2014). The following are some of the most significant legislative and policy frameworks.



Legislation, policies and other instruments (e.g. regulations and directives) specifically providing for matters relating to sexual violence (compiled by drawing on a number of sources such as: Western Cape Government, 2014; NACOSA, 2015)

### 3.3.2 Services and institutions framework to respond to GBV in South Africa

In addition to the legislation and policies mentioned above and in some instances as a result of these, various institutions and services exist to respond to gender-based violence in South Africa. Although the following list is not exhaustive, it illustrates the wide ranging legally mandated

programmes, as well as the role played by non-governmental organisations (NGOs). The literature also points out some of the successes and challenges of these institutions.





#### **Government departments and national institutions**



#### Ministry for Women in the Presidency:

The Ministry runs various initiatives such as the annual campaign of Sixteen Days of Activism for no Violence Against Women and Children from 25 November to 10 December, the 365 days campaign, as well as Women's month in August each year. It also hosts the National Council Against Gender Based Violence which was established in 2012 and advises government on policy and intervention programmes.



#### Department of Social Development (DSD), specifically the Victim Empowerment Programme (VEP):

The VEP is managed by DSD and serves all victims of crime including victims of gender-based and sexual violence (Western Cape Government, 2014). The role of the VEP is to provide for the establishment of inter-departmental/inter-sectoral programmes and policies in order to facilitate greater synergy and coordination between relevant stakeholders and the services they provide (Weideman, 2008). The VEP also focuses heavily on subsidising shelters for women (Western Cape Government, 2014). DSD also developed an integrated Programme of Action to address violence against women (POA: VAWC). This is a comprehensive, multi-sectoral strategic plan for ending violence against women and children. It highlights the responsibility of the different government departments who play a role in this sector. The POA is based on three pillars – prevention and protection, response and care and support. (DSD, 2014)



#### Commission for Gender Equality (CGE):

The mandate of the CGE, as per section 187 (1) of the Constitution, is the protection, development and attainment of gender equality. (SAHRC, 2015)



#### National Task Team on Gender and Sexual Orientation-Based Violence Perpetrated on LGBTI persons:

This task team was established in 2011 by the Minister of Justice and Constitutional Development with the aim to, among other things, develop a national intervention strategy to address violence against LGBTI persons, including "corrective rape". (Department of Justice and Constitutional Development, 2014)



#### **Criminal justice system**



#### South African Police Service (SAPS):

In many instances the police are the first point of call when victims report incidences of sexual or domestic violence and it is therefore necessary that they be responsive and equipped to do so, that victims are able to access police stations or that police arrive timeously when called to the scene, that people are attended to within a reasonable timeframe, and that where possible they are seen by an officer of the same gender (Weideman, 2008). In line with the Domestic Violence Act, police stations must utilise the domestic violence register in order to accurately record incidents and statistics. In addition, Victim Empowerment Centres (VECs) have been established at police stations made up of officers and volunteers who are trained to assist victims of violence, and Family Violence, Child Protection and Sexual Offences (FCS) Units exist to focus specifically on the investigation of these crimes (Gauteng Government, n.d.; SAPS n.d.). However, despite their continued work in this field, SAPS members do not always receive the psychological support services that they need in order to perform their duties related to assisting victims of sexual offences (Weideman, 2014). How police performance is measured also creates a disincentive for them to record crimes, e.g. police are required to reduce violent crime by 4 - 7% per year which might mean that they do not record all crimes reported to them (ISS, 2014).



#### Sexual Offences Courts:

The first sexual offences court was run as a pilot project and was seen as an innovative way to increase prosecutions and assist in preventing secondary victimisation that survivors experience when they engage with the criminal justice system. The Department of Justice and Constitutional Development is in the process of re-introducing these courts across the country. (Department of Justice and Constitutional Development, 2013).





#### **Health services/support**



#### Thuthuzela Care Centres:

Survivors of sexual violence are often in need of a variety of medical interventions/forms of support that the health system should ideally be able to provide for, in addition to needing access to the criminal justice system. In order to provide for this multi-dimensional level of care, Thuthuzela Care Centres (TCCs) exist, which are one-stop facilities for survivors of sexual violence led by the National Prosecuting Authority (NPA), specifically the Sexual Offences and Community Affairs Unit (NACOSA, 2015; UNICEF, n.d.), but are managed by interdepartmental teams from different departments such as Justice, Health, Social Development, Correctional Services, etc. as well as being assisted by a number of NGOs and other civil society partners (NACOSA, 2015; UNICEF, n.d.). A total of 55 functioning TCCs exist across South Africa and an evaluation of their services and how they are supported by NGOs were recently conducted (FPD, 2016). This integrated model has been recognised in South Africa and elsewhere as successful in supporting survivors of sexual assault in a variety of ways, such as reducing secondary trauma of victims, providing them with counselling and safety, affording them an opportunity to shower and providing them with clean clothing, preventing HIV and STI infection and unwanted pregnancies, and facilitating increased prosecution and conviction rates by following the correct procedures for the collection of forensic evidence and facilitating access to the police and other legal support (NACOSA, 2015; UNICEF, n.d.). The functioning of the TCCs is guided by the TCC Blueprint which explains all the steps and processes for the management of sexual assault that has been reported at a TCC in South Africa. It explains the ideal TCC lay-out and staffing, the minimum level of care and the norms and standards for managing victims of assault. It also highlights the roles and responsibilities of other role players, such as other government departments and the NGOs who deliver services within the TCCs. This includes staff members from these departments and NGOs who work within the TCCs (RTI, 2012).



#### Designated rape care centres:

In addition to TCCs, 256 designated rape centres exist in South Africa at hospitals in areas not covered by TCCs. (NACOSA, 2015).



#### Civil society/NGOs

South African civil society, primarily through non-governmental organisations (NGOs), has played a crucial and sustained role in the provision of developmental social welfare services and other socio-economic development and support initiatives. Their role in the provision of services to survivors of sexual violence is crucial and needs to be acknowledged as in many communities NGOs are either the only source of assistance to rape survivors (NACOSA, 2015) or provide a "24-hour 'first response' service to support survivors through the initial trauma process of forensic examination, HIV counselling and testing, provision of post-exposure prophylaxis (PEP), giving a statement and linking with other services and the justice system" (NACOSA, 2015). NGOs therefore offer a variety of services such as counselling, health services, referrals, shelters, legal support services, research into gender-based violence, etc. Within the broader framework of responses to gender-based violence, some literature reflects on the roles and responsibilities of the church in South Africa in the prevention of violence and the provision of support to survivors (Tearfund, 2013) (NACOSA, 2015).

Despite this supportive work of NGOs and their complementary role to services provided by the public health system, Kilonzo (2013:2) has argued that the provision of sexual violence services as projects by NGOs could have negative implications for the scale-up of services "potentially constraining the services access to national supply systems, budgets and other resources that could make scale up a reality".

#### 3.4. Quality health care and barriers to access

### 3.4.1 International and national guidelines and standards in the provision of quality health care to survivors of sexual violence

Not all countries have legislation, policies and protocols in place to provide support to survivors of sexual violence which means that care is inconsistent both across and within countries (Kilonzo et al., 2009; Keesbury and Thompson, 2010). However, South Africa draws on international standards and has put in place national standards and guidelines of its own as discussed in this report.

There is consensus in the literature that survivors require comprehensive care. Such care often refers to both the different dimensions of care (such as physical health, psychosocial support, legal support, etc.) and the principles underlying such care, such as compassion and gender-sensitivity. The objective of comprehensive care is not just to provide immediate care in the aftermath of incidents of sexual violence, but also to help minimise longer-term psychological trauma and secondary victimisation. Such care is not only possible in high-income settings, but through systems of referral and the integration of services into existing healthcare, is also possible in resource-poor countries (Keesbury and Thompson, 2010; Kilonzo, 2013). Examples of what comprehensive care involves includes:



"comprehensive medical management by healthcare providers (including prevention of HIV), short and long-term psychosocial support, and legal assistance to help the survivor access justice ... Many services need to be provided as soon as possible following SV and no later than 72 hours following the assault, including PEP, forensic evidence collection and EC [emergency contraception] (within 120 hours)..." (Keesbury and Thompson 2010:4)

When designing comprehensive services the needs of children, adolescents and others with special needs should also be taken into account (Keesbury and Thompson, 2010) as they make up a substantial number of survivors who access services. Such adaptation could include creating a safe space for them, adapting medical examinations, etc. (Keesbury and Thompson, 2010).

Keesbury and Thompson (2010:5) summarises the different elements of a comprehensive response to sexual violence, as well as the relevant sectors responsible.

Core components of a comprehensive response to Sexual Violence (reproduced from Keesbury and Thompson (2010:5))



Pregnancy testing and emergency contraception
HIV diagnostic testing and counselling and PEP
Prophylaxis for sexually transmitted infections
Vaccination for hepatitis B and tetanus
Evaluation and treatment of injuries, forensic examination and documentation
Trauma counselling
Referrals to/from police and social support sectors



Statement-taking and documentation
Criminal investigation
Collection of forensic evidence and maintaining the chain of evidence
Ensuring the safety of the survivor
Prosecution/adjudication of the perpetrator
Witness preparation and court support
Referrals to/from health and social support sectors



Assessment to determine need for psychosocial services
Referral for short-term and long-term psychosocial support services
Provision of safe housing, relocation services, if required
Reintegration into family/household, if required
Long-term psychosocial counselling and rehabilitation
Referrals to/from police and health sectors
Community awareness-raising and stigma reduction

A number of international and national guidelines apply to the provision of care (including medical care) in South Africa and are briefly described below.

### WHO Guidelines for Medico-legal Care for Victims of Sexual Violence, 2003

The WHO guidelines recognises that survivors of sexual violence access medical care if they are able to do so and that health workers therefore play an important role with respect to the identification of incidents of violence and the provision of services (WHO, 2003). The Guidelines aim to address gaps in the standardisation of care across countries in a number of ways, for example, addressing the knowledge gaps that healthcare workers have, setting and increasing the standards of care, and assisting in improving the forensic services available to survivors, which is essential to successful prosecution (WHO, 2003; NACOSA, 2015). The types of services survivors of sexual violence need and that are provided for in the guidelines include:



"pregnancy testing, pregnancy prevention (i.e. emergency contraception), abortion services (where legal), STI testing and/or prophylaxis, treatment of injuries and psychosocial counselling ... the health sector can act as an important referral point for other services that the victim may later need, for example, social welfare and legal aid." (WHO 2003:11)

#### Department of Health Norms and Standards, 2003

The DoH Norms and Standards provide guidance on the functioning of primary health care (PHC) facilities. They highlight the tasks of DoH officials in ensuring the quality of services delivered and that all equipment is functioning well. They also provide guidance on the cadre of staff who are trained in the management of sexual assault, that the site is victim friendly and that the appropriate medical guidelines for HCT and the provision of PEP are followed.

#### Standards and norms for primary healthcare, 2000

This document highlights the responsibilities of PHCs in the case of domestic violence and sexual assault. This includes that facilities establish a working relationship with the closest police office. It also highlights the training needs of staff, the room and equipment within facilities, the services delivered within the facilities as well as referrals (Christofides et al., 2003).

#### **TCC Blueprint**

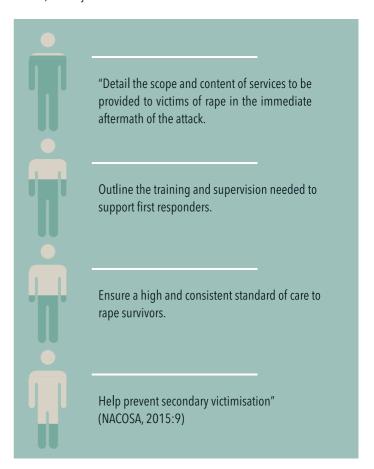
The objectives of the TCC Blueprint are to help limit or prevent the secondary victimisation suffered by many victims of sexual assault in their interaction with the health and criminal justice system; to improve on the timeframe within which cases are concluded (the objective is within 9 months); and to increase the conviction rate for sexual offences. (NPA, n.d.)

To this end the Blueprint sets outs guidelines for the management of different aspects of care, as well as staffing and resources. For example, the Blueprint sets out facility and space requirements for the optimal provision of care – this includes the need for TCCs to be open 24/7 and to be located close to public transport routes and close to a public health facility, the presence of confidential consulting rooms and private facilities for victims to shower or bath, the need for constant availability of staff who are able to conduct forensic examinations and collect evidence, and for 'comfort kits' to be available to victims and toys for child victims. (NPA, n.d.)

The Blueprint furthermore sets out the services that TCCs should provide in order to render it a one-stop-centre, as well as the roles and responsibilities in providing such care. This includes guidelines around legal processes and timeframes for case management, e.g. that a case should be registered on the court roll within 48 hours. (NPA, n.d.)

#### **NACOSA Guidelines**

The Networking HIV&AIDS Community of Southern Africa (NACOSA), together with the Global Fund to Fight AIDS, Tuberculosis and Malaria, developed the Guidelines and Standards for the Provision of Support to Rape Survivors in the Acute Stage of Trauma published in 2015. The Guidelines are specifically aimed at "first responders" (those who help rape survivors in the aftermath of the attack) and realise that it is not always possible for all services to be provided in one location (such as in the TCC model). The objectives of the Guidelines are four-fold:



The Guidelines highlight a number of principles underlying any care that is provided, which includes aspects such as dignity, confidentiality, following a rights-based approach, and ensuring that services are accessible and responsive to all who need them including children, youth and the disabled (NACOSA, 2015).

The recommended standards with regards to health facilities has some overlap with the TCC Blueprint and include:

The environment should be reassuring and include a private waiting area for family and friends. The existence of at least one private and lockable consulting room. That survivors be attended to 45 min – 1 hour from arrival. PEP should be administered within 2 hours of arrival The availability of resource material in all languages relating to HIV care, PEP, termination of pregnancy and coping with rape. The existence of a comprehensive referral list to assist survivors in accessing appropriate care. First responders should be subject to routine supervision and debriefing. 24 Services should ideally be available 24-hours a day, 7 days a week. (NACOSA, 2015:21)

#### Importance of referrals

Resource constraints mean that it is not always possible for all services to be provided at one-stop centres, and services can also be provided at hospitals, community healthcare centres (CHCs) and clinics. The literature suggests that when planning around the provision of services it is necessary to decide what elements of the comprehensive care required by survivors can be provided at facilities and what services need to be referred (Keesbury and Thompson, 2010). Ideally all emergency services should be provided at the health facility, including trauma counselling (Keesbury and Thompson, 2010). When it is not possible for comprehensive services to be provided at facilities, a strong referral system needs to be in place which could include referrals to other healthcare facilities, NGOs, the police, etc. However,

Keesbury and Thompson (2010) argue that referral systems are often not given enough attention in the design of post-violence assault services. There are various factors that influence the strength of the referrals system such as: the "proximity of services to one another, attitudes of staff, levels of awareness of services in community, use of standardised referral algorithms, ongoing meetings between stakeholders". (Keesbury and Thompson, 2010: 32)

3.4.2 Barriers faced by survivors of sexual violence in accessing health services in South Africa

When survivors of sexual violence are not able to access services it adds to feelings of isolation and the impact of violence on themselves and their families (Western Cape Government, 2014). Even when survivors seek assistance, it cannot be assumed that they receive it immediately – in a 2008 study of approximately 4 000 survivors of domestic violence the average respondent sought help five times before receiving any (Weideman, 2008). And despite South Africa's extensive legislative framework aimed at reducing and managing incidents of sexual violence, incidents remain high, as illustrated in this review, and barriers to accessing care exist.



The literature illustrates various barriers that directly impact on a lack of access to healthcare by survivors. The following list is not comprehensive, but rather illustrative of the barriers faced at individual and societal levels, as well as at healthcare facilities these factors are often inter-related:

# Sexual violence is not regarded as a serious health issue by staff, and staff sometimes hold discriminatory views towards victims:

sexual violence services are not always prioritised or regarded as a serious health issue (Christofides, et al., 2005) and are victimisation (Christofides et al., 2005). Other research has shown a lack of willingness by some staff to be involved in certain services (such as termination of pregnancy); a general feeling of discomfort working with victims of trauma; a reluctance to conduct medical exams which would mean staff would need to testify in court; and a lack of sensitivity (WHO, 2003; Christofides et al., 2005; SAHRC, 2015).

#### Lack of resources and infrastructure to provide services:

This could refer to gaps in essential medication, equipment, services, and the infrastructure to treat survivors of sexual violence with sensitivity (Keesbury and Thompson, 2010). The SAHRC (2015) has documented violations of the right to

#### Feelings of self-blame, fear, and lack of awareness of facilities and ability to access them (e.g. lack of transport):

Under-reporting and lack of accessing of care occur for reasons self-blame and shame at being exposed in the community as a victim of sexual violence; an inability to access facilities due to lack of transport or the financial means to arrange transport; and the possibility of negative economic consequences if the victim relies financially on the perpetrator. (Weideman, 2008; Keesbury and Thompson, 2010)

### Lack of skills (general and specialised) on the part of

healthcare providers:
Healthcare staff sometimes lack understanding of the treatment required by survivors of sexual violence, as well as what they are required to do by law. (Keesbury and Thompson, 2010; SAHRC, 2015)

#### Fragmented, uncoordinated care (only focusing on most immediate needs):

legal or psychological) and follow-up (Christofides et al., 2003; Christofides et al., 2005).

The ways in which societal attitudes towards victims of sexual violence influence their reporting of offences and whether they access care is well documented and includes factors such as fear of rejection or retaliation from communities. (Christofides et al., 2005; Keesbury and Thompson, 2010; Kilonzo, 2013; Western Cape Government, 2014)

# Overview of Gauteng and City of Johannesburg (Regions A, D, E and G) - socio-demographic and GBV profile

This section of the desk review and situational analysis relates to the geographic area (Gauteng more generally and City of Johannesburg (Regions A, D, E and G specifically)) that is the focus of the rapid assessment of post-violence care at facility level. It provides a brief description of the demographic and socio-economic profile of the province and district and the situation regarding GBV (prevalence rates, services available and barriers to care).

### 4.1. Demographic and socio-economic profile of Gauteng and City of Johannesburg

Gauteng is one of South Africa's nine provinces and is centrally located, bordering four other (Gauteng Tourism, n.d.). Gauteng is 17 000 km² in size, and hosts almost 25% of the South African population. The province is described as the economic hub of South Africa and generates a third of the country's GDP and contributes 47% of the country's economy. The City of Johannesburg (CoJ) is one of Gauteng's five metropolitan regions. Johannesburg has a rich mining history, with the gold rush of 1886 leading to the formation of the city. CoJ's economic sectors are now centred on finance, manufacturing, trade and services (HSRC, 2014).





Metropolitan map of Gauteng province indicating City of Johannesburg Source: Google maps



Regional map of City of Johannesburg indicating regions Source: CoJ – Department of Economic Development

Source: Google maps

According to the Census 2011 report, Gauteng had a population of 12 272 263 of which 4 434 827 live in CoJ. In the province as a whole, 23.7% of the population are younger than 15. In the CoJ 23.2% of the population are younger than 15. The sex ratio for the province (males per 100 females) is 101.8, while CoJ is at 100.7 (Stats SA, 2011). This can be attributed to economic migration to Gauteng (HSRC, 2014). CoJ is the most populated city in South Africa. Region D contains 25% of the city's population. Women made up approximately 52% of South Africa's population in 2011 (Statistics South Africa, 2011).

The province had an official unemployment rate of 26.3% (with the CoJ lower at 25%). The official youth (15 - 34 years) unemployment rate is higher than the national average at 34%. At 31.50%, the youth unemployment rate for CoJ was slightely lower than that reported for the province (Stats SA, 2011). Informal sector employment in CoJ grew by 210% between 1996 and 2011 (HSRC, 2014).

Statistics related to education were better for CoJ than the province as a whole, perhaps as a result of its urban nature. In CoJ only 2.9% had had no schooling, compared to the provincial average of 3.6%. In addition, 35% had passed matric, which is slightly higher than the provincial average of 34.7%. (Stats SA, 2011).

average size of 3.1, which was the same as that in CoJ and 34.3% of households were female-headed (36.2% in CoJ) (Stats SA, 2011). According to an SAHRC report, in 2008 42% of children in Gauteng lived in poverty, which was significantly lower than the South African average (64%) but higher than the Western Cape (37%) (SAHRC, n.d.). Region G has the highest number of people living in poverty (HSRC, 2014). However, CoJ saw a 5% increase in human development between 1996 and 2011. Within CoJ, Region B has the highest Human Development Index (HDI) at 0.71 and

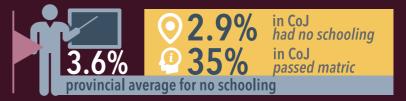
Region G the lowest at 0.67 (HSRC, 2014).

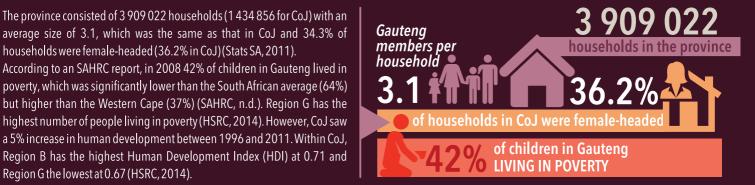
A 2014 Department of Health report on maternal mortality rates for 2011 -2013 showed that Gauteng had the second highest number of reported maternal deaths (19%) compared to other provinces, and that it is the province (shared with KwaZulu-Natal) in which medical and surgical conditions are the second biggest cause of maternal death. This is in contrast to other provinces, where non-pregnancy related infections are the most common causes of maternal deaths (Department of Health, 2014). Of the women who died, and who had tested for HIV, 65% were positive (nationally).

Gauteng 2 272 263 population According to the Census 2011 23.2% of the population in CoJ is younger than 15 years CoJ is the MOST POPULATED CITY in South Africa

> **Provincial** unemployment rate

in CoJ





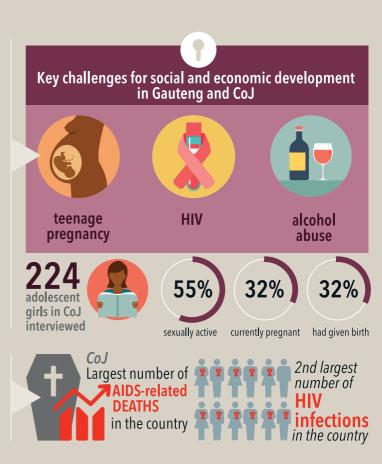


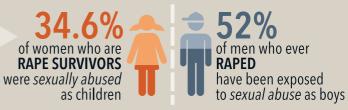
Gauteng and CoJ face a number of social and economic development challenges, of which teenage pregnancy, alcohol abuse and HIV have been identified as some of the key challenges. These are highlighted in this review as they have particular relevance for a discussion on GBV. In CoJ, factors associated with teenage pregnancy are social and cultural (e.g. resourcepoor settings, early sexual debut, substance abuse, alcohol abuse and binge drinking and violence in the community) as well as economic (e.g. blessers and sugar daddies as a means through which to secure economic stability) (Brahmbhatt et al., 2014). Age at first sexual experience is also a behavioural risk factor associated with HIV incidence, together with lack of access to condoms and their use, and large age differences between sexual partners. A study by Brahmbhatt et al. (2014) across five cities in resource-poor urban cities, found that early sexual debut (before the age of 15) influences contraceptive use negatively. The study also found that among 224 adolescent girls in Johannesburg, 55% were sexually active and 32% were currently pregnant and 32% have given birth in the past. Almost 15% of the participants in the study had an abortion in the past.

CoJ had the second largest number of HIV infections and the largest number of AIDS-related deaths in the country (compared to other cities). Within the city, region D has the highest number of HIV infections, but this can be contributed to the fact that this is also the most populated region in the city (HSRC, 2014). Region A has the second highest number of HIV infections in the CoJ.

A major driver for sexual assault is previous exposure to sexual abuse as a child. In Gauteng, 48.8% of women who were sexually or physically abused by their partners experienced sexual abuse as a child and 34.6% of women who are rape survivors were sexually abused as children (Machisa et al., 2011). They also report that 52% of men who ever raped have been exposed to sexual abuse as boys.

Another major social challenge in the province is alcohol abuse (Machisa et al., 2011). A total of 4.2% of women in Gauteng had been raped while drunk/drugged, and of the men surveyed, 14.2% had admitted to forcing a woman to have sex when she was unable to refuse on account of being drunk/drugged. Men also reported that their abuse of other drugs influences their behaviour, increasing abuse. As has been mentioned earlier in this report, alcohol use is associated with a higher risk/vulnerability to GBV, and a study in KZN has also indicated this link (Musariri et al., 2013).









#### Gender-based violence in Gauteng and City of Johannesburg

The rates of under-reporting of sexual violence to the SAPS in Gauteng (as in other provinces) have been illustrated by statistically representative surveys of the nature and pervasiveness of GBV. The research indicates that 51% of Gauteng women said that they had experienced GBV (higher than the 36% in KwaZulu-Natal and 45% in the Western Cape) (Machisa et al., 2011).

A 2011 survey of Gauteng households indicated that 51% of women in Gauteng had been subjected to intimate partner violence (Machisa et al., 2011), and 76% of men admitted to perpetrating GBV. Approximately 12% of women in Gauteng (compared to 5% in KwaZulu-Natal and 6% in the Western Cape) had been raped (Machisa et al., 2011). HIV infection among women who had been sexually abused by an intimate partner is high, at 35% (Musariri et al., 2013). A baseline study in Diepsloot (Region A) showed that 56% of men in Diepsloot had been violent towards women in the past year, 60% multiple times (Sonke Change Trail, 2016). Cultural beliefs and notions of masculinity are a driving force for GBV in Region A, with 35% of men believing that paying lobola means that you own a woman, 70% believe that they can control a woman's friends and movements, and more than half think that a woman must always agree to sex.

Only 0.09% of men and 0.3% of women in Gauteng reported domestic violence, while a total of 18.1% of women said they experienced violence. This indicates that there are high levels of under-reporting of violence against women, while sexual violence by an intimate partner is least reported.

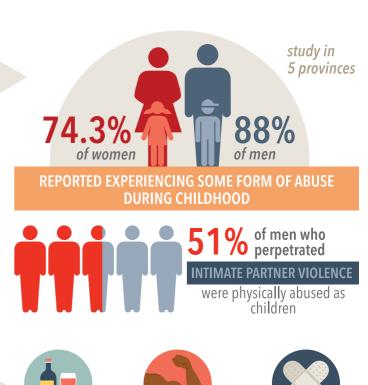
A very high proportion of men and women in Gauteng have been victims of child abuse (Machisa et al., 2011). The majority of women and men who took part in a study on GBV in five provinces in South Africa, had been physically abused as children. A total of 74.3% of women and 88% of men had reported experiencing some form of physical abuse during childhood (Machisa et al., 2011). As has been discussed earlier in this report, child physical abuse and child neglect can be linked to the perpetration of GBV and Musariri et al. (2013) illustrate this link as there was a statistically significant difference in perpetration of intimate partner violence between survivors of child physical abuse and those who had not experienced physical abuse as a child. For example, 20% of men had committed intimate partner violence but had not been physically abused as children, against 51% of men who had reported perpetrating intimate partner violence and who were physically abused as children (Musariri et al., 2013). This is also the case in Diepsloot in Region A, where a third of all men reported that they had been raped or molested as a child (Sonke Change Trail, 2016).

In Gauteng, GBV is linked to the interplay between various individual, community and societal factors. Machisa et al. (2011) reports that GBV in Gauteng is related to patriarchal and masculine gender norms, child abuse as a child, and abuse of alcohol and other drugs.

### 51% OF GAUTENG WOMEN HAD EXPERIENCED GBV

#### A BASELINE STUDY IN DIEPSLOOT SHOWED



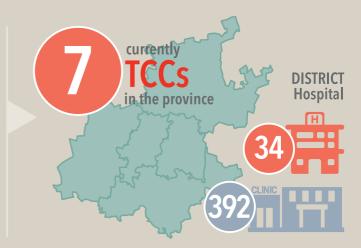


gender norms

alcohol abuse

abuse in childhood

Various institutions and structures exist in the province to support survivors of gender-based and sexual violence. There are currently seven TCCs in the province: (1) Mamelodi TCC at Mamelodi Day Hospital, Mamelodi; (2) Nthabiseng TCC at Chris Hani Baragwanath Hospital, Diepkloof; (3) Lenasia TCC at Lenasia Hospital, Lenasia; (4) Laudium TCC at Laudium Hospital & Community Health Centre, Laudium; (5) Thelle Mogoerane TCC at Thelle Mogoerane Regional Hospital, Vosloorus; (6) Kopanong TCC at Kopanong Hospital, Vereeniging; and (7) Masakhane TCC at Tembisa Hospital, Tembisa; (FPD, 2016). In terms of public health care facilities, there are 34 hospitals (including provincial, regional, district and specialised) and 392 PHC facilities (including Community Health Centres (CHCs), Primary Health Care Clinics (PHCs) both fixed and satellite in Gauteng (Gauteng DoH, 2016).



The SAPS has created 22 family violence, child protection and sexual offences (FCS) units in the province and 58% of the commanding officers in these units are women (Machisa et al., 2011). SAPS also offer Victim Empowerment Centres (VEC) within police stations to provide a more integrated service to victims of GBV. There are 122 of these centres across the province.

family violence, child protection and sexual offences units

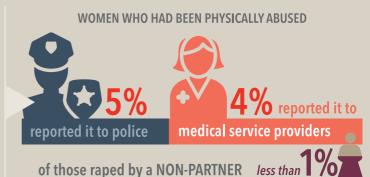
Victim Empowerment Centres

in the province

Data from various directories, such as the 2011 GBV Project by FPD, funded by SIDA, that resulted in service directories listing government and civil society resources that assist victims of violence, or the CSVR directory on counselling services, show that there are many NGOs that provide various levels of assistance (such as counselling, legal assistance, shelters) to victims of gender-based and sexual violence both outside the health facilities and while working in close partnership with facilities (or being based there). Examples of some of these CSOs include People opposing Women Abuse, COPESSA, Lawyers against Abuse, LifeLine and Childline.



Despite the support services that are available, the under-reporting of gender-based and sexual violence and poor use of services also holds true for Gauteng. Research has indicated that the majority of female victims do not report violence to police, or seek medical attention or legal recourse. Five percent of women who had been physically abused reported it to police, while just 4% reported the incident to medical service providers. Of those women who had been raped by a non-partner, less than 1% reported it to police or healthcare providers (Musariri, et al., 2013). Reasons for underreporting and not accessing services in Gauteng are similar to reasons in South Africa more generally (mentioned earlier in this report), although it is worth highlighting research in Gauteng that specifically focuses on reporting and accessing of services.



reported it to police or health care providers

#### Awareness of legislation and rights:

A 2011 study on GBV in Gauteng (Machisa et al., 2011) highlighted that more men (77%) than women (74%) were aware of the Domestic Violence Act, but relatively low proportions of both men and women interviewed were aware of the Sexual Offences Act (36% women and 56% men).



in Gauteng aware of the Domestic Violence Act

#### Prevalence of inappropriate and harmful societal norms:

Barriers to reporting violence and accessing care include the fear of being accused of lying, shame and embarrassment, lack of confidence in the court system, fear of retaliation and the loss of economic support (Vetten, 2014b). For example, in the 2011 cross-sectional survey of Gauteng households 29% of women, and 39% of men said that a woman cannot refuse to have sex with her husband (Machisa et al., 2011). The study also found that payment of lobola equated to ownership and that a wife can then be treated as property. As a result, 26% of men would be outraged if a woman ask him to use a condom and 4% would hit her if she asks to use a condom.



said a woman cannot refuse to have sex with her husband

#### Inaccessibility of services and substandard care:

Coupled with these negative community attitudes, other barriers to accessing care include inaccessible services, e.g. not close to a transport route, women not having the financial means to get to a facility, as well as the possibility of secondary victimisation by service providers (Musariri et al., 2013). Malama (2016) reports that some government clinics in CoJ are reluctant to provide contraceptives to adolescent girls. Girls attempting to access the services reported that staff (nurses, security and well as reception) in some clinics were rude and unhelpful when adolescent girls requested information about contraception. This is in spite of high teenage pregnancy rates in CoJ.

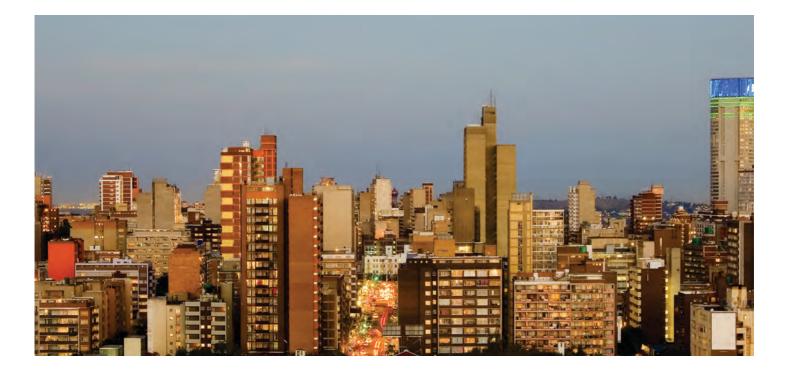


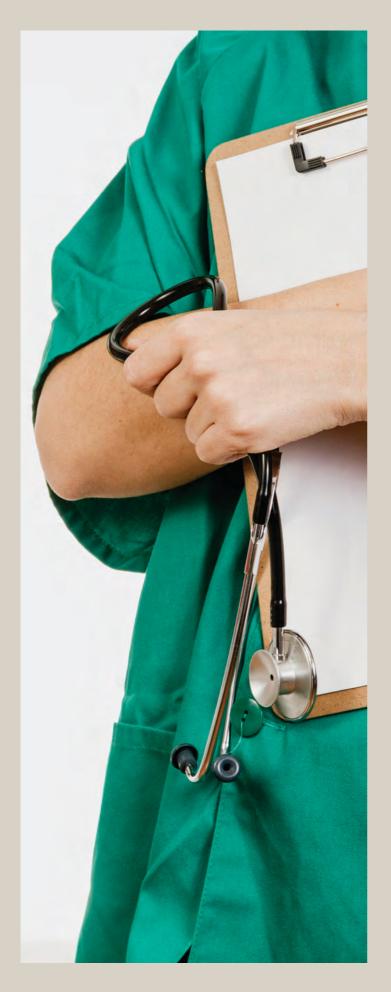


inaccessible services

women not having the financial means to get to a facility

secondary victimisation by service providers





## 5. Conclusion and way forward

This desk review and situational analysis has illustrated the strong legislative and policy framework that exist internationally and within South Africa to address gender-based and sexual violence. Despite these efforts, the prevalence of such violence in South Africa remains extremely high. Many of the sources in this report have indicated that legislation might not be fully understood and therefore not fully implemented by service providers and that knowledge and infrastructure gaps exist that affect the provision of healthcare. Attitudes towards survivors of sexual violence affect the quality of care that they receive and the risk of secondary victimisation, further perpetuating victims' vulnerability.

Clear guidelines exist on the comprehensive, quality care that survivors should receive, including quality healthcare. These guidelines have been presented in this review. The rapid assessment and gap analysis of facilities in City of Johannesburg Regions A, D, E and G that follows will compare resources and skills with internationally accepted guidelines and identify areas where improvements can be made in the short- and longer-term.





# CHAPTER 3: METHODOLOGY

The rapid assessment and gap analysis identified where post-violence care services are available in health facilities in CoJ Regions A, D, E and G. It also identified what is working or not working, identified available structures and assessed the services against a comprehensive package of post-violence care services. It was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two was field work and data collection, and phase three, reporting.

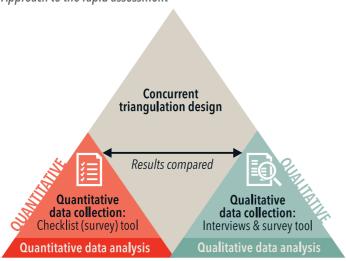
### Approach

The scope of this rapid assessment and gap analysis required the collection of quantitative and qualitative data. The data collection team took a pragmatic approach to the rapid assessment and gap analysis because evaluation, specifically the components related to the functioning of the health facilities, took precedence over the actual method of the evaluation (Creswell, 2009). According to Creswell (2009), problems that are addressed through health and social science research are complex, which makes quantitative or qualitative methods insufficient when used separately. Therefore, mixed methods containing both quantitative and qualitative elements were used (De Vos et al., 2005) and their overall strength can be greater than that of quantitative or qualitative research alone (Creswell and Plano Clark, 2007, as cited in Creswell, 2009).

It is important to note that data were not collected from survivors, victims or clients of the health facilities who used any of the post-violence care services. Data were collected on services provided at the facilities and from key informants.

The data collection team used a concurrent triangulation mixed methods design. Quantitative and qualitative data of equal weight were collected at the same time and integrated during the analysis and interpretation of the findings. The following figure was adapted from Creswell (2009:195) and represents the design of this mixed methods approach.

#### Approach to the rapid assessment



### 2. Sample

The data collection team was asked to collect data from all existing health facilities in the public sector in CoJ (Regions A, D, E and G), therefore sampling techniques were not used. A list of health facilities was constructed from information provided by Anova and Right to Care. This list was cross-referenced with databases available to FPD. A survey of the TCCs was underway under a separate study of TCCs nationally and these facilities was therefore not surveyed again as part of this rapid assessment. Relevant data were drawn from the TCC study.

There were two populations in this rapid assessment and gap analysis, the health facility staff and the NGO staff. The exact number of NGO staff across all facilities was unknown. However, all facilities had a facility manager overseeing the facility. These were the key health facility informants who had to be interviewed and were therefore selected using purposeful sampling. In Region A the team visited 14 facilities. In Region D, E and G 84 facilities were identified, but only 59 were visited for the following reasons:



The facility no longer exists



The data collector couldn't locate the facility



Access was denied due to concerns about approvals obtained from the District Health Committee.

Each facility manager was informed beforehand of the rapid assessment and gap analysis, what it entailed and who needed to be interviewed. The major challenge with scheduling the site visits with facilities was incorrect or invalid contact numbers for the facility. In these cases the data collector physically went to the facility to schedule the visit. There were also some challenges related to the interviews with facility managers, including having to reschedule visits multiple times, resistance to being interviewed and recorded and having to rush through interviews due to the very busy schedules of facility managers. They were also asked to inform their facility's NGO of the site visits so that an NGO representative would be available for the interviews (note: not all health facilities had an NGO assisting them). The NGO informants were conveniently sampled based on who was available at the time of data collection.

## 3 Situational analysis and desk review

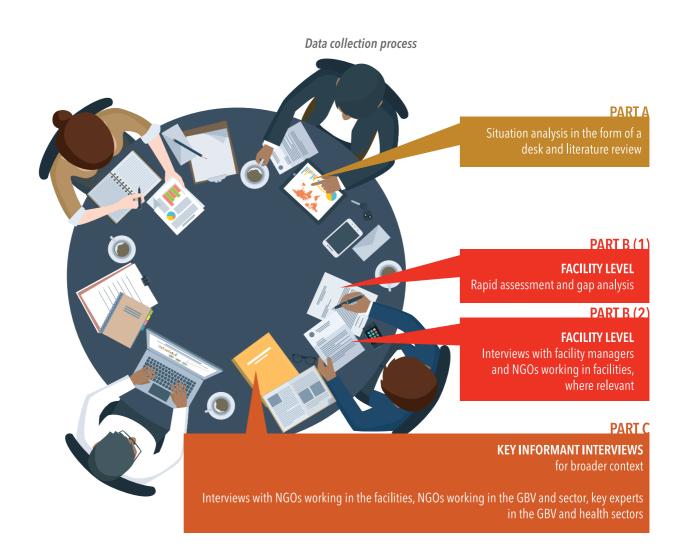
The team conducted a situational analysis using a desk review, using international and local reports, articles and standards. This also informed the data collection tools that was developed as well as the interview schedules, and considered the international standards for managing sexual assaults and highlighted the South African legislative and policy frameworks as well as policy guidelines, norms and standards. The functioning of PHCs, other responses and still existing gaps were discussed. The desk review and situational analysis provide a broad background on the current environment in South Africa in which the PHCs function, taking into account all reports, reviews and assessments done on TCCs, as well as other GBV-related services in South Africa. The team also consulted NGOs, administrative and government secondary data for this.

# Data collection methods, instruments and procedure

The team developed a database containing the information and contact details of all public health facilities in CoJ regions A, D, E and G based on information provided by Anova and Right to Care, as well as other databases available to FPD. This database, containing the contact information of the public health facilities, was used by the data collection team to contact each facility to schedule a site visit. Some of the facilities did not have landlines or the number available was incorrect, in these cases alternative methods of communication, such as email, were used. Following this, data collectors physically went to the facility to schedule the visit. The team first asked to conduct the site visit and for an interview with the facility manager. If he/she was not available the second-in-charge responded to the checklist and interview questions.

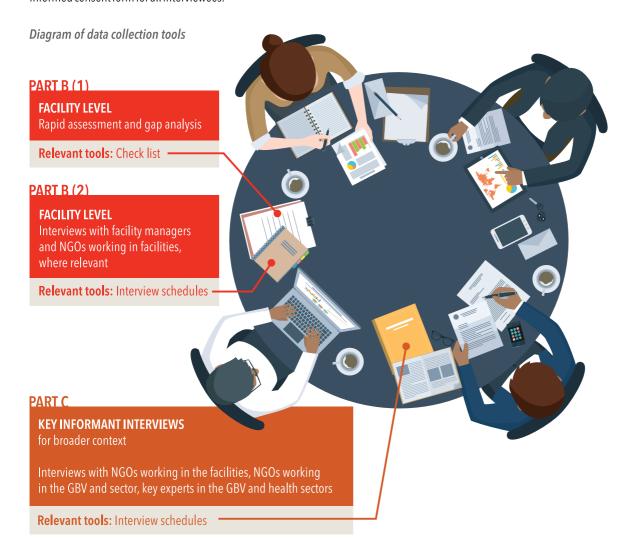
#### 4.1. Data Collection Methods

It is important to note that no data were collected from survivors, victims or clients of the health facilities.



#### 4.2. Data collection tools

The data collection tools for the rapid assessment and gap analysis included an electronic check list and interview schedules. This was supported by an informed consent form for all interviewees.



The checklist tool was developed into an Electronic Application (ODK App) by MPC consulting who use TRISCOMS cloud hosting technology. The ODK App allows users to customize survey tools based on the data that needs to be collected and automatically uploads the data onto a secure cloud-based database. Employees of the Programme Evaluation Unit who conducted the data collection were trained to use the Application on a Tablet. The checklist was completed by the data collector on a walk-through of the facility as well as asking the Facility Manager for the information required.

The checklist tool consisted of open- and closed-ended questions. These questions were grouped under different sections. One (or more) respondent(s) from each facility aided each data collector in the completion of the checklist. The data collectors were also required to use their own discretion and to validate the information given by the respondents.

#### 4.3. Qualitative data acquisition

Semi-structured interview schedules were developed after careful examination of the public health sector in South Africa and relevant literature. As previously mentioned under the sampling section, four groups of participants were interviewed and therefore four different interview schedules were developed for the facility managers, NGOs working within the facilities, key NGOs and GBV experts respectively.

The majority of the interviews were audio-recorded with permission from the participants. Field notes were made when participants consented to be interviewed but not to be audio-recorded. Each interview lasted approximately 10 to 60 minutes.

# 5. Data analysis procedure

#### 5.1. Quantitative data analysis

The quantitative data were exported from the cloud database into MS Excel™, where it was cleaned, coded and descriptively analysed. No inferential analyses were conducted.

#### 5.2. Qualitative data analysis

The audio recordings were transcribed verbatim and analysed through a combination of deductive and inductive thematic coding. Themes were drawn from the semi-structured interview schedules and added to the coding frame. The transcripts were initially read as a whole and notes were made at the end. Codes were developed and grouped as categories under each theme. Structural coding, as First Cycle coding method, was used for the initial analysis of the interview transcripts which resulted in 49 codes. This method was deemed appropriate since multiple participants were interviewed using a semi-structured data-gathering tool. Structural coding is content-specific and is applied to segments of text in order to categorise the data according to specific research questions (Saldaña, 2009). For example: the investigators wanted to find out how victim-friendly the facilities were; structural codes were then created based on this inquiry, which allowed the data analysts to gather indices on the sub-theme of victim-friendliness.

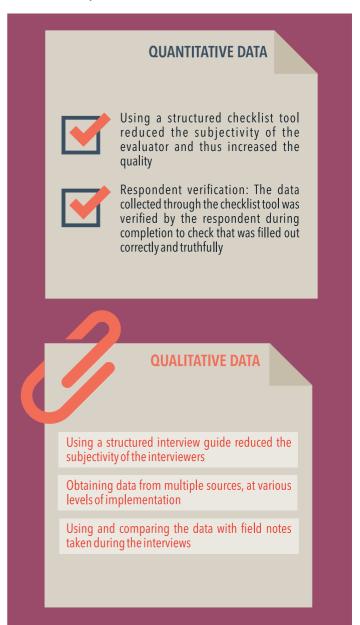
Pattern coding, as Second Cycle coding method, was then used to categorise similarly coded data (Saldaña, 2009). In the Pattern coding method, the First Cycle codes are assessed for commonalities. These commonalities consequently became the Pattern codes that assisted in the development of major themes. The data analysts proceeded with thematic analysis as the final method. Five major themes were developed.

The qualitative data were analysed in MS Word™. The comment function was used to assign codes to the selected text. A block of code was written in Visual Basic 6 which was run as a Macro. The Macro resulted in an output of the coded text and corresponding page numbers, its assigned codes, the category to which each code belonged, and the theme to which each category of codes belonged. This output assisted in the write-up of the findings.

The interviews stimulated discussions around two key terms, namely, *victim* and *survivor*. Since the victims and survivors of sexual assault were central to this evaluation, the five major themes were names 'From victim to survivor: Facility status'; 'From victim to survivor: Challenges'; 'From victim to survivor: Recommendations'; 'From victim to survivor: Role players and stakeholders'; and 'From victim to survivor: The need for intervention.' Each theme is discussed in the various sections in the report.

# **6.** Data verification and quality assurance

Data verification procedure



According to Shenton (2004), in order for the findings to be trustworthy, they have to be credible (internal validity), transferable (external validity/generalisability), dependable (reliability) and confirmable (objectivity). To ensure credibility, the data collection team adopted the correct operational procedures in the collection and analysis of the data. Moreover, the data collection team triangulated different data collection techniques and data sources, used iterative questioning during interviews, ensured that the data collection sessions only involved participants who volunteered to participate, and provided a comprehensive description of the health facilities.

For transferability, the data collection team provided the necessary information so that the findings of this evaluation can be applied to similar situations. This information consisted of a description of the health facilities context, a time period of data collection procedures, the number of data collection opportunities, the data collection methods used, the number of participants, and information about the contextual settings.

The data collection team reported the processes of this evaluation in detail so that future researchers can repeat the work. Specifically they provided a description of the evaluation design, how it was executed and how effective it was. This is reported in order to enhance the dependability of the evaluation.

Confirmability 'is the qualitative investigator's comparable concern to objectivity' Shenton (2004:72) and it is important that the findings accurately reflect the experiences and ideas of the participants and not the preferred recollections of the investigator. To improve the confirmability of the evaluation the data collection team used triangulation strategies to reduce the effect of investigator bias. An example of this strategy is the use of multiple data collectors in this evaluation. The investigators also made field notes with 'reflective commentary' (Shenton, 2004:72).

### 7. Ethics

FPD has an in-house Research Ethics Committee, registered with the National Research Ethics Council of South Africa, who reviewed the proposal and provided approval based on the risk, duration and budget of the rapid assessment and gap analysis. The rapid assessment team worked in close collaboration with the FPD Research Ethics Committee to ensure that all measures were taken to protect the rights of the respondents. The survey component did not require ethical clearance from the FPD Research Ethics committee. The ethics clearance was approved in mid-August 2016, and that allowed the team to apply for DoH District Ethics clearance from the Johannesburg Health District Research Committee. This approval was only granted at the end of November 2016.

The data collection team strictly adhered to the ethical guidelines set out in the Belmont Reports (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979), as well as in accordance with the principles outlined in the UN Evaluation Group (UNEG) 'Ethical Guidelines for Evaluation'.

#### 7.1. Respect for persons

According to the Belmont Report, respect for persons has at least two ethical stances. Firstly, participants should be given the opportunity to act autonomously and be capable of deliberation. Secondly, those who cannot

act autonomously, such as the mentally handicapped, should be protected (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979).

For this rapid assessment, no participants with diminished autonomy were included in the samples. Moreover, participation in interviews was completely voluntary and the opinions of the interviewees and respondents were valued and respected by the data collection team.

#### 7.2. Beneficence

Beneficence is seen as an obligation to the participants, specifically that no harm should be caused to them; that all benefits should be maximised and possible harms should be minimised (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979).

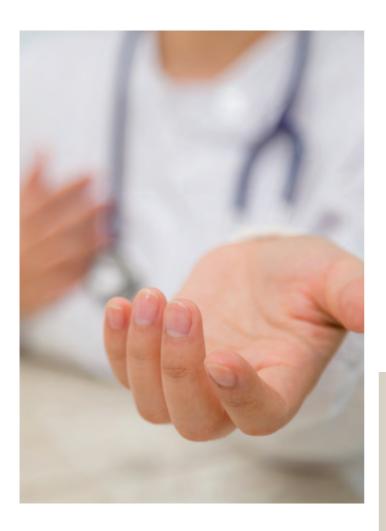
The intention of this rapid assessment and gap analysis was to provide all the stakeholders with information on possible gaps in service delivery and map services delivered. This information could be used in future to improve the quality of services at the facilities. The data collection team ensured that a comprehensive report was developed to achieve this goal.

The team applied protocols to ensure anonymity and confidentiality of key informants as far as possible. Furthermore, the identity of the participants was kept confidential and names were omitted so that the participants remain anonymous. It should, however, be recognised that certain key informants cannot remain anonymous (such as facility managers). Every possible step has been taken to ensure that there is no action against staff members after the interview and the publication of this report.

#### 7.3. Justice

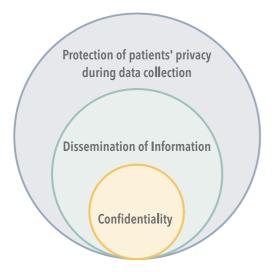
The Belmont Report describes the principle of justice as 'that equals ought to be treated equally' (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979:6). The data collection team made sure that all participants were thoroughly informed of the purpose of this evaluation. Additionally, informed consent was obtained from each participant. The data collectors explained the rapid assessment to all interviewees, as well as the meaning of informed consent and confidentiality. Each interviewee was provided with an informed consent form that explained the process of the interview and what the data will be used for, as well as their right to refuse to participate or withdraw at any time. They were also made aware that their refusal or withdrawal will not have any negative impact on them or their employment.

The data collection team also made sure that the participants were selected fairly without any form of coercion and that the samples were representative of all the facilities where data were collected. This report is intended to aid in the equal distribution of the benefits of this rapid assessment and gap analysis.



#### 7.4. Other aspects

The team was responsible for ensuring the accuracy of the information collected while preparing the reports and will be ultimately responsible for the information presented in the gap analysis. It is however possible that key informants and facility representatives could provide inaccurate data.



#### Confidentiality

Data collected during the interview phases, such as the audio files, transcripts and field notes was kept on a confidential location on FPD's private server, which only the researchers can access. USAID will not have access to any information that the researchers deem confidential. Any paper-based information was kept in a locked filing cabinet on FPD premises that only the lead researcher can access.

#### Dissemination of Information

The data from this rapid assessment and gap analysis is used to compile a National and Facility-Specific Report. USAID may use the information from the report in various ways such as decision making. However, they will not have access to any information that the researchers have declared as confidential. The Report will not contain the names of the respondents, unless they have consented to having their name published.

#### Protection of patients' privacy during data collection

To ensure the privacy of the clients during the data collection, the following measures was put in place:



Visits to the facilities took place on a day that had been agreed to by the Facility Manager. They were responsible for notifying the staff in the facility/department that the rapid assessment would be taking place on that day.



The clients who present at the facility on that day were notified that a Rapid Assessment was taking place and that a researcher would be there, but that they were not there to talk or interact with them.



The researchers had a name badge identifying themselves as a researcher from FPD.



The researchers were sensitised to the environment of the post-violence care services at the facility and ensured that their presence did not infringe on the patients' care or privacy.



The researchers were accompanied by the Facility Manager during the Rapid Assessment and only entered rooms that were not being used by clients at the time. Areas such as the waiting room and reception were avoided as much as possible.



The interviews took place in a room that was not needed by the facility at the time, where privacy could be maintained.

## 8. Limitations

Every possible effort was made to conduct the rapid assessment and gap analysis with all public health care facilities in CoJ Regions A, D, E and G, and to interview all the facility managers, NGOs working within and with the facilities, and CoJ District HAST managers. The following constraints were experienced in the data collection phase:



The findings are based on self-reporting by the facility personnel and NGOs. The findings were not triangulated with client files or interviews with clients.



A number of local government and provincial facilities refused the team access to the facilities based on concerns regarding the research approval obtained from the Johannesburg Health District Research Committee.



The key informants were representative of the 69 health care facilities on CoJ Regions A, D, E and G and three NGOs working within the facilities. The sample was also determined by the availability of personnel on the day of the scheduled interview. The external NGOs and experts in the field of GBV and health sectors interviewed were selected using convenience sampling. FPD identified the most appropriate key informants, and they were selected for interviews.



Despite approaching key government officials for interviews, these never took place. Some officials were unresponsive, others had reservations about whether the ethical clearance obtained was sufficient for them to be interviewed (see point above) despite official DoH ethical processes having been followed. Where individuals had expressed willingness they were only available for interviews outside the timeframe of the study, or interviews were repeatedly postponed. The timing of fieldwork for this study unintentionally coincided with key developments in the tragic case of mentally ill patients who lost their lives following transfer from Life Esidimini hospital. It is possible that this high profile case could have influenced the willingness of officials to be interviewed.

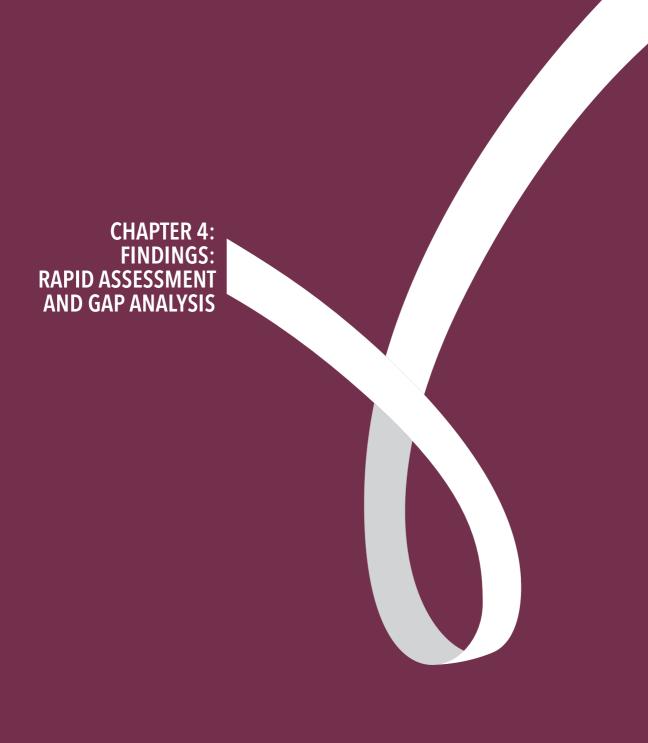


No clients at facilities or victims of GBV were interviewed. This is a limitation with regards to the perceptions of the clients on how victim-friendly and appropriate the services of the facilities are.



The focus of the rapid assessment and gap analysis was on compliance with the TCC Blueprint as well as the NACOSA 2015 guidelines on the functioning of the facilities. It did not assess the compliance of facilities with other national policies, procedures and guidelines.





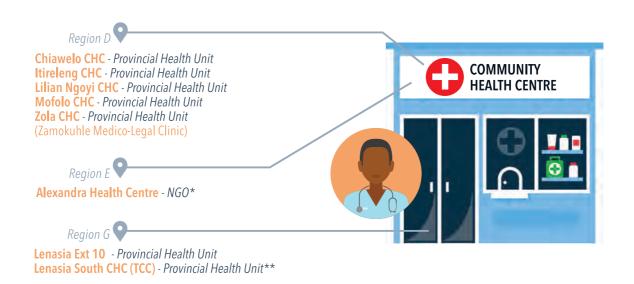
# CHAPTER 4: FINDINGS: RAPID ASSESSMENT AND GAP ANALYSIS

The CoJ Region D, E and G rapid assessment and gap analysis findings are divided into four sections. Section 1 is a summary of the general findings of all facilities in CoJ Regions A, D, E and G. This is based on the key informant interviews as well as the survey of 73 facilities. Data were collected from 73 facilities across Region A (14 facilities), D (26 facilities), E (10 facilities) and G (23 facilities) of Johannesburg. Overall, there were 64 primary health clinics (PHCs), eight community health clinics (CHCs) and one hospital. Section 2-4 is specific to the findings of Regions D, E and G and is region specific and provides a general overview of the three regions.

# City of Johannesburg general findings

Facilities included in data collection





Region A

Bophelong (Region A) Clinic - Local Authority **Ebony Park/ Kaalfontein Clinic** - Local Authority Halfway Clinic - Local Authority Hikhensile Clinic - Local Authority Mayibuye Clinic - Local Authority Midrand West Clinic - Local Authority Mpumelelo Clinic - Local Authority **OR Tambo Clinic** - Local Authority Rabie Ridge Clinic - Local Authority Thuthukani Clinic - Local Authority Witkoppen Clinic - NGO\* Diepsloot Clinic - Provincial Health Unit Evethu Clinic - Provincial Health Unit Nizamiye Clinic - Provincial Health Unit



Region G

Region E

**Bophelong Clinic** - Local Authority **Green Village Clinic** - Local Authority Naledi Clinic - Local Authority Protea Glen Clinic - Local Authority Senaone Clinic - Local Authority Simphumile Clinic - Local Authority Sinethemba Clinic - Local Authority Singobile Clinic - Local Authority Slovoville Clinic - Local Authority Tshepisong Clinic - Local Authority **Zola Gateway Clinic** - Local Authority Diepkloof Provincial Clinic - Provincial Health Unit Mandela Sisulu Clinic - Provincial Health Unit Meadowlands Clinic - Provincial Health Unit Michael Maponya Clinic - Provincial Health Unit Moroka Clinic - Provincial Health Unit Noordgesig Clinic - Provincial Health Unit Orlando Provincial Clinic - Provincial Health Unit Tladi LA Clinic - Provincial Health Unit **Zondi Clinic** - Provincial Health Unit

Region D

Eldorado Park Ext 9 - Local Authority **Ennerdale Ext 8 Clinic** - Local Authority Freedom Park Clinic - Local Authority Lawly 1 Clinic - Local Authority Lawly 2 Clinic - Local Authority Lenasia South Civic Clinic - Local Authority Mid Ennerdale Clinic - Local Authority **Mountainview Clinic** - Local Authority **Protea South Clinic** - Local Authority Thulamtwana Clinic - Local Authority Weilers Farm Clinic - Local Authority Lenasia Health Centre - NGO\* Barney Molokoane Clinic - Provincial Health Unit Eikenhof Clinic - Provincial Health Unit **Ennerdale Ext 9 Clinic** - Provincial Health Unit Kliptown Clinic - Provincial Health Unit Lenasia Clinic - Provincial Health Unit Orange Farm Ext 7 Clinic - Provincial Health Unit Thembelihle Clinic - Provincial Health Unit Vlakfontein Clinic - Provincial Health Unit Wildebeesfontein Clinic - Provincial Health Unit

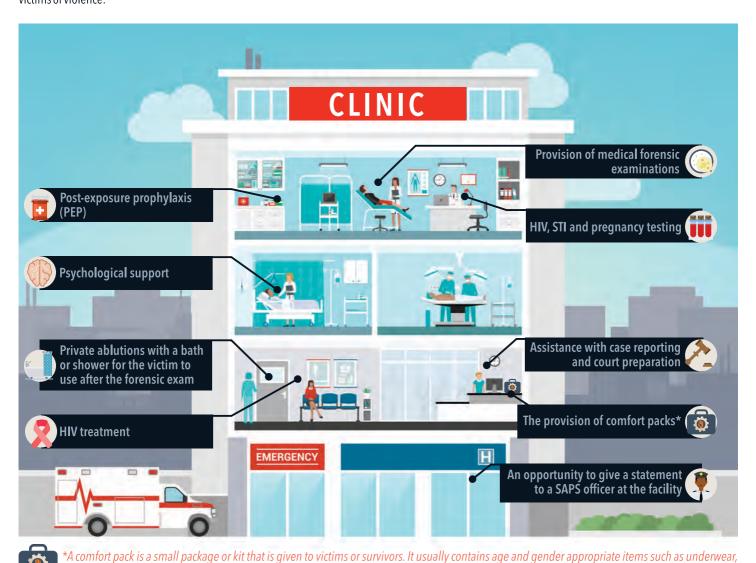
 $\star$ These facilities are classified as NGOs, however they were included in the samples provided by the Department of Health and implementing partners \*\*Lenasia South TCC was the only Thuthuzela Care Centre included in the sample



There are a number of unique findings and challenges in the functioning of the facilities across CoJ Regions A, D, E and G, which can be summarised across a number of themes. These include findings on post-violence care services, health facilities, victim friendliness, service delivery, factors that influence service delivery and services delivered by NGOs.

#### 1.1. Findings on post-violence care services

For the purposes of this rapid assessment and gap analysis the team are defining post violence care as the following 'package of services' provided to victims of violence:



If a facility provides all of the above services to victims of violence they are said to provide post violence care.

The research team attempted to find out what the perceived need for postviolence care services for victims of sexual assault is. With the exception of a few participants, the participants were not aware of an increase in cases of sexual assault. One possible reason for this is that victims are referred elsewhere because the facilities do not provide post-violence services. Another reason could be that no record is kept of the number of reported cases. One participant mentioned that she experienced an increase in sexual violence cases at their facility and they are referring more clients than in the past.

sanitary pads for women and girls, toothbrush and toothpaste, soap, a facecloth and possibly a non-perishable snack.

66

"...I don't think that there's been an increase as such..."

– Key informant - facilities

"...we don't have a high rate of sexual assault."

– Key informant - facilities

"Because we don't report. We don't have statistics."

– Key informant - facilities

One participant provided an interesting comment that cases of sexual assault often remained hidden and that was why they could not say if there was an increase in cases of sexual assault.



"I feel that maybe there is more hidden cases..."

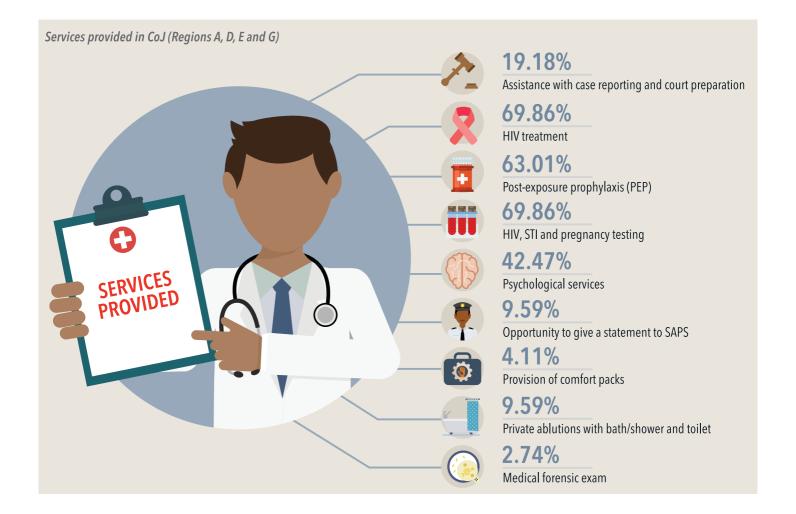
- Key informant - facilities

The research team noticed that facilities had different opinions on what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations. The majority of the facilities in our sample are able to provide some services, such as HIV testing and provision of PEP to all patients in general, but don't provide this service to victims of sexual violence because they have been instructed to only refer them to other facilities.

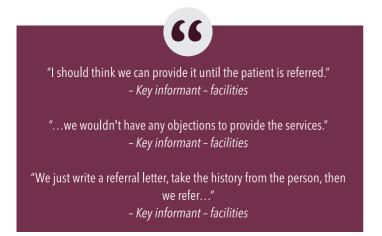
Only two of the facilities visited in the four regions of CoJ where the study took place provide medical forensic examinations, Zola CHC (Zamokuhle Medico-Legal Clinic, Region D) and Lenasia South CHC (Lenasia South TCC, Region G). Only Lenasia South TCC provides the full package of post-violence care services. A compliance audit and gap analysis on the TCCs (FPD, 2016) found that Nthabiseng TCC at the Chris Hani Baragwanath hospital (Region D) also provided these services, but the team were refused access to the hospital.

The majority of facilities provide HIV, STI and pregnancy testing (69.86%), PEP(63.01%) and HIV treatment (69.86%) to all patients in general.





From the interviews the research team found that facilities provide the above services to clients in general, but mostly refer victims of sexual violence to other facilities. A total of 97% of surveyed facilities indicated that they refer victims of sexual assault to other facilities. The main reasons why the attending staff were referring the clients elsewhere were a lack staff trained in conducting a forensic investigation and a lack of equipment and supplies. Some participants thought that their facilities should provide the full range of care available at their facilities to victims of sexual assault.





"...we need people who are trained for that."

– Key informant – facilities

Related to this, is the ability of facilities to provide the required services and assist victims of sexual assault. Individual facilities mentioned that priority was given to victims of sexual assault so that they would be assisted first, and that they can provide basic medical services and treat wounds.



"If a patient comes in they are given priority because we normally know that she [sic] has been assaulted..."

- Key informant - facilities

Some of the facilities provided HIV counselling and testing, pregnancy testing and emergency contraceptives, and even organised transport for the client to the referred facility. However, there were facilities that would not provide medical services to the client in fear of contaminating forensic evidence. For example, one participant in particular mentioned that their facility provided HIV, STI and pregnancy testing, but not to post-violence care victims since they needed to be examined first.



"...with sexual violence we don't actually treat them we just refer them to hospital..."

- Key informant - facilities

"No, because they need to be examined first."

- Key informant - facilities

"Remember, as far as I know we shouldn't even tamper with that patients, with the evidence. So we wouldn't even start saying let's examine you then we can refer you. The minute the patient says then you refer so that you don't tamper with the evidence."

- Key informant - facilities

#### Number of sexual assault cases per week

The majority of facilities (68.49%) reported that they don't see any cases of sexual assault reporting to their facility, or they don't know the number because it isn't recorded. Only two facilities reported seeing an average of 15 cases per week, Zola CHC (Zamokuhle Medico-Legal Clinic) in Region D and Lenasia South CHC (TCC) in Region G. The average across facilities was 0.88 cases per week. These are the only two facilities who were part of the sample that can conduct the required forensic investigation.

It is important to note that facilities highlighted that this is an average number, as the number of cases differ from week to week. Facilities who don't provide forensic investigation services are not required to record the cases that present at the facilities, and this can also influence the findings.



#### AVERAGE NUMBER OF SEXUAL ASSAULT CASES PER WEEK IN CoJ (Regions A, D, E and G)

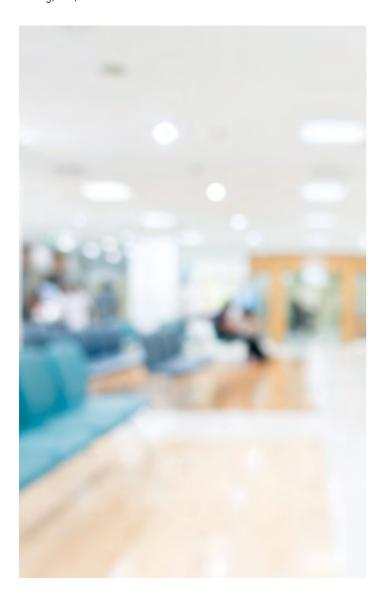


#### 1.2. Findings on referral pathways

As most facilities reported that they refer victims of sexual violence to other facilities for the forensic investigation as well as other post-violence care services, it is important to understand where they refer victims.

Chris Hani Baragwanath Hospital (Nthabiseng TCC), Lenasia South CHC (Lenasia TCC), Tembisa Hospital (Masakhane TCC) and Zola CHC (Zamokuhle Medico-Legal Clinic) were most often reported as the facilities where victims are referred for post-violence care. It is important to note that Tembisa Hospital (Masakhane TCC) is not in City of Johannesburg, but falls under Ekurhuleni district.

The three TCCs provide the full package of post violence care services (FPD, 2016). Zamokuhle Medico-Legal Clinic provides medical forensic examinations; comfort packs and clean clothes; the opportunity to give a statement to a SAPS officer; psychological support; HIV, STI and pregnancy testing; PEP; and HIV treatment.



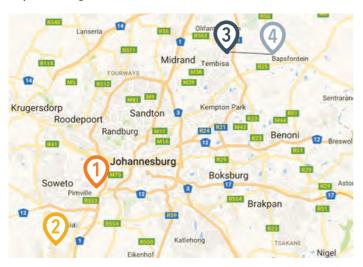
Facilities that receive referrals for post violence care

racinities that receive referrals for post violence care			
+	REFERRAL FACILITY # fa	cilities that refer	
	Chris Hani Baragwanath Hospital (Nthabiseng TCC)*	1 19	
iii	Lenasia South CHC (Lenasia TCC)	2 6	
	Tembisa Hospital (Masakhane TCC)*	3 10	
Ť.	Zola CHC (Zamokuhle Medico-Legal Clinic)	4 0	
	Bheki Mlangeni Hospital	7	
曲	Alexandra Health Centre	5	
m	Chiawelo CHC	5	
THE REPORT OF THE PROPERTY OF	Lillian Ngoyi CHC	4	
	Rahima Moosa Hospital (children)*	3	
	Helen Joseph Hospital (adults)*	3	
	Leratong Hospital*	3	
THE REPORT OF THE PROPERTY OF	Hillbrow CHC*	2	
THE REPORT OF THE PROPERTY OF	Stretford CHC *	2	
m	Dobsonville CHC*	0	
Ť.	Orlando Clinic*	1	
THE STATE OF THE S	Thembelihle Clinic	1	
	Charlotte Maxeke Hospital*	2	
	Edenvale Hospital*	1	
	Dr Yusuf Dadoo Hospital*	1	
THE STATE OF THE S	Discoverers CHC *	1	

<sup>\*</sup> These facilities were not included in the data collection. They were only reported as facilities where victims are referred for post-violence care.

This study found that four of the facilities within Region D and E, self-reported that the facilities do not provide post-violence services, but 21 facilities still refer to Bheki Mlangeni Hospital, Chiawelo CHC, Alexandra Health Centre in region D, and to Lillian Ngoyi CHC in region E. The other 12 referral facilities referred were not part of the study.

#### Map of CoJ Region A, D, E and G referrals



A number of participants mentioned that they did not know whether a client who was referred received the help they needed. It does not seem as though the facilities communicate with each other regarding the outcome of a referral.



A key informant from Region G highlighted that the SAPS also assist with referrals. Importantly there are existing referral pathways among the NGOs as well. One key informant highlighted that their organisation refer clients to other NGOs for psychosocial support services, and another refer clients to the TCCs

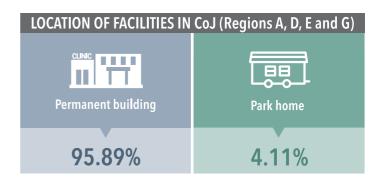


#### 1.3. Facilities and sites

In order to have a better grasp of the facilities' ability to deliver post-violence care services, the research team also investigated the types of buildings, facilities available, space, equipment and supplies, days and hours of services, waiting times, accessibility and psychosocial support.

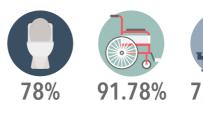
#### Type of buildings

The large majority of facilities in CoJ (Regions, A, D, E and G) are located in permanent buildings (95.89%), only three are located in a park home.



#### Facilities available

The majority of facilities in CoJ (Regions, A, D, E and G) had disabled-friendly ablutions (78%) and wheelchair ramps (91.78%), waiting rooms with seating (73.97%) and examination rooms (100%).





FACILITIES AVAILABLE IN CoJ (Regions A, D, E and G)

	1
Wheelchair ramp	91.78%
NGO room	13.70%
Examination room	100%
SAPS office	4.11%
Counselling room	28.77%
Waiting room with seating	73.97%
Private room for client to rest in	24.66%
Disabled friendly ablutions	78.08%
Private bath/shower facility	9.59%

68

#### **Equipment and supplies**

The majority of facilities in CoJ (Regions, A, D, E and G) have computers (100%), telephones (90.41%), fax machines (52%), photocopiers (91.78%) printer(s) (94.52%), access to the internet (75.34%), IEC materials (76.71%), air conditioners (86.30%) and fire extinguishers (100%).



All of the facilities in CoJ (Regions, A, D, E and G) have syringes, needles, sterile swabs; blood collection tubes, and sharps containers. The majority have scales for adults (95.89%), BP monitors (97.26%), speculums (96.63%), clean linen (89.04%) and hand washing facilities in the exam rooms (93.15%). Only nine (12.33%) have a colposcope, twenty (27.40%) have a gyneacological couch and 45 have lighting for forensic exams (61.64%). A key informant highlighted that there is an uneven distribution of resources across the district.

# 66

"...it is a very patchy system, there're some facilities that's underresourced, and the staff is not sufficiently trained"..."and then there's well-resourced facilities."

– Key informant GBV expert

### MEDICAL EQUIPMENT AVAILABLE ACROSS FACILITIES IN CoJ (Regions A, D, E and G)





It is important to note that some facilities, in addition to Lenasia South CHC (Lenasia TCC), have some of the general and medical equipment available as prescribed by the TCC Blueprint. This includes anatomically correct dolls (5.48%), toys for children (13.07%), comfort packs (5.48%), clean clothing (10.96%), refreshments for clients (5.48%), gyneacological couches (27.4%) and colposcopes (12.33%).

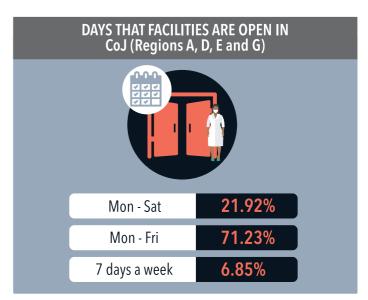
#### Space

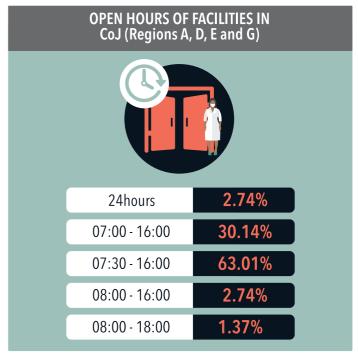
Many facilities mentioned that they need additional space to conduct their work properly. This includes additional counselling rooms, and an area to conduct forensic examination as well as storage space. Victims of sexual assault are usually managed in normal examination rooms, which lack privacy as other patients were sometimes tended to in the same room. A key informant highlighted the need for space that is dedicated to sexual assault victims.



#### Days and hours of service

The majority of facilities in CoJ (Regions, A, D, E and G) are open from Monday to Friday (71.23%), from 7:30 to 16:00 (63.01%). A total of 6.85% are open 7 days a week, and 21.9% are open Monday to Saturday.





Two facilities (2.74%) self-reported that they are open 24 hours of the day. A key informant highlighted that most sexual violence cases are reported at night and during holiday periods.



A major concern is that not all services are delivered every day of the week. A key informant from an NGO highlighted that certain services, such as 'Sexual and reproductive health services' are only available on certain days of the week. This has an impact on the implementations of the DREAMS objectives.



"...there's a specific nurse, at a certain time, in the afternoon mainly, who provide family planning on a specific day, so it is not every day."

– Key informant – NGOs

### Waiting time

The majority of facilities self-reported that patients are attended to within 45 minutes or less. Those facilities that reported longer waiting times, reported waiting times of 2 to 3 hours. Some facilities indicated that they give preference to clients who need post-violence services, but this is rare. A lot of patients arriving at the same time was also reported to be a challenge at the facilities as this, combined with a lack of staff, increased the patient waiting time.

Patients don't wait longer than

45

45

Control of the control of



"...we are still experiencing [sic] high influx of clients."

- Key informant - facilities

"...according to the head count that we see on the monthly basis we supposed to have at least minimum eight professional nurses but then I have five now..."

- Key informant - facilities

### Accessibility

The accessibility of facilities that provide post-violence care services is an important factor in ensuring that the services are used by victims. Across and within regions, there are great variations in opening times, accessibility and awareness of these specific facilities. There are victims who arrive at facilities not knowing that the facility in question does not offer forensic examination services; or, there are victims who report to police stations and are consequently referred to the nearest hospital or TCC. Victims who are not tended to immediately have to wait with other outpatients only to be referred again to another facility. Not all victims have access to transport to attend the facilities they are referred to. Ambulances are often reserved only for those with medical emergencies.



"They don't qualify for the ambulance." - Key informant - facilities

"...somebody can say to you I don't have money for transport..."

– Key informant – facilities

"...there's no transport..." - Key informant - facilities

### Psychosocial support

Many facilities mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support. A total of 42.47% facilities indicated that they can provide psychological services within the facility, but only 13 of the facilities have a psychologist available and only one has a trauma counsellor available. Almost all (71 of the 73 facilities in the sample) had an HCT counsellor available.



Long-term psychosocial support is a big concern. One key informant reported that there are not enough social workers available to assist with counselling. These services, as well as psychologists, are not available over weekends. There are instances where the NGOs linked to the facility, as well as DSD social workers and psychologists can assist with follow-up care. In these cases, there are often other problems, for example the NGOs may not have access to the contact details and address of victims.

NGOs also reported that they do not have transport for follow-up visits to the victim's homes, again compromising long-term psychosocial support. Victims are often not able to afford transport back to facilities for follow-up care.

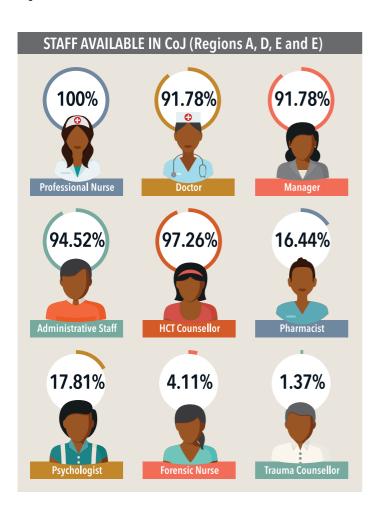
### 1.4. Factors influencing quality of services delivered

As per the discussion in Section 1.1, most facilities provide most of the services expected from a public health facility, and some have the ability to provide some post-violence care services. However, although the services are available, it is the quality of those services that is the challenge. The team found variations in the staff available at different facilities staff, victimfriendliness, and secondary victimisation and scope of responsibilities. There were also problems with delays in service delivery, and problems with follow-up. These factors and challenges are discussed as follows:

### **Human resources**

### Staff available

All of the facilities in CoJ (Regions, A, D, E and G) have at least one professional nurse. The majority have a facility or department manager (91.78%), administrative staff (94.52%), HCT counsellors (97.26%) and doctors (91.78%). Only three facilities (4.11%) have a forensic nurse, one (1.37%) has a trauma counsellor, 13 (17.81%) have a psychologist and 12 (16.44%) have a pharmacist or pharmacy assistant. The three facilities with a forensic nurse are Bheki Mlangeni Hospital, Zola CHC (Zamokuhle Medico-Legal Clinic) and Lenasia South CHC (Lenasia TCC).



Personnel at the facilities highlighted that they cannot provide post-violence care services, as they feel that they need specialised personnel, and preferably doctors, to assist with this.

"...we also need a doctor, a sister and a doctor to do that service."

- Key informant – facilities



Key informant - facilities
 A key informant mentioned that there are enough staff at facilities, but that

find most of the time there's no doctor within the clinic..."

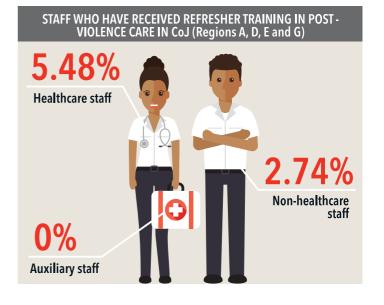
they are not ready to deal with post-violence care.

"We need people, not just warm bodies"..."they must be properly trained on post-violence care"

- Key informant - NGO

### Training of staff

Only four facilities (5.48%) reported that their healthcare staff have received refresher training in post-violence care. These are Bheki Mlangeni, Lillian Ngoyi CHC, Zola CHC (Zamokuhle Medico-Legal clinic) and Lenasia South CHC (Lenasia TCC). Only two (2.74%) facilities reported that their non-healthcare staff had received refresher training in post-violence care. These are Bheki Mlangeni Hospital and Lenasia South CHC (Lenasia TCC). Those who did report receiving training, said it was either provided by Nthabiseng TCC, Hillbrow Clinic or the Eldorado Park Women's Forum. None of the facilities reported that their auxiliary staff had received refresher training. It is important to note that this is self-reported, as FPD has been involved with training in Region A. It is also interesting to note that the facilities mention other facilities as training providers.



The participants were asked to expand on the training needs, specifically with regards to post-violence care. It was clear that additional training is required despite any previous training that the staff may have received on GBV and management of victims of sexual assault.

- "...but in terms of training all the staff I think that's something that need to be done..."
  - Key informant facilities
  - "...we need maybe to be trained..." Key informant facilities

"At least if we have the basic knowledge of what is expected of us and how can we help those clients as they come."

- Key informant - facilities

Some of the participants thought that a lack of training on sexual assault was the reason for the lack of sensitisation observed at the facilities. One participant specifically mentioned that lack of training meant that staff did not know how to correctly deal with a case of sexual assault. Others thought that police officers do not always know the protocols for dealing with people who report as victims of sexual assault. There is a clear need for auxiliary staff training, specifically administration staff and security guards.

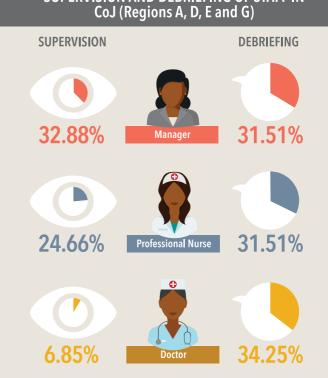


- "Because there was no proper training, nobody is really sensitised about dealing with it..."
  - Key informant facilities
- "...there were people who work at SAPS and I think these people are not sensitised..."
  - Key informant facilities

### Staff supervision and debriefing

Only 33% of managers, 25% of nurses and 7% of doctors received supervision, while 32% of managers and nurses, and 34% of doctors received debriefing.

### SUPERVISION AND DEBRIEFING OF STAFF IN CoJ (Regions A, D, E and G)



A key informant highlighted that staff in public health facilities are not getting adequate emotional support.

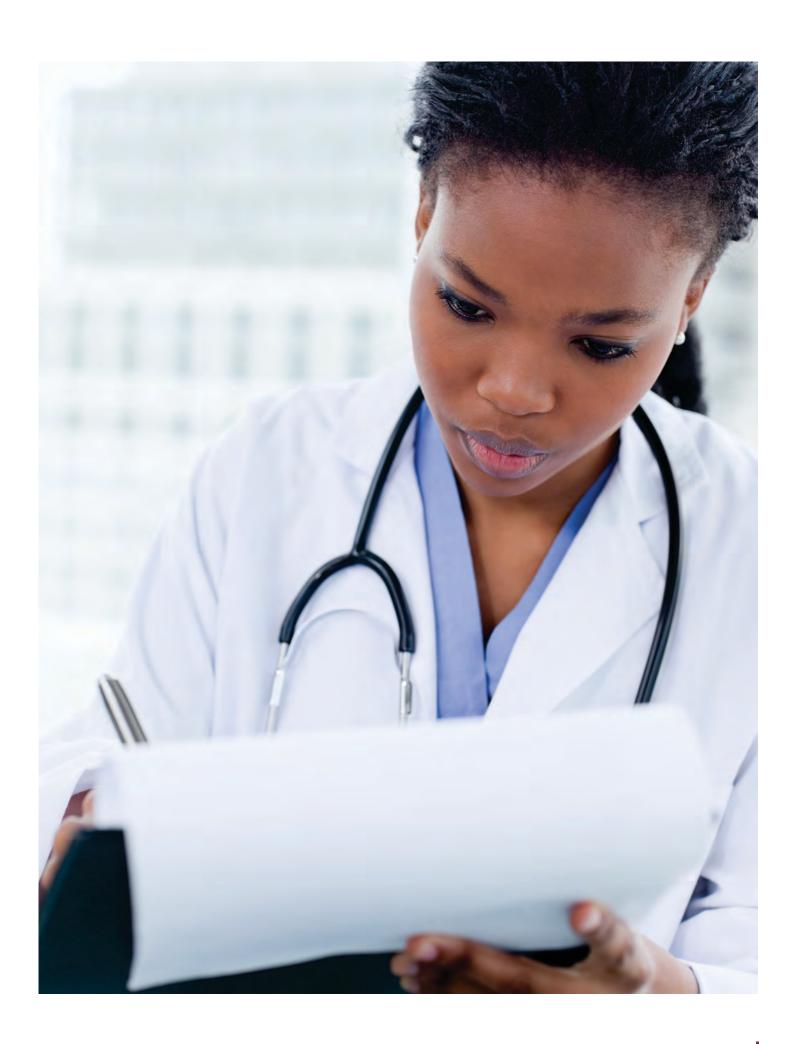




"We're not caring for our doctors and our nurses enough"..."We're only now engaging with what's happening to professionals who listens to horror all day, and we're not addressing it ..." - Key informant - GBV Expert

"If we look at what's happening in our facilities, and we have nurses who don't seem to care, it is symptomatic of a system in major crisis" - Key informant - GBV expert

"Caregivers need care" - Key informant - GBV expert



### 1.5. Victim friendliness and secondary victimisation

Victim friendliness is a major challenge for facilities. Most mentioned that victims may experience secondary victimisation as a result of the lack of victim friendliness of the environment. Auxiliary staff lack sensitivity when treating and receiving clients. Other reported factors that may influence victim friendliness include patient waiting time, the quality of the infrastructure, and issues of privacy and stigma. Victims of sexual violence often have to wait in the same queue as other clients who present at facilities.



"...due to the fact that we don't have resources and train [sic] people in the facility – so I won't say it's friendly..."

- Key informant – facilities

"We don't have the privacy, because everything is done in one place..."

- Key informant - facilities

"...you know at the clinics, people wait quite long as well..."

– Key informant – facilities

"I don't think it will be fair enough for a patient to go, you know, to be transported by public transport when she's been sexually assaulted."

- Key informant - facilities

"...we are unable [sic] even pick out the patient with the sexually violated [sic] because it's hard for them to explain situations in front of everybody..."

- Key informant - facilities

Some of the facilities mentioned that victims are at a risk of experiencing secondary victimisation as a result of being referred to other facilities. This result in victims reporting to the police station, presenting at a facility and then being referred to a centre where post-violence care can be provided. The lack of privacy when assisting victims may also be another factor in secondary victimisation.

A key informant highlighted that there are still cases of young girls who are judged after being a victim of sexual violence. The key informant also highlighted the special needs of child victims, as well as special needs of disabled victims.



"There should be no judgments. I've heard about children who've been laughed at and treated in ways that is not ideal. It's not a professional person's place to judge . . ." - Key informant - GBV Expert

A key informant mentioned that at some facilities the nurses are not properly trained on the provision of PEP and other post-violence care services, and mentioned that there's cases where victims were asked to provide a police case number before they could access post-violence care services.

### 1.6. NGOs as service providers

There are two NGOs within CoJ (Regions A, D, E and G) that provide PHC services.

NGOs providing PHC services



Witkoppen Health and
Welfare Centre is a
comprehensive primary
healthcare centre with
social services in
Fourways, Johannesburg.
They are a private Non
Profit Company (NPC),
NGO and registered NPO
with Section 18A tax
exemption and an ESD
compliant BEE
procurement recognition
level certificate.



Alexandra Health Centre is a non-governmental organisation funded by the provincial government, donors and charitable organisations. The services they provide include treating acute ailments, antenatal delivery and post-natal care, growth monitoring and immunisation, family planning, and outreach services.



It is important to understand the contribution of NGOs to the functioning of public healthcare facilities in CoJ (Regions A, D, E and G). We found that the NGOs offered a variety of services that helped the smooth functioning of the facilities, and provided additional post-violence care services that cannot be provided by the facilities themselves. Just under half (46.58%) of the facilities in CoJ (Regions, A, D, E and G) have an NGO working with them. Below lists the NGOs providing services in CoJ facilities and the services they provide.

NGOs providing services in facilities in CoJ (Regions A, D, E and G)

### AIDS Healthcare Foundation



HIV Programme support HIV/AIDS advocacy

### ANOVA



HIV Programme support CCMDT Training

### **CaSIPO** (Care and Support to Improve Patient Outcomes)



HIV Programme support Strengthening referral systems

### COPESSA (Community-based Prevention and Empowerment Strategies in SA)



Counselling
Social Work

### Eldorado Park Women's Forum



Psychosocial supportAwareness in the community

### Hands of Compassion



 Hands of Compassion Clinic: PHC services, HIV/ AIDS services, family planning services
 Child and Youth Centre: Place of safety

### Ikhaya Lothando Community Centre



Support pregnant HIV+ women Drop off shelter for orphans Counselling

### Ikusasa Lethu Youth Project



| HCT Counsellors | OVC drop in centre | Home-based care

### JISS (Johannesburg Institute of Social Services)



Gender-based violence
Child and Family Care Units
OVC support

### Jozi Ihlomile



Awareness campaigns about HIV/AIDS
Support HIV and TB programmes

### Khomanani Campaign



| Distribution of HIV, TB and STI materials | Distribution of condoms | Compared to ##

Support staff

### Ladies of Hope



Home-based care
Counselling
Feeding scheme

### LifeLine



Counselling

### **Midrand Association for Home Based Care**



Home-based care
HCT ■ HIV support group

TB treatment services

OVC support

Support for survivors of abuse and rape

### **New Start**



HCT

Medical male circumcision
Parenting support

### Nisaa Institute for Women's Development



Raising public awareness about GBV Staff training Counselling

### **Nompilo Home Based Care**



Social services Counselling Staff training HIV/AIDS support

### Philani Maternal, Child Health and Nutrition Project



Support pregnant mothers
OVC support

### **PUSH** (Persevere Until Something Happens)



Support HIV+ children and OVCs Psycho-social services

### Right to care



HCT services
Support staff (data capturers) ■ Training staff

Support HIV/AIDS programmes

Family planning services

Medical Male Circumcision

SANCA (South African National Council on Alcoholism and Drug Dependence): Nishtara Alcohol and Drug Centre

Alcohol and drug abuse or dependence

### Thibologa Sign Language Institution



Sign language training Interpretation service Training deaf people in computer literacy Advocating for the deaf community

### Ububele



Early childhood development programmesProvide training in early childhood developmentPsychosocial support

### Usizo Thuso Community Centre



Support HIV+ children and OVCs
Psycho-social services

### Witkoppen Health and Welfare Centre



**PHC** services

NGOs assist with providing additional services that facilities cannot provide. There were many reported benefits to having an NGO associated with facilities, including providing continuous support to clients, rallying communities for campaigning activities, training, counselling and psychosocial support.

The participants were asked if any NGOs were providing post-violence services at the facilities. According to the participants, the NGOs that are linked to facilities do not provide forensic post-violence services, but they do provide other services such as HIV counselling and testing, training, campaigning and psycho-social support. The general opinion was that the NGOs are providing a valuable service when linked to a facility.



"...deal with the emotional well-being and the psychological well-being of the person..."

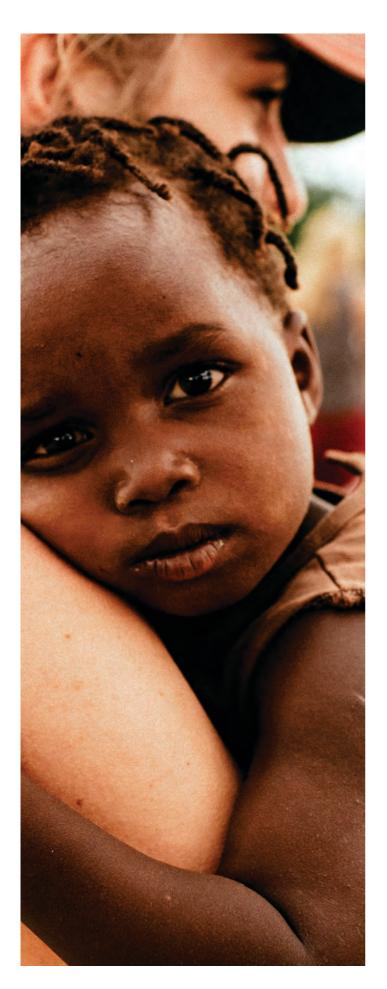
- Key informant - facilities

"They do give support." – Key informant – facilities

"...usually they come in and help us with the clubs that we are organising at the moment."

- Key informant - facilities

"They give us a bit of training." - Key informant - facilities





"It's so much. The NGO [sic] gives total care to our clients..."

- Key informant - facilities

"...they identify something and they feel that there is a need to refer that patient then [sic] they come and communicate to you..."

- Key informant - facilities

"They've actually helped us to cut the waiting time for patients."

- Key informant - facilities

In general, the relationships between the facilities and the NGOs are good, but participants highlighted the value of good communication strategies between the NGOs and the facilities. There were facilities that had challenging experiences with stakeholders such as the NGOs. For example, the NGOs would be responsible for placing staff at the facilities. The permanent staff would have to train these people, only to have them leave the facility after 2 years. The process of training is then repeated with the next placement.



"...the next challenge is NGOs – they bring their people in and train people... Because they are contracted, isn't it? Under EPWP. They work for a period of the [sic] year, maximum two years – after that then taken out then new people used to come in. So [sic] keep on training and training and training."

- Key informant - facilities

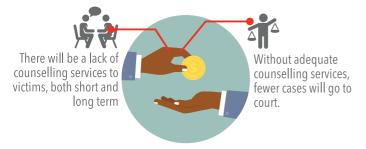
Other NGOs are also actively involved in the CoJ (Regions A, D, E and G). Some of the support services delivered by other NGOs include violence prevention through community awareness campaigns, school campaigns on GBV, training, emergency shelters, protection orders, court preparation and other legal aspects as well as psychosocial support.



"NGOs are delivering services that the government should, but can't..."

– Key informant – GBV Expert

The financial sustainability of NGOs and how insecurities in the funding sectors is influencing their work needs to be factored into any intervention. A number of key informants highlighted that financial constraints are influencing the ability of NGOs to deliver the above mentioned services. The following services will be influenced if NGOs are not adequately funded:

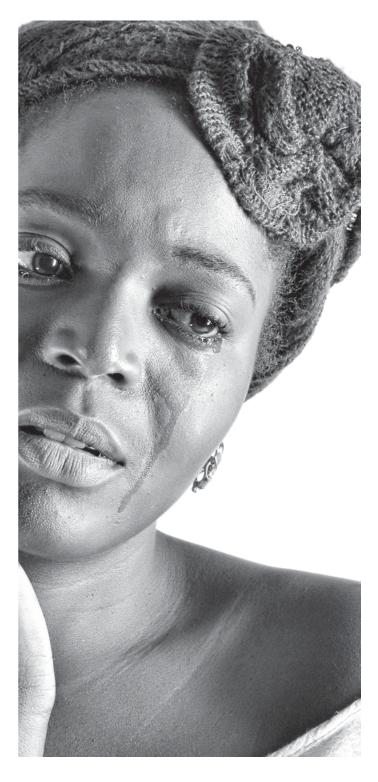


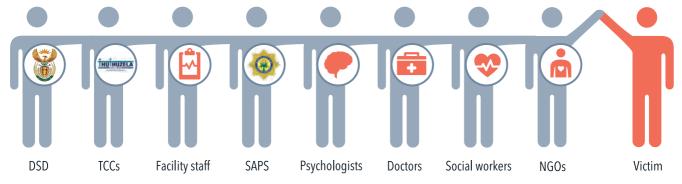
One key informant mentioned that NGOs are have a high turnover of social workers, as they cannot compete with government salaries.



### 1.7. Other stakeholders

The aim of the rapid assessment and gap analysis was not to investigate the relationship with other stakeholders, but the key informants highlighted challenges that they experience with other stakeholders. Various role players and stakeholders were identified during the interviews. These role players and stakeholders consist of various organisations, groups and sub-groups of people and include both victim and service provider; specifically, the Department of Social Development, Thuthuzela Care Centres, facility staff members, the South African Police Service, psychologists, social workers, doctors, NGOs and the victims themselves. It was mentioned that there's a lack of communication between the TCCs and the facilities. Key informants highlighted that they do not get feedback on referred clients, and that there is not an integrated approach to providing post-violence care services.





66

"I will say like communication – like whoever that we are referring, let us get a feedback..."

- Key informant - facilities

"I think you've just go to work together as a team..."

– Key informant – facilities

"...the police also need to come to the party be part of a parcel [sic] like this..."

- Key informant - facilities

"I need to have a direct number of Thuthuzela where I know am not going through the switchboard to communicate with somebody indirectly..."

- Key informant - facilities

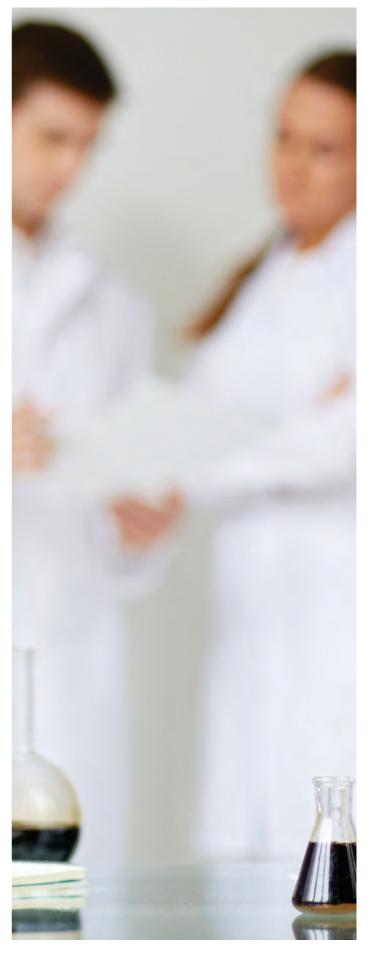
A key informant highlighted that many departments and NGOs are still working in silos, and this is hindering stakeholder cooperation. A number of participants also mentioned that there is a lot of politics in the sector and this is influencing the ability of stakeholders to provide post-violence care in a coordinated, integrated manner.



"There's just so much petty politics..."

- Key informant - GBV expert





### 1.8. Overall findings

Overall findings from in CoJ (Regions A, D, E and G)

OPENING TIMES		Fax machines	65 Out of 73 90.41%
Facility is open 24 hours a day	2 Out of 73 2.74%	Photocopiers	38 Out of 73 52.05%
Facility is open 7 days a week	5 Out of 73 6.85%	Printers	69 Out of 73 94.52%
Facility is open Monday to Friday	52 Out of 73 71.23%	Internet	55 Out of 73 75.34%
Facility is located in a permanent building	70 Out of 73 95.89%	Camera for evidence	5 Out of 73 6.85%
Facility is located in a park home	3 Out of 73 4.11%	Fans	47 Out of 73 64.38%
Average number of Sexual Offence cases per week	0.88 Out of 73	Air conditioner	63 Out of 73 86.30%
Average waiting time of 45 minutes	58 Out of 73 79.45%	Heater	56 Out of 73 76.71%
SERVICES PROVIDED		Fridges	73 Out of 73 100%
Medical Forensic Examination	2 Out of 73 2.74%	Microwave ovens	69 Out of 73 94.52%
Bath or shower facility	7 Out of 73 9.59%	Fire extinguishers	<b>72</b> Out of <b>73</b> 98.63%
Provision of comfort packs and clean clothes	3 Out of 73 4.11%	Lockable cabinet	66 Out of 73 90.41%
Statement taken by a SAPS investigating officer	7 Out of 73 9.59%	Refreshments for victims	4 Out of <b>73</b> 5.48%
Psychological services	31 Out of 73 42.47%	Clean clothing	8 Out of <b>73</b> 10.96%
HIV, STI and pregnancy testing	51 Out of 73 69.86%	Comfort packs	4 Out of 73 5.48%
Provision of post-exposure prophylaxis	46 Out of 73 63.01%	Toys	10 Out of 73 13.70%
Referral for HIV treatment	51 Out of 73 69.86%	Anatomically correct dolls	4 Out of 73 5.48%
Assistance with case reporting and court preparation	14 Out of 73 19.18%	IEC material	56 Out of 73 76.71%
FACILITIES AVAILABLE		Adult height and weight measures	70 Out of 73 95.89%
Private ablutions with bath or shower	7 Out of 73 9.59%	Children's scale	69 Out of 73 94.52%
Disabled-friendly ablutions	57 Out of 73 78.08%	Childrens measuring board	<b>59</b> Out of <b>73</b> 80.82%
Private room for victims to rest in	18 Out of 73 24.66%	BP monitors	<b>71</b> Out of <b>73</b> 97.26%
Waiting room	54 Out of 73 73.97%	Syringes, needles, sterile swabs	73 Out of 73 100%
Counselling office	21 Out of 73 28.77%	Blood collection tubes	73 Out of 73 100%
SAPS office	3 Out of 73 4.11%	Examination gloves	<b>71</b> Out of <b>73</b> 97.26%
Examination room	73 Out of 73 100%	Sharps container	73 Out of 73 100%
NGO room	10 Out of 73 13.70%	Lighting for examination	45 Out of 73 61.64%
Wheelchair ramp	67 Out of 73 91.78%	Gynaecological couch	<b>20</b> Out of <b>73</b> 27.40%
EQUIPMENT AVAILABLE		Speculums	<b>72</b> Gut of <b>73</b> 98.63%
Computers	73 Out of 73 100%	Colposcope	9 Out of <b>73</b> 12.33%
Telephones	65 Out of 73 90.41%	Gown for victim	59 Out of 73 80.82%
		Clean bed linen	65 Out of 73 89.42%

STAFF (FULL/PART TIME)	
Department/ Facility Manager	<b>67</b> Out of <b>73</b> 91.78%
Professional Nurse	73 Out of 73 100%
Forensic Nurse	3 Out of 73 4.11%
Doctor	67 Out of 73 91.78%
Administrative staff	69 Out of 73 94.52%
Trauma Counsellor	1 Out of <b>73</b> 1.37%
HCT Counsellor	71 Out of 73 97.26%
Psychologist	13 Out of 73 17.81%
Pharmacist	12 Out of 73 16.44%
TRAINING IN PROVIDING POST VIOLENCE	CARE

### TRAINING IN PROVIDING POST-VIOLENCE CARE

Healthcare Staff	4 Out of 73	5.48%
Non-healthcare Staff	2 Out of 73	2.74%
Auxiliary Staff	0 Out of 73	0.00%

### FACILITIES WITH AN NGO

Facilities with an NGO 34 Out of 73 46.58%



Michael Maponya Clinic - Provincial Health Unit

Moroka Clinic - Provincial Health Unit

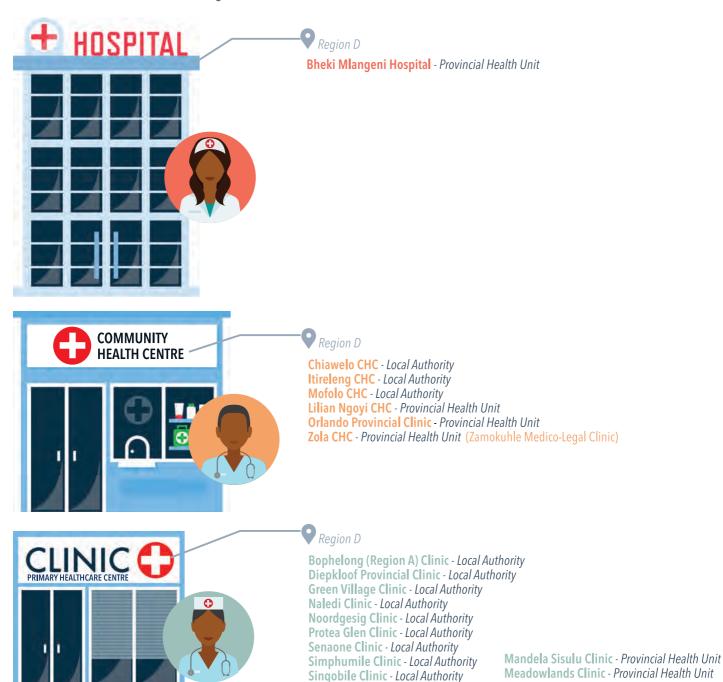
Sinethemba Clinic - Provincial Health Unit

Zola Gateway Clinic - Provincial Health Unit

## 2 City of Johannesburg Region D findings

This section provides specific findings on the 26 facilities that were visited in CoJ Region D. Data were collected from 26 facilities across Region D. One facility was a hospital, six were CHCs and 19 PHCs. A total of 16 facilities were categorised under the Local Authority, and the remaining 10 are Provincial.

Facilities included in data collection in Region D

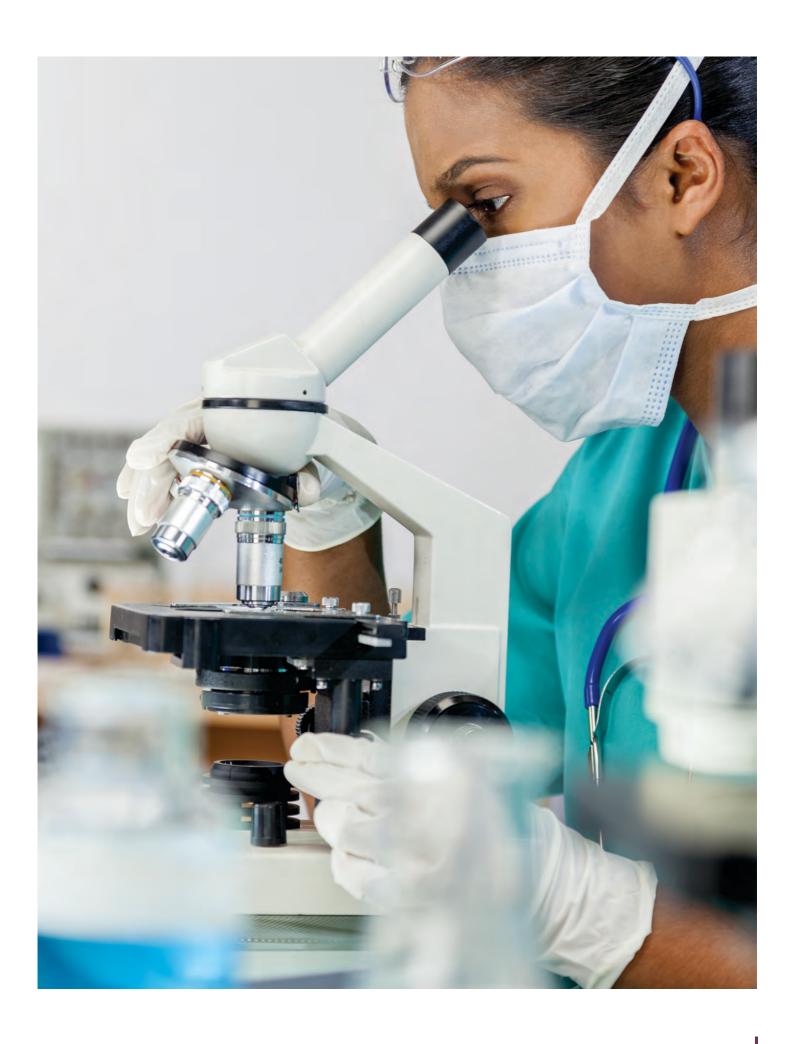


Slovoville Clinic - Local Authority

Tshepisong Clinic - Local Authority

Tladi LA Clinic - Local Authority

**Zondi Clinic** - Local Authority



### 2.1. Findings on post-violence care services

For the purposes of this rapid assessment we are defining post-violence care as the following 'package of services' provided to victims of violence:



If a facility provides all of the above services, to victims of violence, they are said to provide-post violence care.

The research team attempted to find out what perceived need for post-violence care services for victims of sexual assault. Few participants are aware of an increase in cases of sexual assault. One possible reason for this is that victims are referred elsewhere because the facilities do not provide post-violence services. Another reason could be that no record is kept of the number of reported cases. This is also confirmed by a key informant from an NGO in Region D.

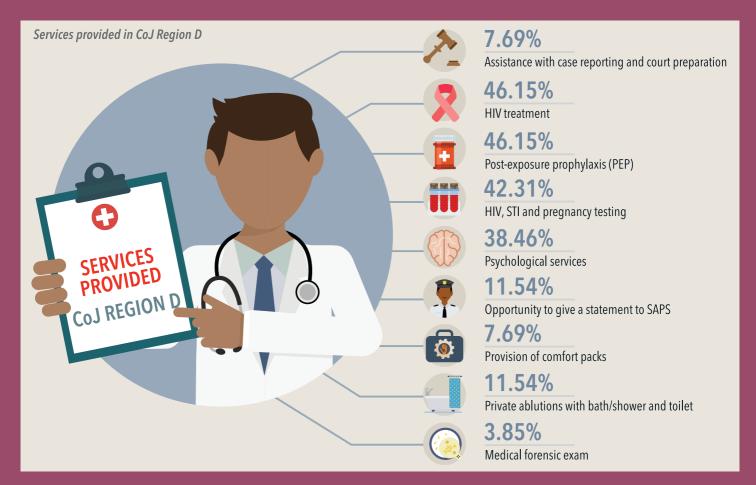


The research team noticed that facilities had different opinions on what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations. The majority of the facilities in our sample are able to provide some services, such as HIV testing, to all patients in general, but do not provide this service to victims of sexual violence because they have been instructed to only refer them.

Only one facility surveyed in Region D provides the medical forensic examination (Zola CHC, also called Zamokuhle Medico-Legal Clinic). However, a compliance audit and gap analysis on the TCCs (FPD, 2016) found that Nthabiseng TCC at the Chris Hani Baragwanath hospital (Region D) also provided these services, but the team was refused access to the hospital. Nthabiseng TCC provide all the essential services as defined above, while Zola CHC does not provide the opportunity to bath/shower, provide a statement to a SAPS officer or assistance with court preparation. It is interesting to note that Bheki Mlangeni Hospital provide a number of post-violence care services such as bath/shower facilities, the opportunity to give a statement to a SAPS officer, psychological support, and assistance with case reporting and court preparation as well as the required medical equipment, although they do not provide forensic investigation services.

Only 11.54% (3 facilities) offer bath or shower facilities and provide the opportunity for statement taking by a SAPS investigating officer. Only 38.46% (9 facilities) provide psychological services and seven facilities reported that they have a psychologist in service. Just under half of facilities provide HIV treatment (46.15%), PEP (46.15%) and HIV, STI and pregnancy testing (42.31%). Two facilities are able to assist with case reporting and court preparation.



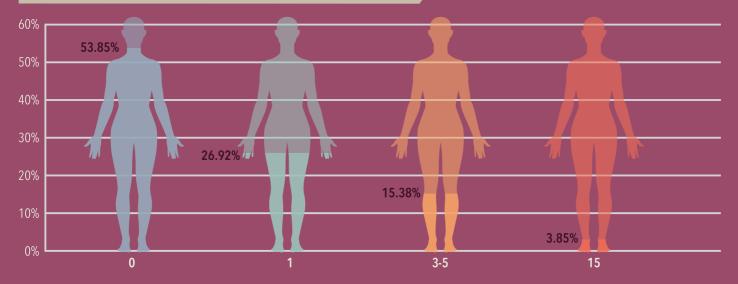


From the interviews the research team found that facilities provide the above services to clients in general, but 25 refer victims of sexual violence to other facilities. Only Zola CHC do not refer victims of sexual assault, as they provide forensic services. The main reasons why the attending staff were referring the clients elsewhere was a lack of forensically trained staff and a lack of equipment and supplies. Some participants thought that their facilities should provide the full range of care available to victims of sexual assault at their facilities.

### Number of sexual assault cases per week

The majority of facilities (53.85%) reported that they do not see any cases of sexual assault. Only one facility, Zola CHC (Zamokuhle Medico-Legal Clinic), reported seeing an average of 15 cases per week. The average across all facilities in Region D is 1.46 cases of sexual assault per week. This is probably linked to the presence of the Medico-Legal Clinic that has a much higher case load than other facilities because they provide almost the full package of post-violence care.

### AVERAGE NUMBER OF SEXUAL ASSAULT CASES SEEN PER WEEK



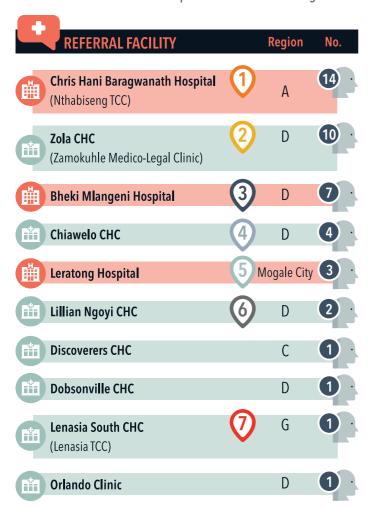
This finding must be read with caution for two reasons. Firstly, facilities reported that the number of cases of sexual assault vary from week to week. Secondly, facilities who do not provide forensic investigation services are not required to record the cases that present at the facilities, and this can also influence the findings.

### 2.2. Findings on referral pathways

All facilities (except Zola CHC (Zamokuhle Medico-Legal Clinic)), reported that they refer victims of sexual violence to other facilities for the forensic investigation as well as other post-violence care services, it is important to understand where they refer victims to.

As there are two facilities in Region D that can conduct forensic investigations, Zola CHC (Zamokuhle Medico-Legal Clinic) and Nthabiseng TCC at Chris Hani Baragwanath Hospital, 24 facilities reported that they refer victims of sexual assault to them. Victims are also referred to one other TCC (Lenasia TCC) in region G. The TCCs provide the full package of post-violence care services (FPD, 2016).

Facilities that receive referrals for post violence care from Region D

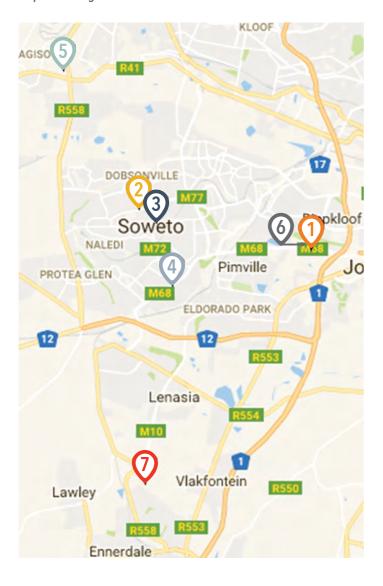


Four of these facilities were not included in the data collection (Leratong Hospital, Discoverers CHC, Dobsonville CHC, Orlando Clinic), and were reported only as facilities where victims are referred for post-violence care. An NGO active in Region A also refers victims to Discoverers CHC in Region C, as they have a post-rape care centre during the day. The findings suggest that facilities refer victims of sexual assault to other facilities who self-reported that they do not provide post-violence care services. These include Bheki Mlangeni Hospital, Chiawelo CHC and Lilian Ngoyi CHC.



See the map below to the referral pathways for post-violence care in Region D.

### Map of CoJ Region D referrals



The referral pathways for Region D are a major problem, because victims need to travel long distances to the referral facilities. This is hampered by access to transport and leads to secondary victimisation.



### 2.3. Facilities and sites

In order to have a better idea of the facilities' ability to deliver post-violence care services, the research team also investigated the facilities and sites, including types of buildings, facilities available, space, equipment and supplies, days and hours of services, waiting times, accessibility and psychosocial support.

### Type of buildings

All facilities, except one, are located in permanent buildings in Region D. Naledi Clinic is located in a parkhome.



### Facilities available

The majority of facilities in Region D have disabled-friendly ablutions (76.92%), wheelchair ramps (88.46%), a waiting room with seating (80.77%) and examination rooms (100%).









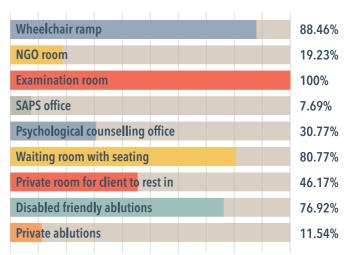
76.92%

88.46%

80.77%

100%

### **FACILITIES AVAILABLE IN REGION D**



### **Equipment and supplies**

The majority of facilities in Region D have the general equipment necessary to run a clinic. The majority of facilities have computers (100%) and telephones (96.15%), fax machines (69.23%), printers (92.31%), IEC material (80.77%), air conditioners (69.23%) and fire extinguishers (96.15%).

With regards to post-violence care, some of the facilities have comfort packs (7.69%), clean clothing (15.38%), refreshments (7.69%). Only one facility had toys for children to play with while they are waiting. None of the facilities reported that they have a camera for photographing forensic evidence or anatomically correct dolls.

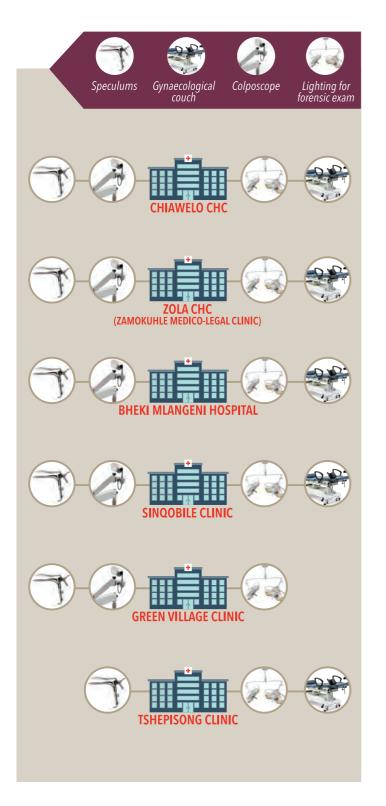
**GENERAL EQUIPMENT AVAILABLE IN REGION D FACILITIES** 84.62% 0.00% Anatomically Educational and IEC materials correct dolls 7.69% 15.38% Comfort packs Clean clothes Refreshments 100% Lockable cabinet Fire extinguisher Microwave 76.92% 100% 73.08% Fridge for Heaters Aircon medicine and bloods 0.00% Cameras for evidence Fans Email/Internet 96.15% Printer Photocopier Fax machine Telephone Computer

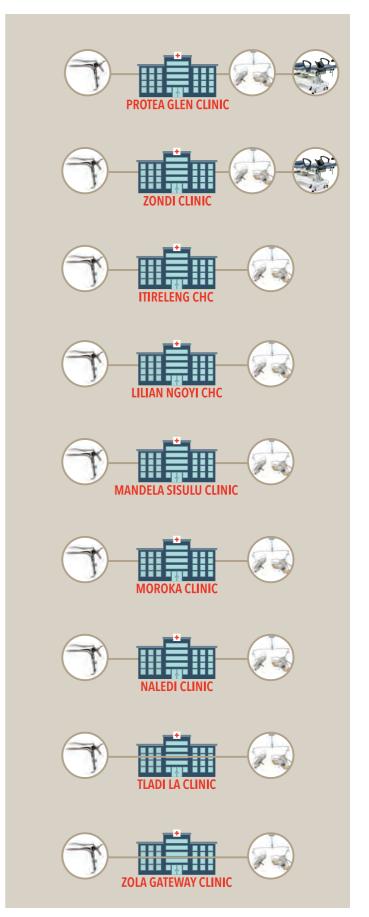
All the facilities have syringes, needles, sterile swabs, blood collection tubes, sharps containers and speculums. The majority of facilities have examination gloves (96.15%), scales (92.31%), BP monitors (96.15%), clean linen (88.46%) and hand washing facilities in the examination rooms (88.46%). A total of six facilities have a colposcope (23.08%), nine have a gyneacological couch (34.26%) and 15 have a light for forensic examination (57.69%).



Eight of the 26 facilities surveyed in Region D have all or most of the equipment required to upscale their post-violence care services. An additional seven facilities have half of the medical equipment required. The illustration below highlights the potential for scale up.

Facilities in Region D with equipment needed for PVC

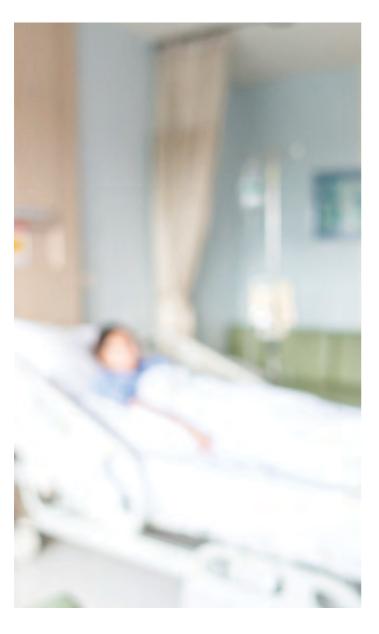




### Space

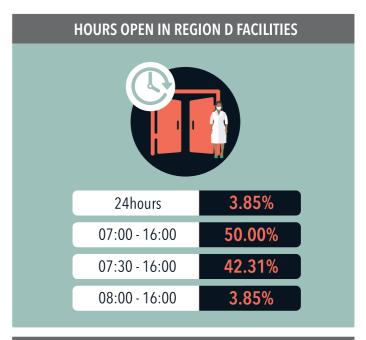
Many facilities mentioned a need for additional space to conduct their work properly. This includes a need for additional counselling rooms, and an area to conduct forensic examination as well as storage space. Victims of sexual assault are consulted in normal examination rooms which lacked privacy as other patients were sometimes tended to in the same room.

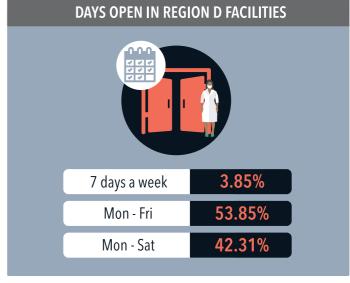




### Days and hours of service

Half of the facilities in Region D are open from 07:00 to 16:00 (50%), from Monday to Friday (53.85%). Only one facility (Lilian Ngoyi CHC) is open 24 hours a day, 7 days a week.





### Waiting time

Approximately 70% of facilities in Region D reported a waiting time of 45 minutes or less. Those who reported a longer waiting time reported a 2 to 4 hour waiting time.



### Accessibility

Accessibility to facilities that provide post-violence care services is an important factor in ensuring that the services are used by victims. Across regions and within regions, there are great variations in opening times, accessibility and awareness of the facilities that do provide the required services. There are victims who arrive at facilities not knowing that the facility in question does not offer forensic examination services, or there are victims who report to police stations and are consequently referred to the nearest hospital or TCC. Victims who are not tended to immediately have to wait with other outpatients only to be referred again to another facility. Not all victims have access to transport to attend the facilities they are referred to. Ambulances are often reserved only for those with medical emergencies. A key informant from Region D highlighted that distance, access to transport and money for transport are major issues influencing accessibility.

### Psychosocial support

Many facilities mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support. A total of 38.46% (10) facilities indicated that they can provide psychological services within the facility but only one has a trauma counsellor available and 26.92% have a psychologist available. It is likely that the psychosocial support is provided by social workers, counsellors and supporting NGOs. All except one of the facilities in the sample had an HCT counsellor available.

facilities can provide 38.46%
psychological services 38.46%
facility has a 26.92
facilities have a 45 of 26
HCT counsellor available



### 2.4. Factors influencing quality of services delivered

As per the discussion in Section 2.1, most facilities provide most of the necessary services required of a public health facility, and many have the ability to provide some post-violence care services. However, although the services are available, it is the quality of those services that is the challenge. The team found variations in staff available, victim friendliness, and issues with secondary victimisation and scope of responsibilities. There were also problems with delays in service delivery, and problems with follow-up. These factors and challenges are discussed below.

### **Human resources**

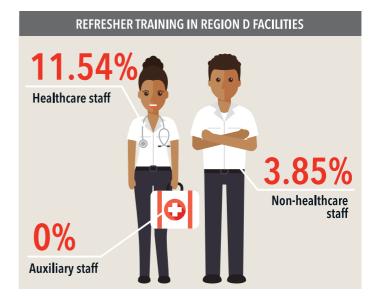
### Staff available

The majority of staff have a facility or Department Manager, administrative clerks and doctors (88.46%), professional nurses and HCT counsellors (96.15%). Only one facility has a trauma counsellor (3.85%), two have a forensic nurse (7.69%), and seven have a psychologist and pharmacist (26.92%).

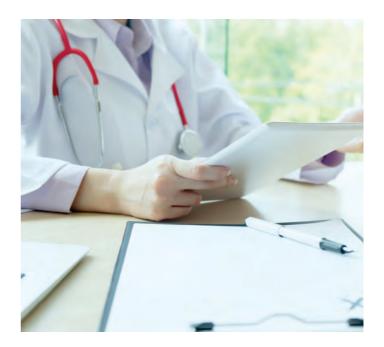
# Professional Nurse 88.46% Professional Nurse 96.15% 96.15% Administrative Staff Psychologist Professional Nurse Region D FACILITIES 88.46% 96.15% Pharmacist 7.69% 3.85% Trauma Counsellor

### Training of staff

Only three facilities reported that their healthcare staff have received refresher training in post-violence care (11.54%) and one facility that their non-healthcare staff had received refresher training (3.85%). The facilities reported that they received training by Nthabiseng TCC and Hillbrow Clinic. No facilities' auxiliary staff received refresher training.

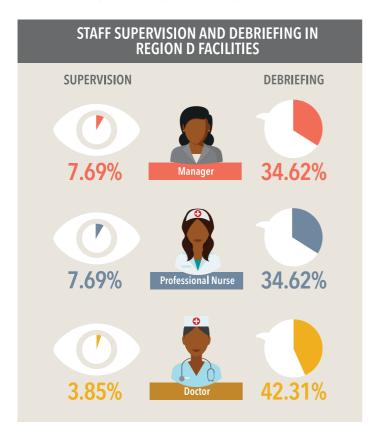


"Because there was no proper training, nobody is really sensitised about dealing with it [gender-based violence]"
... Key informant - facilities



### Staff supervision and debriefing

There is a major concern regarding staff supervision as well as debriefing in Region D. Only one facility reported that their doctors are receiving regular debriefing, and only two facilities reported that their professional nurses and facility managers receive regular debriefing.



### 2.5. Victim friendliness and secondary victimisation

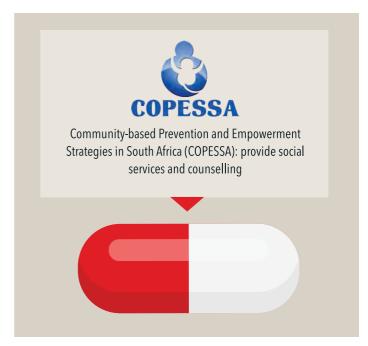
Victim friendliness is a major challenge for facilities. Most mentioned that victims may experience secondary victimisation as a result of the lack of victim friendliness of the environment. Auxiliary staff lack sensitivity when treating and receiving clients. Other factors that may influence victim friendliness include patient waiting time, the quality of the infrastructure, issues of privacy and stigma.

Some of the facilities mentioned that victims are at risk of experiencing secondary victimisation as a result of being referred to other facilities. The lack of privacy when assisting victims may also be another factor in secondary victimisation.

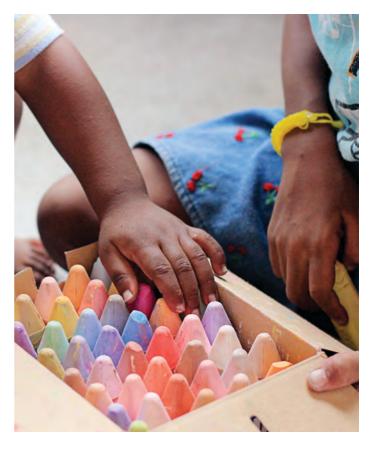


### 2.6. NGOs as service providers

Only one facility had an NGO providing services in their facility.



As this NGO already provides social services and counselling in one facility in Region D, they could potentially be scaled-up to provide these services in more facilities in Region D.



### 2.7. Overall findings of Region D

### Overall findings from Region D

OPENING TIMES		Fax machines	18 Out of 26 69.23%
Facility is open 24 hours a day	1 Out of 26 3.85%	Photocopiers	<b>24</b> Out of <b>26</b> 92.31%
Facility is open 7 days a week	1 Out of 26 3.85%	Printers	<b>24</b> Gut of <b>26</b> 92.31%
Facility is open Monday to Friday	14 Out of 26 53.85%	Internet	23 Out of 26 88.46%
Facility is located in a permanent building	25 Out of 26 96.15%	Camera for evidence	0 Out of 26 0.00%
Facility is located in a park home	1 Out of 26 3.85%	Fans	16 Out of 26 61.54%
Average number of Sexual Offence cases per wee	k 1.46 Out of 26	Air conditioner	18 Out of 26 69.23%
Average waiting time of 45 minutes	18 Out of 26 69.23%	Heater	<b>19</b> Out of <b>26</b> 73.08%
SERVICES PROVIDED		Fridges	25 Out of 26 96.15%
Medical Forensic Examination	1 Out of 26 3.85%	Microwave ovens	<b>24</b> Out of <b>26</b> 92.31%
Bath or shower facility	3 Out of 26 11.54%	Fire extinguishers	25 Out of 26 96.15%
Provision of comfort packs and clean clothes	2 Out of 26 7.69%	Lockable cabinet	21 Out of 26 80.77%
Statement taken by a SAPS investigating officer	3 Out of 26 11.54%	Refreshments for victims	2 Out of 26 7.69%
Psychological services	10 Out of 26 38.46%	Clean clothing	3 Out of 26 11.54%
HIV, STI and pregnancy testing	11 Out of 26 42.31%	Comfort packs	2 Out of 26 7.69%
Provision of post-exposure prophylaxis	12 Out of 26 46.15%	Toys	1 Out of 26 3.85%
Referral for HIV treatment	12 Out of 26 46.15%	Anatomically correct dolls	0 out of 26 0.00%
Assistance with case reporting and court preparation	2 Out of 26 7.69%	IEC material	21 Out of 26 80.77%
FACILITIES AVAILABLE		Adult height and weight measures	24 Out of 26 92.31%
Private ablutions with bath or shower	3 Gut of 26 11.54%	Children's scale	25 Out of 26 96.15%
Disabled-friendly ablutions	20 Out of 26 76.92%	Childrens measuring board	19 Out of 26 73.08%
Private room for victims to rest in	12 Out of 26 46.15%	BP monitors	25 Out of 26 96.15%
Waiting room	21 Out of 26 80.77%	Syringes, needles, sterile swabs	26 Out of 26 100%
Counselling office	8 Out of 26 30.77%	Blood collection tubes	26 Out of 26 100%
SAPS office	2 Out of 26 7.69%	Examination gloves	25 Out of 26 96.15%
Examination room	26 Out of 26 100%	Sharps container	26 Out of 26 100%
NGO room	5 Out of 26 19.23%	Lighting for examination	15 Out of 26 57.69%
Wheelchair ramp	23 Out of 26 88.46%	Gynaecological couch	9 Out of <b>26</b> 34.62%
EQUIPMENT AVAILABLE	23 (01/0/20 00.40/0	Speculums	26 Out of 26 100%
Computers	26 Out of 26 100%	Colposcope	6 Out of <b>26</b> 23.08%
Telephones	25 Out of 26 96.15%	Gown for victim	21 Out of 26 80.77%
icicpiiolies	25 00.15/0	Clean bed linen	23 Out of 26 88.46%

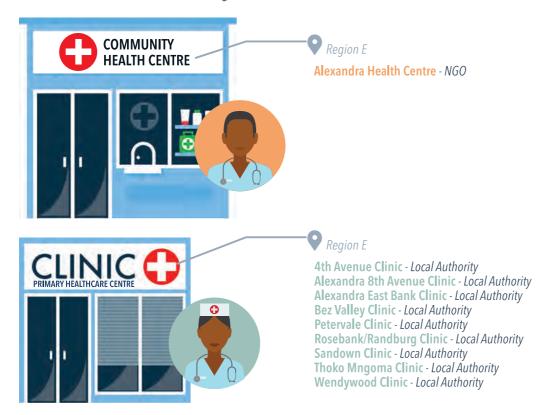
STAFF (FULL/PARTTIME)	
Department/ Facility Manager	23 Out of 26 88.47%
Professional Nurse	25 Out of 26 96.15%
Forensic Nurse	2 out of 26 7.69%
Doctor	23 Out of 26 88.46%
Administrative staff	23 Out of 26 88.46%
Trauma Counsellor	1 Out of <b>26</b> 3.85%
HCT Counsellor	<b>25</b> Out of <b>26</b> 96.15%
Psychologist	7 Out of <b>26</b> 26.92%
Pharmacist	7 Out of 26 26.92%
REFRESHER TRAINING IN SEXUAL ASSAULT	
Healthcare Staff	1 Out of 26 11.54%
Non-healthcare Staff	1 Out of 26 3.85%
Auxiliary Staff	0 Out of 26 0.00%
FACILITIES WITH AN NGO	
Facilities with an NGO	1 Out of 26 3.85%



# **3** City of Johannesburg Region E findings

This section provide specific findings on the 10 facilities that were visited in CoJ Region E. Data were collected from ten facilities across Region E. Nine of the facilities are PHCs and one is a CHC. Nine facilities were categorised under the Local Authority and one is an NGO.

Facilities included in data collection in Region E





### 3.1.

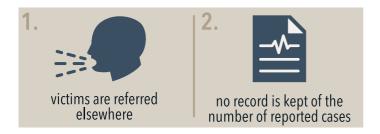
### Findings on post-violence care services

For the purposes of this rapid assessment we are defining post-violence care as the following 'package of services' provided to victims of violence:



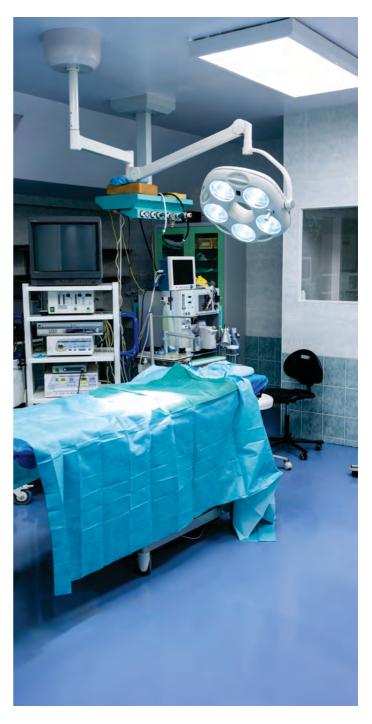
If a facility provides all of the above services, to victims of violence, they are said to provide post-violence care.

The research team attempted to find out the perceived need for postviolence care services for victims of sexual assault. Few participants were aware of an increase in cases of sexual assault. One possible reason for this is that victims are referred elsewhere because the facilities do not provide post-violence services. Another reason could be that no record is kept of the number of reported cases.

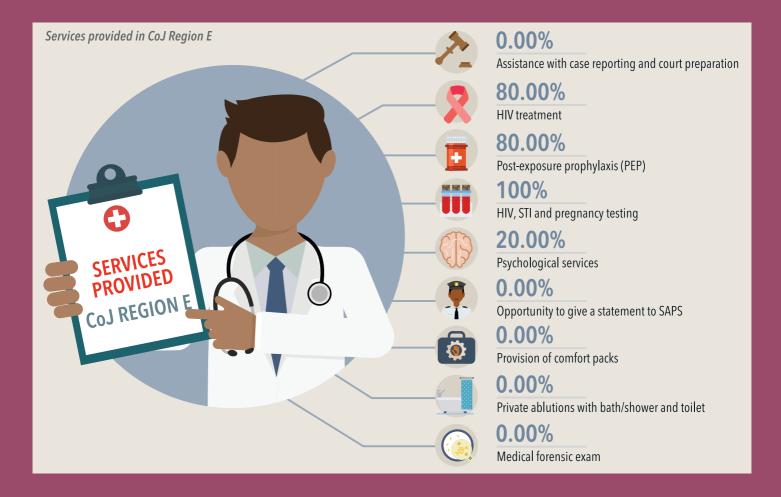


The research team noticed that facilities had different opinions on what postviolence care entails and who they should be providing these services to.

Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations. The majority of the facilities in our sample are able to provide some services, such as HIV testing, to all patients in general, but do not provide this service to victims of sexual violence because they have been instructed to only refer them.



None of the facilities in Region E provide medical forensic examinations, private bath/shower facilities, comfort packs or the opportunity for victims to give a statement to SAPS. Most provide HIV treatment and PEP (80%), and all provide HIV, STI and pregnancy testing. Only 20% (two facilities) provide psychological services. None are able to assist with case reporting and court preparation.



From the interviews the research team found that facilities provide the above services to clients in general, but all ten refer victims of sexual violence to other facilities. The main reasons why the attending staff were referring the clients elsewhere were a lack of forensically trained staff and a lack of equipment and supplies. Some participants thought that their facilities should provide the full range of care available to victims of sexual assault.

### Number of sexual assault cases per week

All the facilities in Region E reported that they do not receive any cases of sexual violence. However, during the individual interviews, a number of facility managers mentioned that the majority of their cases of sexual assault involve children as victims. The fact that PHCs and CHCs are not required to record cases of sexual assault might be the reason why they said that they do not receive any cases.

### 3.2. Findings on referral pathways

As all facilities reported that they refer victims of sexual violence to other facilities for the forensic investigation as well as other post-violence care services, it is important to understand where they refer victims to. In spite of reporting that they do not receive cases of sexual assault at the ten facilities surveyed in Region E, five facilities refer victims to Alexandra Health Centre. It is important to note that Alexandra Health Centre said that they do not provide medical forensic examinations, but refer patients to Wynberg Police Station. The remaining five facilities refer victims to facilities outside Region E. None of the facilities reported that they refer victims to any of the TCCs in City of Johannesburg.

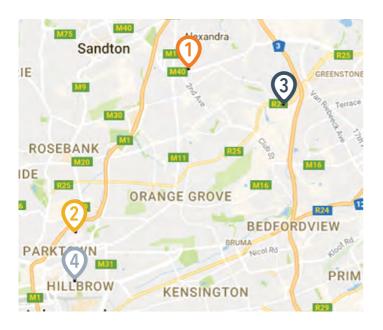
### Facilities that receive referrals for post violence care



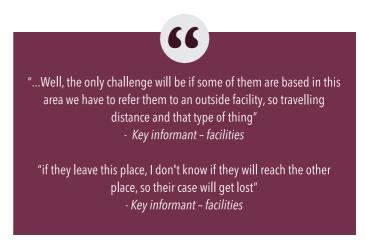
Only Alexandra Health Centre was included in the data collection. The remaining facilities were only reported as facilities where victims are referred for post-violence care. A key informant has, however, mentioned that Hillbrow CHC does provide forensic investigation services as part of their post-violence care package.

See the map to see referral pathways for post-violence care in Region E.

### Map of CoJ Region E referrals



The referral pathways for Region E are a major problem, as victims need to travel long distances to the referral facilities. This is hampered by access to transport and leads to secondary victimisation.



### 3.3. Facilities and sites

In order to have a better grasp of the facilities' ability to deliver post-violence care services, the research team also investigated the facilities and sites, including types of buildings, facilities available, space, equipment and supplies, days and hours of services, waiting times, accessibility and psychosocial support.

### Type of buildings

All of the facilities that were included in the survey in Region E are located in permanent buildings.

### Facilities available

All of the facilities in Region E have examination rooms, the majority have disabled-friendly ablutions and a wheelchair ramp (90%), but only 40% have a waiting room with seating.

### **FACILITIES AVAILABLE IN REGION E** Wheelchair ramp 90.00% NGO room 10.00% **Examination room** 100% **SAPS** office 0.00% Psychological counselling office 20.00% Waiting room with seating 40.00% Private room for client to rest in 20.00% Disabled friendly ablutions 90.00% Private ablutions/shower facility 0.00%

### **Equipment and supplies**

The majority of facilities in Region E have the general equipment necessary to run a clinic. All facilities in Region E have computers, telephones, printers, air conditioners and fire extinguishers. Only half of the facilities have access to the internet. With regards to post-violence care, none of the facilities have comfort packs, but one facility has an evidence camera, clean clothing and refreshments. None of the facilities had toys for children to play with while they are waiting.



All of the facilities in Region E have syringes, needles and sterile swabs, blood collection tubes, sharps containers, scales, BP monitors, speculums, clean linen and gowns for patients. Only one facility has a colposcope, five have lighting for forensic examinations. Some facilities have some of the medical equipment described in the TCC Blueprint and therefore have the ability to upscale post-violence care services.



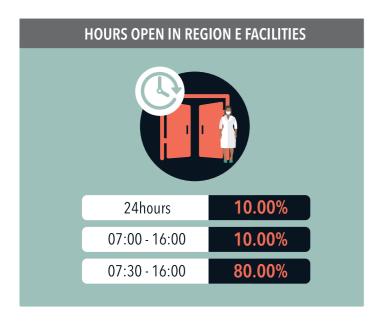
### Space

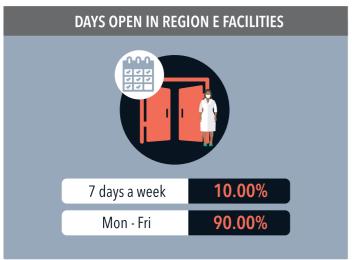
Many facilities mentioned that they need additional space to conduct their work properly. This includes additional counselling rooms, and an area to conduct forensic examinations, as well as storage space. Victims of sexual assault are managed in normal examination rooms, which lacked privacy as other patients were sometimes tended to in the same room.



### Days and hours of service

The majority of facilities in Region E are open from 07:30 to 16:00 (80%), from Monday to Friday (90%). Alexandra Health centre is open 24/7, thus creating the possibility for upscaling their post-violence services.







"...Usually if it's at night, that they present."

- Key informant - facilities

### Waiting time

Four facilities (40%) reported a waiting time of 45 minutes or less to see a healthcare worker. The rest reported waiting times of 2 to 3 hours.





"...people wait quite long as well..." - Key informant - facilities

### Accessibility

Accessibility to facilities that provide post-violence care services is an important factor in ensuring that the services are used by victims. Across and within regions, there are great variations in opening times, accessibility and awareness of the facilities that do provide the required services. There are victims who arrive at facilities not knowing that the facility in question does not offer forensic examination services or there are victims who report to police stations and are consequently referred to the nearest hospital or TCC. Some victims are referred to facilities who do not provide the required post-violence care services either. Victims who are not tended to immediately have to wait with other outpatients only to be referred again to another facility. Not all have access to transport to attend the facilities they are referred to. Ambulances are often reserved only for those with medical emergencies.





"sometimes the patient haven't got money to go there"

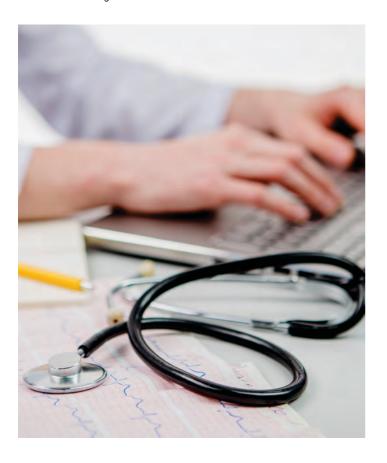
- Key informant - facilities

### Psychosocial support

Many facilities mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support. Only two facilities in Region E indicated that they can provide psychological services within the facility and only one has a psychologist available and none have a trauma counsellor available. One of the facilities in the sample does not have an HCT counsellor available.

### 3.4. Factors influencing quality of services delivered

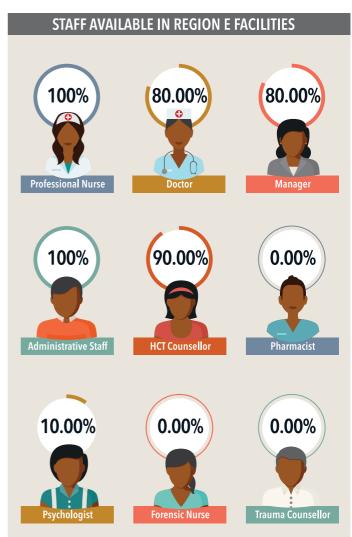
As per the discussion in Section 3.1, most facilities provide most of the necessary services required of a public health facility, and some have the ability to provide some post-violence care services. However, although the services are available, it is the quality of those services that is a challenge. There were variations in staff available, victim friendliness, and issues with secondary victimisation and scope of responsibilities. There were also problems with delays in service delivery, and problems with follow-up. These factors and challenges are discussed below.



### **Human resources**

### Staff available

All the facilities in Region E have professional nurses and administrative staff. Nine have HCT counsellors, eight have a facility manager and a doctor. None have a forensic nurse, trauma counsellor or pharmacist.



### Training of staff

None of the healthcare staff, non-healthcare staff or auxiliary staff at any of the facilities reported that have received training on post-violence care. Various staff members in Region E highlighted their training needs, specifically in the management of sexual assault.



"When the clients come, she might not come straight to me. The first people who will see that patient - it might be the security or the cleaners – they should know exactly how to handle that patient."

- Key informant - facilities



"Sometimes you'll do something not knowing, like interfering with the evidence, you understand" - Key informant - facilities

"I'm not trained to fill a J88" - Key informant - facilities

### Staff supervision and debriefing

All of the facilities reported that their staff are not supervised, and only one facility reported that their staff receive debriefing.

# STAFF SUPERVISION AND DEBRIEFING IN REGION E FACILITIES SUPERVISION DEBRIEFING 10.00% Professional Nurse 10.00%

### 3.5. Victim friendliness and secondary victimisation

Victim friendliness is a major challenge for facilities. Most mentioned that victims may experience secondary victimisation as a result of the lack of victim friendliness of the environment. Auxiliary staff lack sensitivity when treating and receiving clients. Other factors reported that may influence victim friendliness include patient waiting time, the quality of the infrastructure, issues of privacy and stigma.



"We are not sensitised" - Key informant - facilities

"I think if all of us starting from security, cleaners to technicians, we can have at least that basic knowledge"

- Key informant - facilities

"They need a place where they can privately explain their situation, not in the reception in front of everyone" - Key informant - facilities

Some of the facilities mentioned that victims are at risk of experiencing secondary victimisation as a result of being referred to other facilities. In Region E, some of the referral facilities (specifically Alexandra Health Centre) do not provide the required service either, and they refer to Wynberg Police Station. The lack of privacy when assisting victims may also be another factor in secondary victimisation.

Staff are not adequately trained on secondary victimisation and sensitisation, as well as which evidence to preserve in the case of sexual assault.



"We don't have the privacy, because everything is done in one place" – Key informant - facilities

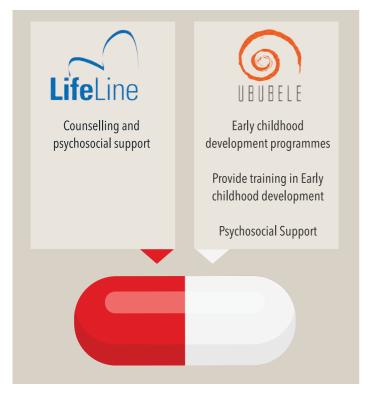


### 3.6.

### NGOs as service providers

Only two facilities (20%) reported that they have an NGO providing a service in their facility.

NGOs in Region E facilities



NGOs assist with providing additional services that facilities cannot provide. There were many benefits to having an NGO associated with facilities, including providing continuous support to clients, rallying communities together for campaigning activities, training, counselling and psychosocial support.

The participants were asked if any NGOs were providing post-violence services at the facilities. According to the participants, the NGOs that are linked to facilities do not provide forensic post-violence services, but they do provide other services such as HIV counselling and testing, training, campaigning and psycho-social support. The general opinion was that the NGOs are providing a valuable service when linked to a facility.



### 3.7.

### **Overall findings of Region E**

Overall findings from Region E

Facility is open 24 hours a day Facility is open 7 days a week Facility is open Monday to Friday Facility is located in a permanent building Facility is located in a park home Average number of Sexual Offence cases per week Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court preparation	1 9		10.00%
Facility is open Monday to Friday Facility is located in a permanent building Facility is located in a park home Average number of Sexual Offence cases per were Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court		out of <b>10</b>	
Facility is located in a permanent building Facility is located in a park home Average number of Sexual Offence cases per were Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	9		10.00%
Facility is located in a park home Average number of Sexual Offence cases per week Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court		out of 10	90.00%
Average number of Sexual Offence cases per week Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	10	out of <b>10</b>	100%
Average waiting time of 45 minutes  SERVICES PROVIDED  Medical Forensic Examination  Bath or shower facility  Provision of comfort packs and clean clothes  Statement taken by a SAPS investigating officer  Psychological services  HIV, STI and pregnancy testing  Provision of post-exposure prophylaxis  Referral for HIV treatment  Assistance with case reporting and court	0	out of 10	0.00%
SERVICES PROVIDED  Medical Forensic Examination  Bath or shower facility  Provision of comfort packs and clean clothes  Statement taken by a SAPS investigating officer  Psychological services  HIV, STI and pregnancy testing  Provision of post-exposure prophylaxis  Referral for HIV treatment  Assistance with case reporting and court	ek 0	out of 10	0.00%
Medical Forensic Examination Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	4	out of 10	40.00%
Bath or shower facility Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court			
Provision of comfort packs and clean clothes Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	0	out of 10	0.00%
Statement taken by a SAPS investigating officer Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	0	out of <b>10</b>	0.00%
Psychological services HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	0	out of <b>10</b>	0.00%
HIV, STI and pregnancy testing Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	0	out of 10	0.00%
Provision of post-exposure prophylaxis Referral for HIV treatment Assistance with case reporting and court	2	out of <b>10</b>	20.00%
Referral for HIV treatment Assistance with case reporting and court	10	out of <b>10</b>	100%
Assistance with case reporting and court	8	out of 10	80.00%
	8	out of <b>10</b>	80.00%
·	0	out of 10	0.00%
FACILITIES AVAILABLE			
Private ablutions with bath or shower	0	out of 10	0.00%
Disabled-friendly ablutions	9	out of <b>10</b>	90.00%
Private room for victims to rest in	2	out of 10	20.00%
Waiting room	4	out of 10	40.00%
Counselling office	2	out of 10	20.00%
SAPS office	0	out of <b>10</b>	0.00%
Examination room	10	out of 10	100%
NGO room	1	out of 10	10.00%
Wheelchair ramp	9	out of 10	90.00%
EQUIPMENT AVAILABLE			
Computers	10	out of <b>10</b>	100%
Telephones	10	out of <b>10</b>	100%

Fax machines	7 Out of 10 70.00%
Photocopiers	9 Out of 10 90.00%
Printers	10 Out of 10 100%
Internet	5 Out of 10 50.00%
Camera for evidence	1 Out of 10 10.00%
Fans	0 Out of 10 0.00%
Air conditioner	10 Out of 10 100%
Heater	8 Out of 10 80.00%
Fridges	10 Out of 10 100%
Microwave ovens	10 Out of 10 100%
Fire extinguishers	10 Out of 10 100%
Lockable cabinet	10 Out of 10 100%
Refreshments for victims	1 Out of 10 10.00%
Clean clothing	1 Out of 10 10.00%
Comfort packs	0 Out of 10 0.00%
Toys	0 Out of 10 0.00%
Anatomically correct dolls	0 out of 10 0.00%
IEC material	4 Out of 10 40.00%
Adult height and weight measures	10 Out of 10 100%
Children's scale	10 Out of 10 100%
Childrens measuring board	7 Out of 10 70.00%
BP monitors	10 Out of 10 100%
Syringes, needles, sterile swabs	10 Out of 10 100%
Blood collection tubes	10 Out of 10 100%
Examination gloves	10 Out of 10 100%
Sharps container	10 Out of 10 100%
Lighting for examination	6 Out of 10 60.00%
Gynaecological couch	5 Out of 10 50.00%
Speculums	10 Out of 10 100%
Colposcope	1 Out of 10 10.00%
Gown for victim	10 Out of 10 100%
Clean bed linen	10 Out of 10 100%

STAFF (FULL/PARTTIME)	
Department/ Facility Manager	8 Out of 10 80.00%
Professional Nurse	10 Out of 10 100%
Forensic Nurse	0 Out of 10 0.00%
Doctor	8 Out of 10 80.00%
Administrative staff	10 Out of 10 100%
Trauma Counsellor	0 Out of 10 0.00%
HCT Counsellor	9 Out of 10 90.00%
Psychologist	1 Out of 10 10.00%
Pharmacist	0 Out of 10 0.00%
REFRESHER TRAINING IN SEXUAL ASSAULT	
Healthcare Staff	0 Out of 10 0.00%
Non-healthcare Staff	0 Out of 10 0.00%

0 Out of 10 0.00%

2 Out of 10 20.00%

### FACILITIES WITH AN NGO

Auxiliary Staff

Facilities with an NGO



# City of Johannesburg Region G findings

This section provide specific findings on the 23 facilities that were visited in CoJ Region G. Data were collected from 23 facilities across Region G. Twenty two are PHCs and one a CHC. A total of 14 facilities were categorised under the Local Authority, and nine are Provincial.

Facilities included in data collection in Region G





Region G

Idorado Park Ext 9

Eldorado Park Ext 9 - Local Authority
Ennerdale Ext 8 Clinic - Local Authority
Ennerdale Ext 9 Clinic - Local Authority
Freedom Park Clinic - Local Authority
Lawly 1 Clinic - Local Authority
Lawly 2 Clinic - Local Authority
Lenasia Ext 10 - Local Authority
Lenasia Ext 5 - Local Authority
Lenasia Health Centre - Local Authority
Lenasia South Civic Clinic - Local Authority
Mid Ennerdale Clinic - Local Authority
Mountainview Clinic - Local Authority
Protea South Clinic - Local Authority
Thulamtwana Clinic - Local Authority

Barney Molokoane Clinic - Provincial Health Unit Eikenhof Clinic - Provincial Health Unit Kliptown Clinic - Provincial Health Unit Orange Farm Ext 7 Clinic - Provincial Health Unit Thembelihle Clinic - Provincial Health Unit Vlakfontein Clinic - Provincial Health Unit Weilers Farm Clinic - Provincial Health Unit Wildebeesfontein Clinic - Provincial Health Unit



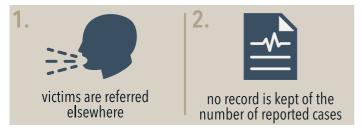
### 4.1. Findings on post-violence care services

For the purposes of this rapid assessment we are defining post-violence care as the following 'package of services' provided to victims of violence:



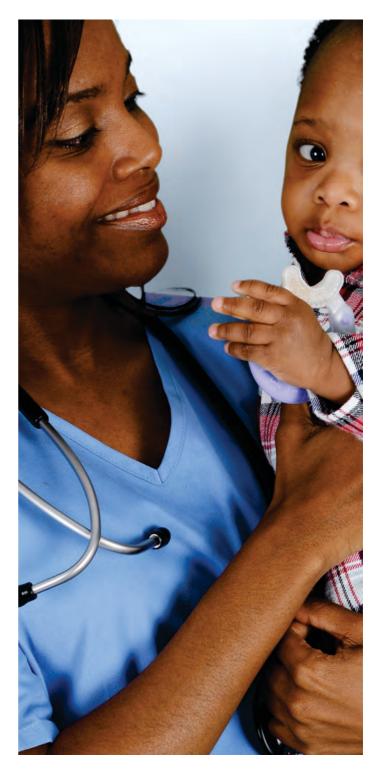
If a facility provides all of the above services, to victims of violence, they are said to provide post-violence care.

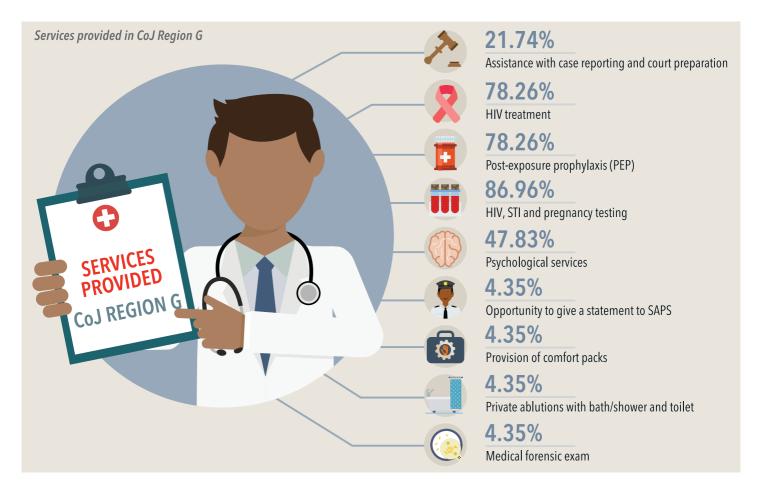
The research team attempted to find out the perceived need for post-violence care services for victims of sexual assault. Few participants were aware of an increase in cases of sexual assault. One possible reason for this is that victims are referred elsewhere because the facilities do not provide post-violence services. Another reason could be that no record is kept of the number of reported cases.



The research team noticed that facilities had different opinions on what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations. The majority of the facilities in our sample are able to provide some services, such as HIV testing, to all patients in general, but do not provide this service to victims of sexual violence because they have been instructed to only refer them.

Only one facility provides forensic medical examination in Region G – Lenasia South CHC (Lenasia TCC). They are also the only facility to provide the full package of post-violence care services, including bath and shower facilities, statement taking by SAPS and comfort packs and clean clothes. The majority of facilities in Region G provide HIV, STI and pregnancy testing (86.96%), PEP and HIV treatment (78.26%). Almost half the facilities, 47.83% (11 facilities) provide psychological services.





From the interviews the research team found that facilities provide the above services to clients in general, but 22 of the 23 facilities refer victims of sexual violence to other facilities. The main reasons why the attending staff were referring the clients elsewhere were a lack of forensically trained staff and a lack of equipment and supplies. Some participants thought that their facilities should provide the full range of care available to victims of sexual assault.

### Number of sexual assault cases per week

The majority of facilities in Region G reported that they do not receive any cases of sexual violence (73.91%), five facilities reported seeing 1 to 2 cases per week (21.47%) and one facility reported seeing up to 15 cases per week (Lenasia TCC). The average number of sexual assault cases seen per week across Region G is 0.95. This is lower than Region D (1.46) but higher than Region E(0).

### AVERAGE NUMBER OF SEXUAL ASSAULT CASES SEEN PER WEEK



### 4.2. Findings on referral pathways

As 22 facilities reported that they refer victims of sexual violence to other facilities for the forensic investigation as well as other post-violence care services, it is important to understand where they refer victims to.

As there's only one facility Region G that can conduct forensic investigations and provide the full package of post-violence care, many clients are referred to facilities outside Region G. A total of 65% of facilities (15) refer Lenasia South CHC (where the Lenasia TCC is based) within Region G. A total of five facilities (21%) refer to Chris Hani Baragwanath Hospital (where the Nthabiseng TCC is located) in Region D, and three facilities refer to both.

Facilities that receive referrals for post-violence care

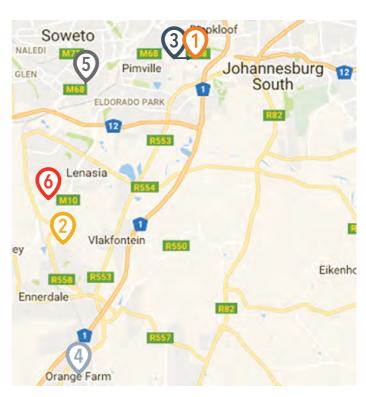


Two of these facilities were not included in the data collection (Chris Hani Baragwanath Hospital - Nthabiseng TCC and Stretford CHC). They were only reported as referral facilities. Both facilities refused the research team access because of concerns regarding the research approval process. However, during the TCC compliance audit and gap analysis, it was found that Nthabiseng TCC provide the required post-violence care services (FPD, 2016). The team cannot report on the ability of Stretford CHC to deliver post-violence care services.

The findings suggest that some facilities refer victims of sexual assault to other facilities who self-reported that they do not provide post-violence care services. These facilities include Chiawelo CHC, Thembelihle PHC and Lilian Ngoyi CHC. They refer to both Nthabiseng and Lenasia TCCs

See the map for the referral pathways for post-violence care in Region G.

### Map of CoJ Region G referrals



The referral pathways for Region G is a major problem, as victims need to travel long distances to the referral facilities. This is hampered by access to transport and leads to secondary victimisation.



### 4.3.

### **Facilities and sites**

In order to have a better grasp of facilities' ability to deliver post-violence care services, the research team also investigated the facilities and sites, including types of buildings, facilities available, space, equipment and supplies, days and hours of services, waiting times, accessibility and psychosocial support.

### Type of buildings

Most facilities in Region G are located in permanent buildings. Only Thembelihle Clinic is located in a park home.



### Facilities available

All of the facilities in Region G have examination rooms. Most have disabledfriendly ablutions (65.22%), a wheelchair ramp (91.30%) and a waiting room with seating (91.30%).









### **FACILITIES AVAILABLE IN REGION G** Wheelchair ramp 91.30% NGO room 8.70% 100% **Examination room SAPS** office 4.35% Psychological counselling office 30.43% 91.30% Waiting room with seating Private room for client to rest in 4.35% Disabled friendly ablutions 65.22% Private ablutions/shower facility 4.35%

### **Equipment and supplies**

The majority of facilities in Region G have the general equipment necessary to run a clinic. All facilities in Region G have computers and fire extinguishers. The majority have telephones (73.91%), printers (91.30%), IEC material (82.61%) and air conditioners (86.96%).

With regards to post-violence care, one of the facilities (Lenasia TCC) has comfort packs, clean clothing, and refreshments. A total of 17.39% have evidence cameras, 21.74% facilities had toys for children to play with while they are waiting, and three (13.04%) reported that they provide clean clothes to victims of sexual assault.



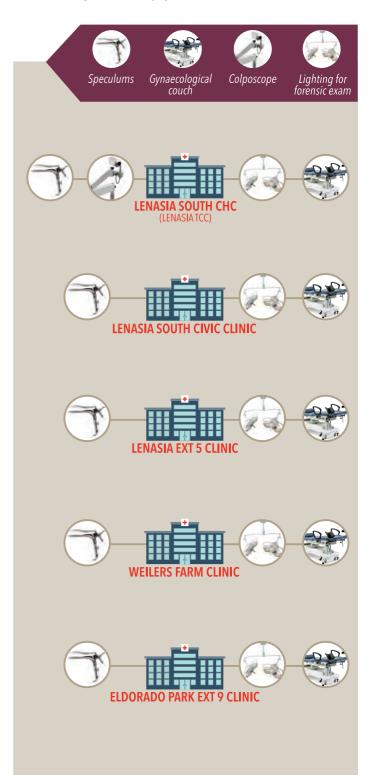
All the facilities in Region G have syringes, needles and sterile swabs, blood collection tubes, sharps containers, scales, and hand washing facilities in the exam rooms. Most have examination gloves, (82.61%), BP monitors (95.65%), lighting for forensic examinations (73.91%), and clean linen (78.26%) and patient gowns (73.91%). Only one has a colposcope (Lenasia TCC) and five have gyneacological couches (21.74%).

Medical Equipment available in Region G facilities

**MEDICAL EQUIPMENT AVAILABLE** IN REGION G FACILITIES Examination room with lockable door 100%-100%-Hand washing facility for examinations 73.91%-Gowns Clean bed linen 78.26%-Sufficient lighting for forensic examination 73.91%-21.74%-Gyneacological couch 95.65%-Speculums Colposcope 4.35% 95.65%-Blood pressure monitors Measuring boards for infants 91.30% 86.96%-Children/infant scale 95.65%-Scale and height measures for adults Sharps container 100%-Pregnancy testing kit 100%-95.65% Examination gloves 82.61%-Sterilising equipment Blood collection tubes 100%-100% Syringes, needles, swabs

Five of the 23 facilities surveyed in Region G have all or most of the equipment required to upscale their post-violence care services. An additional 17 facilities have both speculums and lighting for forensic examinations. The graph below shows the potential for scale up in Region G.

Facilities in Region G with equipment needed for PVC



### Space

Many facilities said they need additional space to conduct their work properly. This includes additional counselling rooms, and an area to conduct forensic examination as well as storage space. Victims of sexual assault are managed in normal examination rooms which lack privacy as other patients were sometimes tended to in the same room.

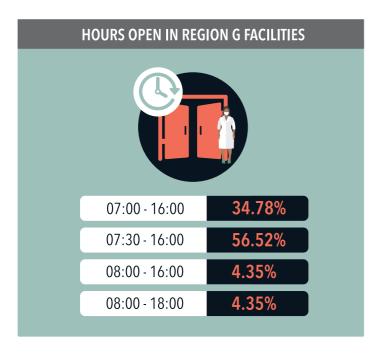


"space is a challenge" - Key informant - facilities

"Even the social worker, when she comes, she doesn't have a room to work in." – Key informant - facilities

### Days and hours of service

The majority of facilities in Region G are open from Monday to Friday (73.91%). Only one facility is open 7 days a week. None of the facilities in Region G provide a 24 hour service. Most are open from 07:30 to 16:00.



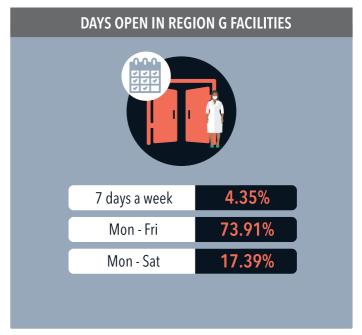
### Waiting time

Twenty-two facilities (95.65%) reported that patients wait 45 minutes or less before being helped. A key informant highlighted that waiting times increase when there is a shortage of staff.











### Accessibility

Accessibility to facilities that provide post-violence care services is an important factor in ensuring that the services are used by victims. Across regions and within regions, there are great variations in opening times, accessibility and awareness of the facilities that do provide the required services. There are victims who arrive at facilities not knowing that the facility in question does not offer forensic examination services or, there are victims who report to police stations and are consequently referred to the nearest hospital or TCC. Only one facility in Region G can provide the full package of post-violence care services as per the TCC Blueprint. Victims who are not tended to immediately have to wait with other outpatients only to be referred again to another facility. Not all victims have access to transport to attend the facilities they are referred to. Ambulances are often reserved only for those with medical emergencies.



"...the patient will jump into the transport and then they ask you how are they going to come back

- Key informant - facilities

### Psychosocial support

Many facilities mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support. A total of 47.83% facilities indicated that they can provide psychological services within the facility, but only four have a psychologist available and none have a trauma counsellor available. It is likely that psychosocial support is provided by social workers, counsellors and supporting NGOs. Twenty-two of the 23 facilities surveyed had an HCT counsellor available.



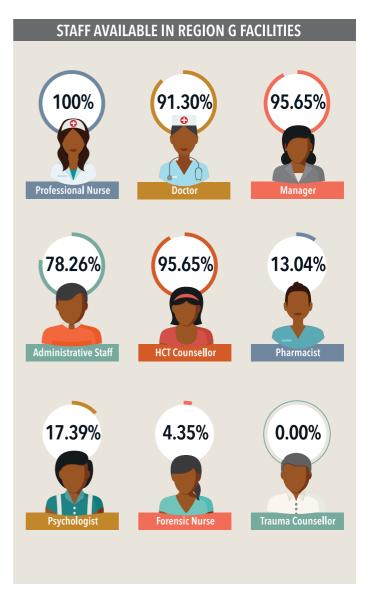
### 4.4. Factors influencing quality of services delivered

As per the discussion in Section 4.1, most facilities provide most of the necessary services required of a public health facility, and some have the ability to provide some post-violence care services. However, although the services are available, it is the quality of those services that is the challenge. The team found variation in the staff available in different facilities, victim friendliness, and issues with secondary victimisation. There were also problems with delays in service delivery, and problems with follow-up. These factors and challenges are discussed below.

### **Human resources**

### Staff available

All the facilities in Region G have professional nurses, and most have a facility manager (95.65%), doctors (91.30%) administrative staff (78.26%), and HCT counsellors (95.65%). One facility has a forensic nurse (Lenasia TCC) and none has a trauma counsellor.



### Training of staff

Only one facility reported that their staff had received refresher training in post-violence care (Lenasia South TCC). They received this training in 2016 from Eldorado Park Women's Forum.



"We need basic training for everybody, not just a specific person."

– Key informant - facilities

"We don't even know what to do when such a patient comes."

- Key informant - facilities

### Staff supervision and debriefing

Eight facilities (34.78%) reported that their facility managers are supervised, seven (30.43%) that their professional nurses are supervised, and three (13.04%) that their doctors are supervised. Four facilities (17.39%) reported that their facility manager receives debriefing, and three (13.04%) that their nurses and doctors receive debriefing.

# SUPERVISION SUPERVISION 34.78% Manager 17.39% 13.04% Debriefing 17.39% 13.04%



"the nurses are suffering from burn-out." - Key informant - facilities

### 4.5. Victim friendliness and secondary victimisation

Victim friendliness is a major challenge for facilities. Most mentioned that victims may experience secondary victimisation because the environment is not victim friendly. Auxiliary staff lack sensitivity when treating and receiving clients. Other factors that may influence victim friendliness include patient waiting time and issues of privacy. Many clients do not have access to private transport, increasing their secondary victimisation.



"They don't qualify for the ambulance." - Key informant - facilities

"....it means they have to go on their own of which somehow it's traumatising." – *Key informant - facilities* 

Some of the facilities mentioned that victims are at risk of experiencing secondary victimisation as a result of being referred to other facilities. This is especially the case with facilities who refer to other facilities that do not provide post-violence care. Lack of privacy when assisting victims may be another factor in secondary victimisation.

### 4.6.

### NGOs as service providers

Eighteen facilities (78.26%) reported that they have an NGO working with them. The following NGOs are supporting facilities in the provision of post-violence care: Eldorado Park Women's Forum (psychosocial support, awareness in the community), Ikhaya Centre (drop off shelter, counselling), Ikusasa Lethu Youth Project (drop in centre), Johannesburg Institute of Social Services (GBV, child and family care units), Ladies of Hope (counselling), Nisaa Institute for Women's Development (GBV awareness, GBV training, counselling), PUSH (psychosocial support) and Usizo Thuso Community Centre (social services, counselling). It should be investigated if these NGOs can expand their services to other regions of Johannesburg.

NGOs in Region G facilities

# ANOVA HI CO ANOVA HEALTH INSTITUTE

HIV Programme support

| CCMDT | Training

### **Eldorado Park Women's Forum**



| Psychosocial support | Awareness in the community

### Ikhaya Lothando Community Centre



| Support pregnant HIV+ women | Drop off shelter for orphans | Counselling

### Ikusasa Lethu Youth Project



HCT Counsellors
OVC drop in centre
Home-based care

### JISS (Johannesburg Institute of Social Services)



Gender-based violence Child and Family Care Units OVC support

### Jozi Ihlomile



Awareness campaigns about HIV/AIDS
Support HIV and TB programmes

### Khomanani Campaign



Distribution of HIV, TB and STI materials Distribution of condoms Support staff

### **Ladies of Hope**



Home-based care Counselling Feeding scheme

### Nisaa Institute for Women's Development



Raising public awareness about GBV Staff training Counselling

### **PUSH** (Persevere Until Something Happens)



Support HIV+ children and OVCsPsycho-social services

### Thibologa Sign Language Institution



Sign language training Interpretation service Training deaf people in computer literacy Advocating for the deaf community

### Usizo Thuso Community Centre



Support HIV+ children and OVCs
Psycho-social services

NGOs assist with providing additional services that facilities cannot provide. There were many reported benefits to having an NGO associated with facilities, including providing continuous support to clients, rallying communities together for campaigning activities, training, counselling and psychosocial support.



"Lots of ..... very in the sense that they are supporting us, relieving some of the pressure from the clinic and we working as a team. They are adding whatever advice, whatever skills they have they adding more to our skills." – Key informant - facilities

"You learn such a lot from the NGOs and the NGOs are in the community so you learn more about the community through the NGOs firstly and then it's a support system."

- Key informant - facilities



### 4.7. Overall findings of Region G

### Overall findings from Region G

OPENING TIMES		Fax machines	5 Out of 23 21.74%
Facility is open 24 hours a day	0 Out of 23 0.00%	Photocopiers	19 Out of 23 82.61%
Facility is open 7 days a week	1 Out of 23 4.35%	Printers	<b>21</b> Out of <b>23</b> 91.30%
Facility is open Monday to Friday	17 Out of 23 73.91%	Internet	14 Out of 23 60.87%
Facility is located in a permanent building	22 Out of 23 95.65%	Camera for evidence	4 Out of 23 17.39%
Facility is located in a park home	1 Out of 23 4.35%	Fans	18 Out of 23 78.26%
Average number of Sexual Offence cases per wee	k 0.95 out of 23	Air conditioner	20 Out of 23 86.96%
Average waiting time of 45 minutes	22 Out of 23 95.65%	Heater	20 Out of 23 86.96%
SERVICES PROVIDED		Fridges	23 Out of 23 100%
Medical Forensic Examination	1 Out of 23 4.35%	Microwave ovens	20 Out of 23 86.96%
Bath or shower facility	1 Out of 23 4.35%	Fire extinguishers	23 Out of 23 100%
Provision of comfort packs and clean clothes	1 Out of 23 4.35%	Lockable cabinet	<b>21</b> Out of <b>23</b> 91.30%
Statement taken by a SAPS investigating officer	1 Out of 23 4.35%	Refreshments for victims	1 Out of 23 4.35%
Psychological services	11 Out of 23 47.83%	Clean clothing	3 Out of 23 13.04%
HIV, STI and pregnancy testing	20 Out of 23 86.96%	Comfort packs	1 Out of 23 4.35%
Provision of post-exposure prophylaxis	18 Out of 23 78.26%	Toys	5 Out of 23 21.74%
Referral for HIV treatment	18 Out of 23 78.26%	Anatomically correct dolls	2 Out of 23 8.70%
Assistance with case reporting and court preparation	5 Out of 23 21.74%	IEC material	18 Out of 23 82.61%
FACILITIES AVAILABLE		Adult height and weight measures	22 Out of 23 95.65%
Private ablutions with bath or shower	1 Out of 23 4.35%	Children's scale	20 Out of 23 86.96%
Disabled-friendly ablutions	15 Out of 23 65.22%	Childrens measuring board	<b>21</b> Out of <b>23</b> 91.30%
Private room for victims to rest in	1 Out of 23 4.35%	BP monitors	<b>22</b> Out of <b>23</b> 95.65%
Waiting room	21 Out of 23 91.30%	Syringes, needles, sterile swabs	23 Out of 23 100%
Counselling office	7 Out of 23 30.43%	Blood collection tubes	23 Out of 23 100%
SAPS office	1 Out of 23 4.35%	Examination gloves	22 Out of 23 95.65%
Examination room	23 Out of 23 100%	Sharps container	23 Out of 23 100%
NGO room	2 Out of 23 8.70%	Lighting for examination	17 Out of 23 73.91%
Wheelchair ramp	21 Out of 23 91.30%	Gynaecological couch	5 Out of 23 21.74%
EQUIPMENT AVAILABLE	Z   Out of 23 / 1.30 / 0	Speculums	22 Out of 23 95.65%
	23 Out of 23 100%	Colposcope	1 Out of 23 4.35%
Computers	17 Out of 23 73.91%	Gown for victim	17 Out of 23 73.91%
Telephones	on or 23 / 3.7 1 /0	Clean bed linen	18 Out of 23 78.26%

### **STAFF** (FULL/PART TIME)

22 Out of 23 95.65% Department/ Facility Manager out of **23** 100% Professional Nurse out of **23** 4.35% Forensic Nurse out of **23** 91.30% Doctor 18 Out of 23 78.26% Administrative staff 0 out of 23 0.00% Trauma Counsellor out of **23** 95.65% **HCT** Counsellor Out of **23** 17.39% Psychologist out of **23** 13.04% Pharmacist

### REFRESHER TRAINING IN SEXUAL ASSAULT

Healthcare Staff

Non-healthcare Staff

1 out of 23 4.35%

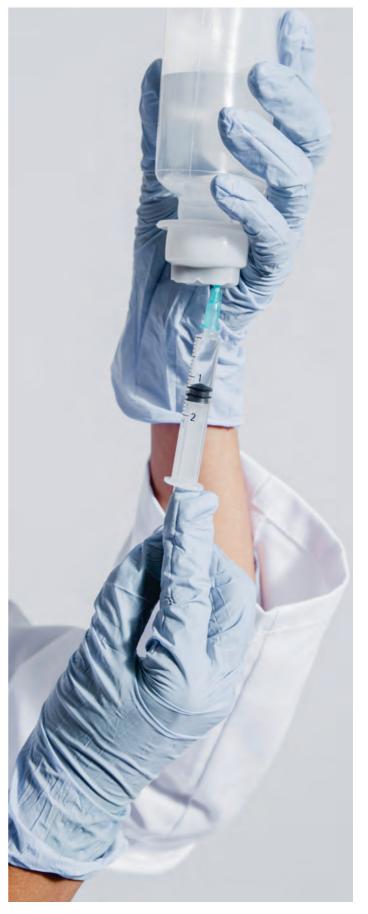
Auxiliary Staff

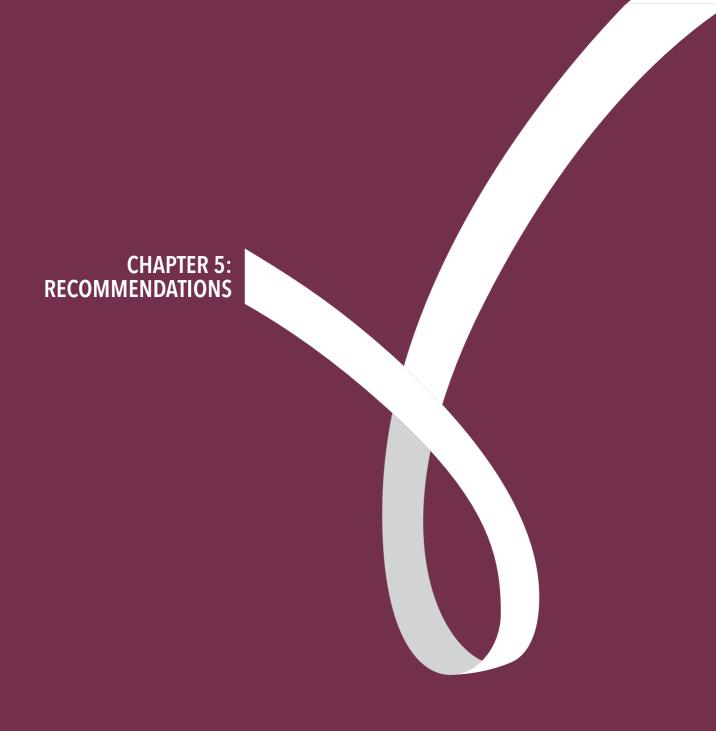
0 out of 23 0.00%

### FACILITIES WITH AN NGO

Facilities with an NGO 18 Out of 23 78.26%



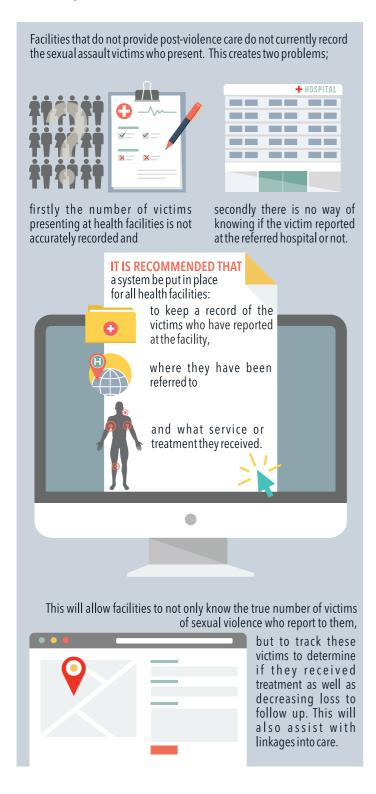


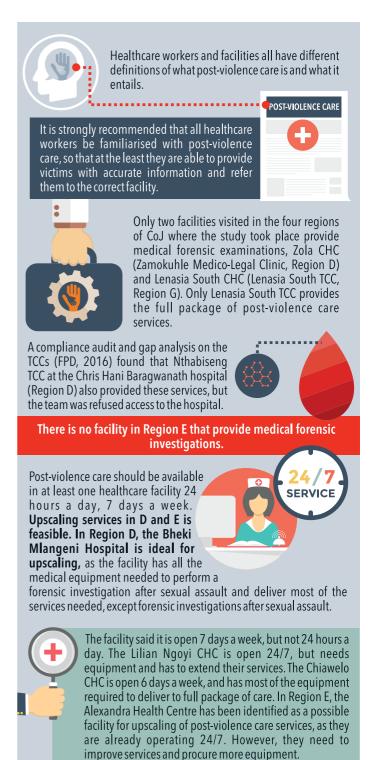


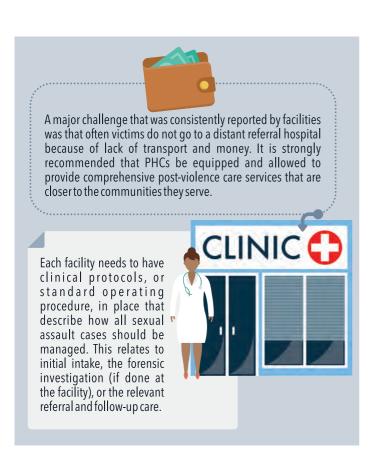
# CHAPTER 5: RECOMMENDATIONS

In order to improve the service delivery and functioning of the facilities CoJ (Regions A, D, E and G) and to investigate upscaling of the delivery of post-violence care services, the research team have a number of recommendations, structured in the same way as the findings in the previous chapter.

# Recommendations on post-violence care services



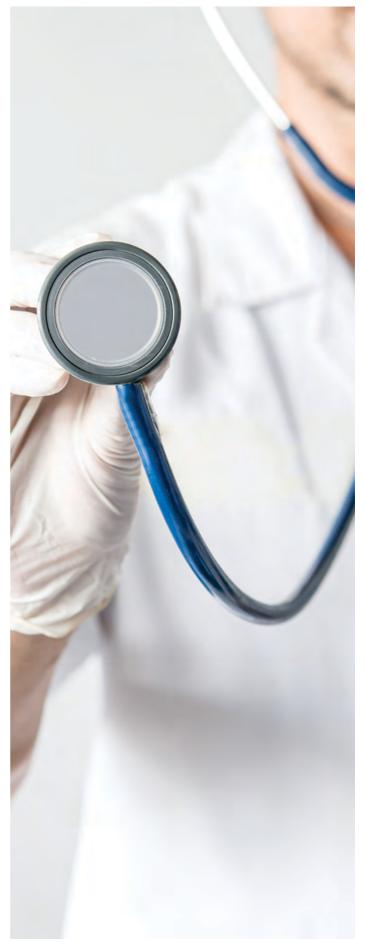




# **2.** Recommendations on referral pathways

A formal directory of post-violence care service providers should be compiled for all stakeholders, including SAPS and NGOs within the regions, to prevent people being referred to facilities that can't help them. The results of this rapid assessment and gap analysis can guide the development of such a directory. All stakeholders would need to be trained in its use.





# **3** Recommendations on facilities and sites

### 3.1. Facilities

Amajor challenge identified is that post-violence care units and TCCs often do not have their own dedicated telephone line. When a clinic phones to refer a patient they are put through to the hospitals' switchboard and very often not transferred to the correct place.

Post-violence care units and TCCs need to have their own telephone line that people can phone directly.

### 3.2. Equipment

If post-violence care services, including medical examinations, are upscaled at facilities, these facilities need be supplied with working equipment to ensure that the functioning of the facility is not limited and that post-violence services are delivered.

This includes medical examination tools (a colposcope, gyneacological couch and lighting for forensic exam) and all ICT related equipment.







### 3.3. Space



It is important that all facilities have adequate space to safeguard the privacy and confidentiality of victims.

It is preferable to have a private, separate examination room, as well as a counselling room that is used exclusively for sexual assault victims.

### 3.5. Psychosocial support



Only one facility in CoJ (Region A, D, E and G) has a trauma counsellor, and only 13 have psychologists available.

It is recommended that the NDoH, together with DSD, strengthen the capacity to deliver appropriate short-term and long-term psychosocial support to victims. This can be delivered by NGOs, but clarity is needed on the funding required.



Clear protocols are needed for the services delivered by NGOs and the services delivered by DSD staff.

At least one social worker or psychologist should be appointed per facility, to ensure long-term psychosocial support. Where this is not possible, it is recommended that the NDoH meet with DSD regarding the availability of social workers and psychologists and how to reduce waiting times for victims.





The facilities, together with the NGOs and DSD, need to track referred clients and ensure that they receive long-term psychosocial support.

The ways in which psychosocial support is provided to clients who are far removed from the facilities needs to be investigated.

It is recommended that the services be adapted for child victims to ensure a more child-centred approach and that there is better support for mentally challenged victims.



### Recommendations to improve service delivery



There is a clear need for additional training on sensitisation on sexual violence, and this must be extended to auxiliary staff members (including contracted workers such as cleaners and security guards).

The training programmes should be

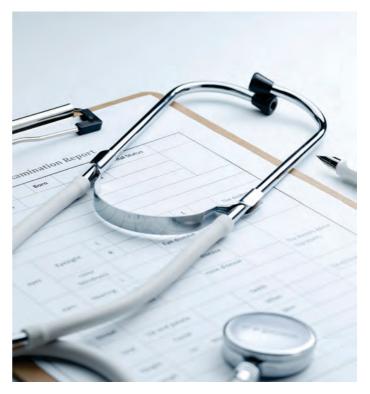




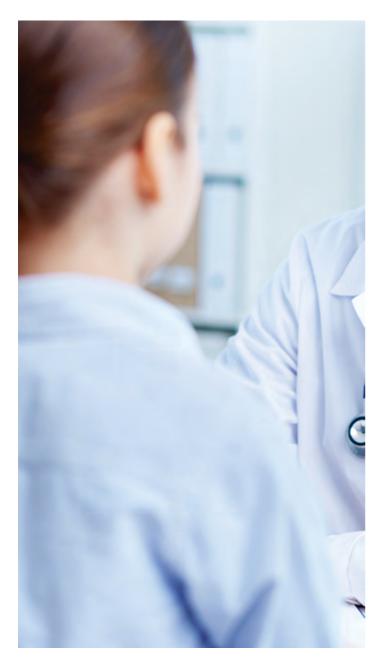
Cross-training is required with all facilities, referral providers, NGOs and CBOs, SAPS and other stakeholders. This must include



This will also provide an opportunity for different stakeholders to understand who is providing which services and the referral pathways.



### 4.2. Debriefing



All staff members involved in GBV at the facilities should receive regular, face-to-face debriefing to provide them with coping mechanisms in the environment in which they work.

There should be a better structure in place to provide emotional and psychosocial support to all staff members involved in the facilities.

This can form part of the Employee Wellness programme, but must be structured and confidential. Alternatively, facilities and other stakeholders must determine who is responsible for providing the debriefing. NGOs can assist with this, if their staff are properly trained on vicarious trauma.

### 4.3. Victim friendliness and secondary victimisation

If sexual assault victims present at the general emergency room of a facility, their care should be prioritised and they should be moved to the front of the queue (but not ahead of serious, acute medical emergencies), or to a private exam room. In addition to this, facilities must investigate ways to ensure that they minimise multiple referral points within facilities. Facilities must investigate how they can streamline services, record the case and communicate with other staff in order to reduce secondary victimisation.

The first responder at facilities must be properly trained to ensure that the victim does not have to repeat themselves frequently as they are referred within facilities.



## **5.** Recommendations on NGOs



A community mapping exercise should be conducted to determine which NGOs are involved in GBV services in all regions. This rapid assessment and gap analysis only identified the NGOs who are directly involved with facilities, and not those NGOs providing services outside facilities. This should include information about services delivered, location, population served, hours of service and referral pathways. This will enable NGOs and facilities to upscale all post-violence care, and specifically address



advocacy



community awareness



counselling services

All stakeholders, such as DoH, DSD and donors, should recognise the work that NGOs are doing and pay them appropriately.



· ·



Innovation greater efficiency

capacity development

is needed to build resilience within the NGO sector.

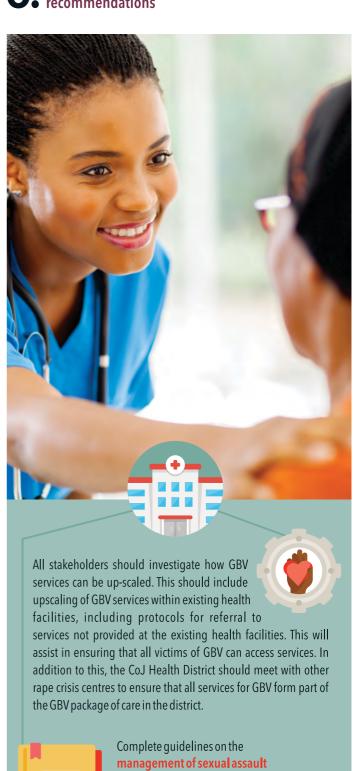


There should be better communication channels between NGOs and facilities to ensure that there is clarity on their roles and responsibilities.

There is a clear need in Regions D and E for more facilities to be linked with NGOs who can assist them with service delivery, specifically psychological support for both victims of GBV as well as facility staff.



6. Other recommendations



**GUIDELINES** 

referrals and

quidelines.

are needed. These must also integrate the

relevant health related, STI, HIV and PEP

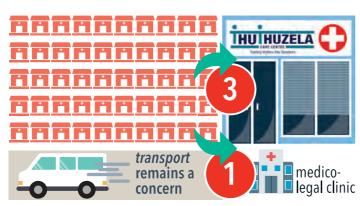


# CHAPTER 6: CONCLUSIONS

This rapid assessment and gap analysis was conducted between August 2016 and March 2017 using a mixed methods approach of key informant interviews and an application-based survey using tablets. Interviews and data collection took place between November 2016 and March 2017.



There are only three facilities in the four regions of CoJ that provide forensic investigations, and only two facilities that provide the full package of post-violence care as defined by the TCC Blueprint. There are differences in post-violence care available between regions, with regions D and G better equipped with the correct facilities, equipment and services. The findings suggest that very few facilities in CoJ (Regions A, D, E and G) are ready to upscale their post-violence care services based on the current opening hours, equipment and ability to provide psychosocial support. There is no proper record of the number of sexual assault cases reported at facilities who do not deliver post-violence care services, as these victims are referred elsewhere.



There is great concern over the referral pathways within CoJ (Regions A, D, E and G). Fifty-five facilities refer to three TCCs (Nthabiseng, Lenasia and Masakhane TCCs) and one medico-legal clinic. The remainder refer to 16 other facilities (inside and outside the regions). Many of the facilities within the region, who were part of this study, reported that they do not provide post-violence care services. Some of the facilities outside the regions might provide the required services. There is also concern about transport to the referral facilities, as many of them are far from where the victims present. This is a major issue in Regions A and E.



Most facilities have the required facilities (such as ablution facilities, examination rooms, and a wheelchair ramp) and most of the required equipment to upscale their delivery of post-violence care services. Postviolence care specific equipment such as anatomically correct dolls, comfort packs and clean clothes, colposcopes and examination lights are needed to deliver post-violence care services according to the TCC Blueprint. There are still facilities that need additional space. Many key informants highlighted the lack of adequate, private counselling space as well as private, separate examination rooms for victims of sexual assault. Most facilities reported that their clients wait less than 45 minutes for service. Many victims struggle to access post-violence care services as a result of incorrect referral pathways and because they lack access to transport. Almost half of facilities reported that they can provide psychosocial support to victims of sexual violence, but that they have limited personnel. There is only one trauma counsellor across the 73 facilities surveyed, and there are limited numbers of psychologists available.

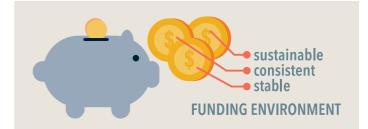
There are a number of factors that influence the quality of services delivered:



### **Human resources**

Most facilities are well staffed, although more trauma counsellors and psychologists are needed. Facilities reported that they receive regular debriefing, but key informants highlighted that this is not adequate in the very stressful and emotional work environment where these staff are working.

There are problems within the funding environment that need to be addressed. A sustainable, consistent and stable funding environment is required to ensure that the necessary services can be delivered at all facilities.





### **Training**

Only four facilities reported that they have received refresher training on managing sexual assault. There is a clear need to expand the training to include auxiliary workers and other stakeholders. If the provision of post-violence care is upscaled to more facilities additional training will be needed in the management of sexual assault and conducting a medical investigation.

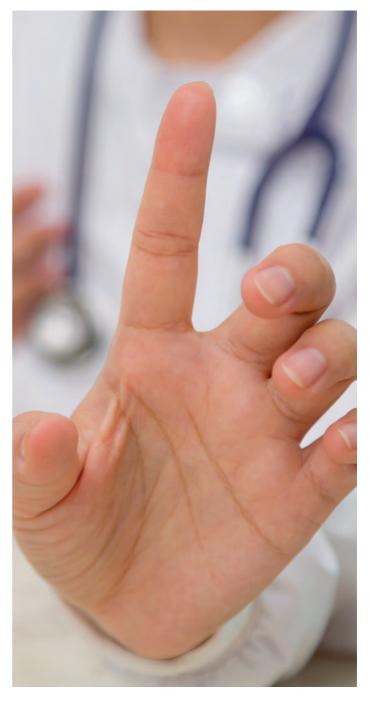


### **Victim friendliness**

Victim friendliness in the facilities is still a major problem. There is still a lot of secondary victimisation because sites are not victim friendly, SAPS staff are insensitive and counselling rooms and privacy within the facilities is inadequate. Victims often have to wait in line with other outpatients and also experience secondary victimisation when they are referred.

There are 25 NGOs who deliver services in 46.58% of the facilities in CoJ (Regions A, D, E and G). There are some problems with regards to the relationships between the NGO and DoH staff. It is important to note that the NGOs are contributing to the continuum of care for victims of sexual assault. The research team also found that although only 25 NGOs were identified working within the facilities, there are many more in all the regions who are providing additional support.





The evaluation team made a number of recommendations to improve the service delivery, the functioning of the facilities and the potential upscaling of post-violence care. The recommendations can be summarised as follows:



### Post-violence care service delivery recommendations

Facilities need to record all victims of sexual assault who present, even if they are referred to other facilities. This will ensure that follow-up care can be provided.

There are a number of facilities who are open 24/7, and they are ideally situated to upscale their post-violence care services. This should be piloted first before roll-out to other facilities.

Stakeholders need to investigate how access to transport can be improved when victims are referred to other facilities.



### **Facility and site recommendations**

Telephones dedicated to units who deliver post-violence care services in facilities are needed.

In the case of upscaling of post-violence care services, additional medical equipment will be needed.

Facility managers should investigate the possibility of a dedicated examination room and counselling room for victims of sexual assault.

Short- and long-term psychosocial support to victims is needed. DoH, DSD and the NGOs need to investigate ways to improve this.



### Referral pathways recommendations

A referral directory for facilities who cannot provide post-violence care services should be developed.

All stakeholders, including SAPS, NGOs and CBOs need to be trained in the use of such a referral directory.



### Improvement of service delivery recommendations

Refresher training, training on the management of sexual assault and how to conduct a forensic investigation is required.

All stakeholders must be involved in training (DoH staff, DSD, SAPS as well as NGOs and CBOs working in the regions).

There is a clear need for post-violence care services to be upscaled in CoJ. It is clear that some facilities have the potential for upscaling, and where this is not possible, proper referral is required. The team believes that if the recommendations are adhered to all post-violence care services in the CoJ will be strengthened.



### **NGO** recommendations

Stakeholders must conduct a community mapping exercise to understand which other post-violence care services are delivered in the area and widen the support for victims.

NGOs need to be recognised for the services they provide and should be adequately remunerated.

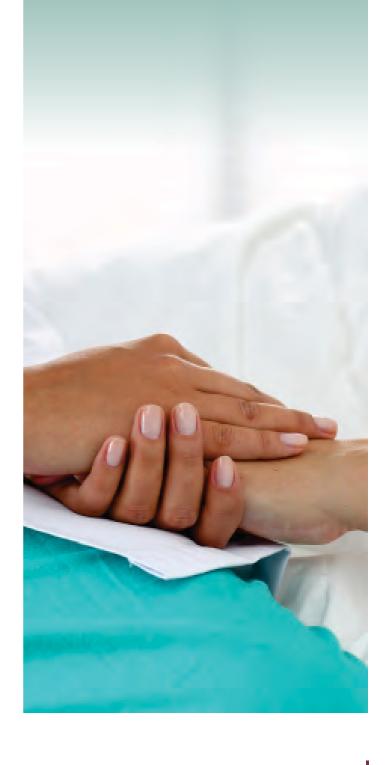
Communication channels between NGOs and facilities need to be improved.



### Other recommendations

New, inclusive guidelines need to be developed for the management of sexual assault in South Africa.

All stakeholders need to investigate how GBV services can be upscaled. This should include upscale of GBV services within existing health facilities. In addition to this the model should be linked with the other existing rape crisis centres and Kgomotso Care Centres.





### REFERENCES

- 1. Abrahams, N., Jewkes, R., Laubscher, R. (1999). I do not believe in democracy in the home. Men on relationships with and abuse of women. Medical Research Council Technical Report, Medical Research Council, Tygerberg.
- 2. Abrahams, N., Mathews, S., Jewkes, R., Martin, L., and Lombard, C. (2012). Every eight hours: Intimate femicide in South Africa 10 years on. Cape Town, The South African Medical Research Council.
- 3. Bennett J. (2010). Circles and circles: Notes of African feminist debates around gender and violence in the c21, Feminist Africa Issue 14, pp.21-48.
- 4. Bloom SL. (2008). **Domestic Violence. Encyclopaedia of Gender and Society**. SAGE.
- 5. Brahmbhatt, H. et al, 2014. 'Prevalence and determinants of adolescent pregnancy in urban disadvantaged settings across five cities'. **The Journal of Adolescent Health**. Vol 5 p45 57
- 6. Centre for the Study of Violence and Reconciliation (CSVR) (n.d.). (accessed 3 October 2016). http://www.csvr.org.za/wits/gender/directory/kwazulu/COUNSELLING%20SERVICES%20ETHEKWINI.htm
- 7. Coie, JD., Watt NF., West, SG., Hawkins JD., Asarnow JR., Markman HJ., Ramey SL., Shure MB., and Long B. (October 1993). The Science of Prevention: A conceptual framework and some directors for a national research program, **American Psychologist**, Volume 48, Number 10, pp 1013-1022.
- 8. Commission for Employment Equity. (2014). 14<sup>th</sup> Commission for Employment Equity. Annual Report 2013-2014. South Africa. Department of Labour, Chief Directorate of Communication.
- 9. Christofides, N.J., Webster, N., Jewkes, R.K., Loveday, P., Martin, L.M, Abrahams, A., Kim, J. (2003). **The state of sexual assault services: Findings for a situation analyses of services in South Africa.** Centre for Health Policy School of Public Health: University of Witwatersrand
- 10. Christofides, NJ., Jeweks, RK., Bester N., Loveday P., Abrahams N., and Martin LJ. (2005). Other patients are really in need of medical attention: the quality of health services for rape survivors in South Africa. **Bulletin of the World Health Org** 83(7): 495-502.
- 11. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007
- 12. Curran, R., Zengele, B., and Mukamana, S. (2013). **Breaking the silence. A needs assessment of survivors of sexual violence in KwaZulu Natal, South Africa**. Report commissioned by Tearfund.
- 13. Davis R. (22 August 2013). **Analysis: Gender-based violence and the South African woman's other problems**, Daily Maverick. http://www.dailymaverick.co.za/article/2013-08-22-analysis-gender-based-violence-and-the-sa-womens-other-problems/
- 14. Department of Health (DoH) (2003). National Management Guidelines for Sexual Assault. Pretoria: Department of Health
- 15. Department of Health (DoH) (2014). Saving Mothers 2011-2013: Sixth Report on confidential enquiries into maternal deaths in South Africa. Compiled by the National Enquiry into Maternal Deaths.
- 16. Department of Justice and Constitutional Development (2013). **Report on the re-establishment of sexual offences courts**. Ministerial Advisory Task Team on the Adjudication of Sexual Offence Matters. http://www.justice.gov.za/reportfiles/other/2013-sxo-courts-report-aug2013.pdf
- 17. Department of Justice and Constitutional Development (2014). **National Task Team on Gender and Sexual Orientation-based Violence Perpetrated on LGBTI persons.** http://www.justice.gov.za/vg/lgbti/2014-LGBTI-CommStrategy.pdf
- 18. Department of Social Development, 2014. **South African integrated programme of action: Addressing Violence Against Women and Children** (2013-2018). Department of Social Development: Pretoria
- 19. Department of Women, children and people with disabilities (Minister Lulu Xingwana). (22 April 2013). **Presentation on the National Council of Gender-Based Violence and its priority programmes**, at a Joint meeting of the multi-party women's caucus.
- 20. DREAMSa, n.d. Innovation challenge brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
- 21. DREAMSb, n.d. Strategic Plan: DREAMS. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
- 22. Foundation for Professional Development (FPD). (2016). Thuthuzela Care Centres Compliance Audit and Gap Analysis. FPD, Pretoria.
- 23. Gauteng Department of Health, (2016). All Gauteng clinics. http://www.health.gpg.gov.za/hospitals/Pages/default.aspx
- 24. Gauteng Government, n.d. Victim Empowerment. http://www.gautengonline.gov.za/Residents/Documents/victim\_empowerment\_booklet.pdf
- 25. Gauteng Tourism (n.d.) Gauteng Tourism fact sheets. http://www.gauteng.net/resources/factsheets/general-facts
- 26. Herstad, B. (2009). **Gender-related Barriers to HIV Prevention Methods: A Review of Post-exposure Prophylaxis (PEP) Policies for Sexual Assault.** Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.
- 27. Human Sciences Research Council. (2014). The City of Johannesburg (COJ) Economic Overview: 2013 A Review of the State of the Economy and other Key Indicators. HSRC: Pretoria
- 28. Hwenha, S. (2014). **Reframing interventions to end gender-based violence in South Africa: Lessons learnt from CSI-funded programmes**. Prepared for First Rand by Tshikululu Social Investments: Johannesburg
- 29. Institute for Security Studies. (2011). South African Police Services, Crime Report for 2010/11. Pretoria
- 30. ISS Crime Hub. (2014). **Explaining the official crime statistics for 2013/14.** http://www.issafrica.org/uploads/ISS-crime-statistics-factsheet-2013-2014.pdf
- 31. Jewkes R. (not-dated). GBV prevention: are we getting any closer?, Gender and Health Research Unit, Medical Research Council. Pretoria.
- 32. Jewkes, R., Dunkle, K., Nduna, M., and Shai, N. (2010). Intimate partner violence, relationship power inequity, an incidence of HIV infection in young women in South Africa: A cohort study. **The Lancet**, vol. 376, no. 9734: 41-48.
- 33. Jewkes, R. (2012). Rape perpetration: A review. Pretoria, Sexual Violence Research Initiative.

- 34. Johnston, H. (2014). **Voting for Change? Women and Gender Equality in the 2014 South African Elections**. Johannesburg: Heinrich Böll Stiftung, Southern Africa.
- 35. Keesbury, J. and Thompson, J. (2010) A step-by-step guide to strengthening sexual violence services in public health facilities: Lessons and tools from sexual violence services in Africa. This publication was produced for review by the United States Agency for International Development.
- 36. Keesbury, J. and Askew, I. (2010). Comprehensive responses to gender based violence in low-resource settings: Lessons learned from implementation. Lusaka: Population Council
- 37. Keesbury, J. and Elson, L. (2010). PEPFAR special initiative on sexual and gender-based violence: Final evaluation. Lusaka: Population Council.
- 38. Kilonzo, N., NdungGÇÖu, N., Nthambur, i N., Ajema, C., Taegtmeyer, M., Theobald, S., et al. (2009). Sexual violence legislation in sub-Saharan Africa: the need for strengthened medicolegal linkages. **Reproductive Health Matters**. 17(34):10-19
- 39. Kilonzo, N., Dartnall, E., and Obbayi, M. (2013). **Briefing paper: Policy and practice requirements for bringing to scale sexual violence services in low resources settings**. LVCT and SVRI. LVCT, Mairibi, Kenya.
- 40. Kim, J. and Motsei, M. (2002). 'Women enjoy punishment': attitudes and experiences of gender-based violence among PHC nurses in rural South Africa, **Social Science and Medicine** 54, pp 1243-1254.
- 41. Koraan, R. and Geduld, A. (2015). **Corrective rape of lesbians in the era if transformative constitutionalism in South Africa**. Potchefstroom Electronic Law Journal. (18)5
- 42. Krug, EG., Mercy, JA., Dahlberg, LL., and Zwi, AB. (October 2002). **The World Report on Violence and Health**, The Lancet, Volume 360(9339): 1083-1088
- 43. Machisa, M., Jewkes, R., Lowe-Morna, C., Rama, K. (2011). **The war at home: Gender Based Violence Indicators Project**, Gender Links: Johannesburg
- 44. Malama, G., 2016. Girls challenge access to contraceptives at Johannesburg clinics. Teen Voices: Womensenews.org
- 45. Matthews S. (December, 2013). **Presentation to the FNB Roundtable Discussion**. Johannesburg.
- 46. McCoy, D. and Bamford, L. (1998) **How to conduct a rapid situation analysis: A guide for health districts in South Africa**. Published by Health Systems Trust: Durban.
- 47. Medical Research Council (MRC). (2010). The 2nd South African National Youth Risk Behaviour Survey
- 48. Mpani, P. and Nsibande, N., Tshwaranang Legal Advocacy Centre (2015). **Understanding gender policy and gender-based violence in South Africa. A literature review.** For Soul City: Institute for Health and Development Communication
- 49. Musariri L., Nyambo V., Machisa M. (2013). The Gender Based Violence Indicator Study. KwaZulu-Natal. Gender Links. South Africa
- 50. National Prosecuting Authority (NPA) n.d. Thuthuzela Care Centres. Revised Blueprint.
- 51. NACOSA (2015). **Guidelines and recommended standards for the provision of support to rape survivors in the acute stage of trauma**. Published by NACOSA with support from the Global Fund to Fight AIDS, Tuberculosis & Malaria.
- 52. National Planning Commission. (2011). **Diagnostic report**. Pretoria.
- 53. National Planning Commission. (2010). **Development Indicators**. Pretoria.
- 54. OCHA(UN). (2008). **Use of Sexual Violence in Armed Conflict: Identifying Gaps in Research to Inform More Effective Interventions**. UN OCHA Research Meeting 26 June 2008 OCHA Policy Development and Studies Branch 20 June 2008. Discussion Paper 1 Sexual Violence in Armed Conflict: Understanding the Motivations.
- 55. Parliamentary Research Unit. (2013a). Statistics and figures relating to Violence Against Women in South Africa. Submission to Parliament.
- 56. Parliamentary Research Unit (2013b). Legislation relation to violence against women in South Africa and the challenges relating it its implementation and success. Submission to Parliament.
- 57. Peacock, D. and Levack, A. (2004). The Men as Partners Programme in South Africa: Reaching men to end gender-based violence and promote sexual and reproductive health. International Journal of Men's Health, 3(3) pp. 173 188
- 58. Pettifor, A., Rees, H., Stevens, A., Hlongwa-Madikizela, L., MacPhail, C., Vermaak, K., et al. (2004). **HIV & sexual behaviour among young South Africans: A national survey of 15-24 year olds.** Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.
- 59. Presidency, sponsored by UNICEF (2009). Situation analysis of children in South Africa. The Presidency, Republic of South Africa.
- 60. Presidency (Office of the Rights of the Child) and sponsored by UNICEF. *DREAMS innovation challenge* brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
- 61. PricewaterhouseCoopers. (2013). **PwC's fifth edition of the Executive Directors' Remuneration Practices and Trends Report: South Africa 2013**, https://businesstech.co.za/news/general/42427/pay-in-south-africa-men-vs-women/
- 62. RAPCAN and MRC. (nd). Service responses to the co-victimisation of mother and child: missed opportunities in the prevention of domestic violence. Cape Town.
- 63. Rape Crisis Cape Town Trust. (2013). **Challenges and Successes in Addressing Violence Against Women**. Presentation to the Parliamentary Portfolio Committee on Women, Children, Youth and Persons with Disabilities. Cape Town.
- 64. Rasool, S., Vermaak, K., Pharoah, R., Louw, A. and Stavrou, A. (2003) **Violence against women: A national Survey.** Institute for Security Studies. https://www.issafrica.org/research/books/violence-against-women.-a-national-survey-s-rasool-k-vermaak-r-pharoah-a-louw-a-stavrou
- 65. RTI (2012). Final compliance audit of 23 Thuthuzela Centres. Pretoria: USAID

- 66. Saldaña, J. (2009). The coding manual for qualitative researchers. London: SAGE.
- 67. Sonke Gender Justice Network, (2013). **Detailed policy report for South Africa: Engaging Men in GBV and HIV prevention, SRHR promotion, parenting and LGBTI rights.** www.genderjustice.org.za/resources
- 68. Sonke Change Trail (2016). **Men's use of violence against women: Urgent change is needed in Diepsloot.** A Wits-Sonke Project. *Whatworks.co.za*
- 69. South African Human Rights Commission. (2015). **Equality Report**. Johannesburg.
- 70. South African Human Rights Commission. (2010). Section 184(3) Report 2006-2009. Johannesburg.
- 71. South African Human Rights Commission. (2014). Report on the Right to Access Sufficient Water and Decent Sanitation. Johannesburg.
- 72. South African Human Rights Commission. (n.d). Report on Children's Rights to an Adequate Standard of Living. Johannesburg
- 73. South African Police Service (n.d). Victim empowerment service in the South African Police Service. http://www.saps.gov.za/resource\_centre/women\_children/amended\_victim\_empo\_service.pdf
- 74. Statistics South Africa (2011). Census 2011. Municipal Fact Sheet. Statistics South Africa.
- 75. Statistics South Africa (2012) Social profile of vulnerable groups in South Africa 2002 to 2012, Report number 03-19-00.
- 76. Statistics South Africa (2013). **Gender Statistics in South Africa, 2011**. Stats SA, Pretoria.
- 77. SWEAT (2012). Beginning to Build the Picture: South African national survey of Sex workers' knowledge, experiences and behaviour. Cape Town: SWEAT
- 78. SWEAT (2004). Work wise: Sex worker handbook on human rights, health and violence. Cape Town: SWEAT.
- 79. Tearfund. (2013). Breaking the silence. The role of the church in addressing sexual violence in South Africa. Tearfund.
- 80. UNICEF.(n.d.) Thuthuzela Care Centres http://www.unicef.org/southafrica/hiv\_aids\_998.html
- 81. United Nations. (2015). Sustainable Development Goals. http://www.un.org/sustainabledevelopment/gender-equality/
- 82. Vetten, L. (2014a). Rape and other forms of sexual violence in South Africa. Institute for Security Studies. Policy Brief 72
- 83. Vetten, L. (2014b). Evaluation synthesis Violence. Gauteng Provincial Government: Johannesburg.
- 84. Vogelman, L. and Eagle. G. (1991). Overcoming Endemic Violence Against Women. Social Justice. Vol. 18. No. 1 to 2. P. 209 to 229
- 85. Watson, J. 2015. The role of the state in addressing sexual violence: Assessing policing service delivery challenges faced by victims of sexual offences. APCOF Policy Paper No 13
- 86. Weideman, M. (2008). **Report on the National Quantitative Study on the Nature and Prevalence of Domestic Violence in South Africa**, conducted for Development Research Africa on behalf of the National Department of Social Development.
- 87. Weideman, M. (2011). **16 Days of activism: objectification of women, alcohol use and domestic violence in South Africa**. Polity. http://polity.org.za/article/16-days-of-activism-objectification-of-women-alcohol-use-and-domestic-violence-in-south-africa-2011-12-02
- 88. Weideman, M. (2014). Qualitative assessment of institutional factors influencing the implementation of the Domestic Violence Act no. 116 of 1998, and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. For Tswaranang Legal Advocacy Centre.
- 89. Western Cape Government: Department of Social Development. (2014). **An evaluation of the Victim Empowerment Programme**. Conducted by the Gender Health and Research Unit at the University of the Western Cape.
- 90. Wekerle, C. & Wolfe, D. A. (1999). Dating violence in mid-adolescence: theory, significance and emerging prevention initiatives, **Clinical Psychology Review**, Vol. 19, pp. 435-456
- 91. World Health Organisation (n.d.). **Violence against women and HIV/AIDS: Critical intersections. Violence against sex workers and HIV prevention**. Information Bulleting Series, No. 3. A UNAIDS Initiative. The Global Coalition on Women and AIDS. http://www.who.int/gender/documents/sexworkers.pdf
- 92. World Health Organisation. (2002a). Injuries and Violence Prevention Department, Guide to United Nations Resources and Activities in the Prevention of Interpersonal Violence. Geneva, Switzerland.
- 93. World Health Organisation. (2002b). **Sexual violence. In: World report on violence and health.** Geneva, World Health Organization, 2002:149–181. Edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano.
- 94. World Health Organisation. (2003). Guidelines for medico-legal care for victims of sexual violence. Geneva.
- 95. World Health Organisation. (2005) **WHO multi-country study on women's health and domestic violence against women: prevalence, health outcomes and women's responses**. Geneva: Switzerland.
- 96. World Health Organisation (2014). Global status report on violence prevention. World Health Organisation: Geneva





