# Rapid assessment and gap analysis: Post-violence care services at public health facilities in **UMkhanyakude** (Hlabisa and Mtubatuba)

A **DREAMS** INITIATIVE

Conducted by
Foundation for Professional Development

March 2017

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## Acknowledgements

The team wishes to express their gratitude to all the key informants and facility managers who were willing to spare their time and share their experiences and insights with us. We believe that this rapid assessment and gap analysis will go a long way towards contributing to the provision of post-violence care to victims of violence.


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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 |
| **CEDAW** | Convention for the Elimination of all forms of Discrimination Against Women |
| **CGE** | Commission for Gender Equality |
| **CHC** | Community Health Centre |
| **CSO** | Civil Society Organisation |
| **DoH** | Department of Health |
| **DoJ** | Department of Justice |
| **DREAMS** | Determined, Resilient, Empowered, AIDS-free, Mentored, Safe |
| **DSD** | Department of Social Development |
| **DVA** | Domestic Violence Act |
| **FCS** | Family Violence, Child Protection and Sexual Offences Unit |
| **FPD** | Foundation for Professional Development |
| **GBV** | Gender-based violence |
| **GNP** | Gross National Product |
| **HIV** | Human immunodeficiency virus |
| **IDP** | Integrated Development Plan |
| **iMMR** | Institutional Maternal Mortality Ratio |
| **IP** | Implementing partner |
| **ISS** | Institute for Security Studies |
| **KZN** | KwaZulu-Natal |
| **LGBTI** | Lesbian, gay, bisexual, trans and intersex persons |
| **MRC** | Medical Research Council |
| **NACOSA** | Networking HIV & AIDS Community of South Africa |
| **NGO** | Non-governmental organisation |
| **NHRD** | National Health Research Database |
| **NPA** | National Prosecuting Authority |
| **OCHA** | UN Office of the Coordination of Humanitarian Affairs |
| **PEP** | Post-exposure prophylactics |
| **PEPFAR** | US President's Emergency Plan for AIDS Relief |
| **PEPUDA** | Promotion of Equality and Prevention of Unfair Discrimination Act |
| **PHC** | Primary Healthcare centre |
| **PwC** | PricewaterHouseCoopers |
| **RAPCAN** | Resources Aimed at the Prevention of Child Abuse and Neglect |
| **SADC** | Southern African Development Community |
| **SAHRC** | South African Human Rights Commission |
| **SAPS** | South African Police Service |
| **SDG** | Sustainable Development Goals |
| **SOA** | Sexual Offences Act |
| **Stats SA** | Statistics South Africa |

| | |
|---|---|
| **STI** | Sexually transmitted infection |
| **SV** | Sexual violence |
| **SWEAT** | Sex Worker Education and Advocacy Task Force |
| **TB** | Tuberculosis |
| **TCCs** | Thuthuzela Care Centre |
| **VECs** | Victim Empowerment Centre |
| **VEP** | Victim Empowerment Programme |
| **VSCs** | Victim Support Centres |
| **UN** | United Nations |
| **UNCRC** | United Nations Convention of the Rights of the Child |
| **UNEG** | United Nations Evaluation Group |
| **UNICEF** | United Nations Children's Fund |
| **UNPF** | United Nations Population Fund |
| **WHO** | World Health Organisation |

# EXECUTIVE SUMMARY

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## Background

This rapid assessment and gap analysis of post-violence care services at public health facilities in UMkhanyakude (Hlabisa and Mtubatuba) is grounded in the DREAMS initiative. The DREAMS (**D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored, **S**afe) initiative aims at reducing HIV infections among adolescent girls and young women in ten sub-Saharan African countries, of which South Africa is one (DREAMSa, n.d.).[1] 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 annually, which is the equivalent of around 1 000 girls daily (DREAMSa, n.d.). This means that nearly half of all new HIV infections in 2014 among adolescent girls and young women were in the ten DREAMS countries (DREAMSa, n.d.).

HIV-prevention among adolescent girls and young women has generally positive outcomes for their lives in terms of educational attainment, wellbeing and health and overall development. The DREAMS initiative draws on evidence-based approaches to HIV prevention and is holistic in that the approach considers factors outside health that increases vulnerability to HIV infection. These include structural drivers such as poverty, gender inequality and sexual violence (DREAMSb, n.d.). DREAMS is implemented with support from the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill & Melinda Gates Foundation, and Girl Effect (DREAMSa, n.d.).

**380 000**

**adolescent girls and young women are infected with HIV every year**

**1 000** **girls every day**

[1]The other nine countries are Kenya, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

In the DREAMS initiative the Foundation for Professional Development (FPD) is a technical assistance partner to the following:

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

As a component of the technical assistance provided, FPD conducted a rapid assessment and gap analysis of public healthcare facilities in UMkhanyakude: Hlabisa and Mtubatuba.

## Purpose

The purpose of this rapid assessment and gap analysis is 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 focuses on all the components related to the functioning of post-violence care services at public health facilities in UMkhanyakude: Hlabisa and Mtubatuba. It assess the quality of services provided, the equipment at facilities, the staffing and qualifications of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working within the facility.

The rapid assessment and gap analysis results are intended to contribute to the improvement of the services delivered at facilities. They are intended to contribute to better informed decision-making about 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, increase secondary school enrolment, attendance and completion and to decrease HIV risk.

## Methodology

The rapid assessment and gap analyses assessed the provision of post-violence care at all 18 public health facilities in Hlabisa and Mtubatuba.

The study was conducted in three phases. Phase one involved conducting a desk review and situational analysis, the second phase was field work and data collection, and the third phase was reporting.

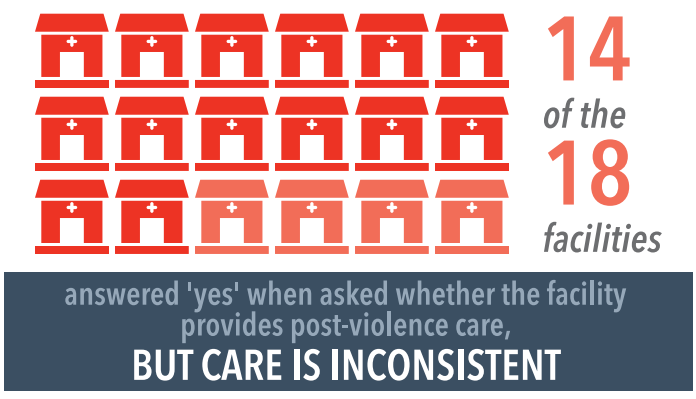

Data collection at facility-level consisted of a check-list completed by the facility manager with the assistance of a data collector to answer questions about the provision of post-violence care at the facility, as well as broader questions about equipment and staffing. An application (ODK App) and survey tool was developed in collaboration with Medical Practice Consulting, who use 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.

This data were supplemented with short semi-structured interviews with facility managers to explore some of their answers in more detail. In addition, where possible, short interviews took place with the NGOs supporting the facilities in order to better understand their roles. Where relevant, interviews were also conducted with NGOs not specifically supporting the facilities but working in the field of gender-based violence more generally. All interviews were thematically analysed and the findings integrated with those from the facility survey.

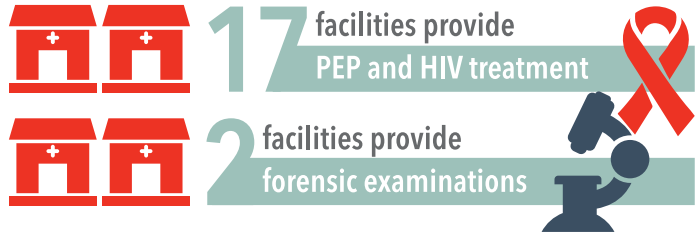
The study was conducted between September 2016 and February 2017.


## Major findings

The data illustrate that interviewees at facilities had different assessments or definitions of what post-violence care entails and who they should be providing these services to. Although 14 of the 18 facilities (77.78%) answered 'yes' when asked whether the facility provides post-violence care, some were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations, for example. Additionally, all of the facilities in the sample are able to provide some services, such as HIV testing, but some don't provide this service to victims of sexual violence because their understanding is that they should first refer victims in order not to interfere with the collection of evidence.




Two facilities reported that they perform medical forensic examinations – Mtubatuba Clinic and Hlabisa Hospital (during the district session). None of the facilities in Hlabisa and Mtubatuba provide the full package of post-violence care services. All of the facilities provide HIV testing, and 17 (94.44%) can provide PEP and HIV treatment, which means that these services are potentially available to victims of sexual violence at all facilities irrespective of their ability to provide the full package of care.




All of the facilities in Hlabisa and Mtubatuba refer victims to Hlabisa Hospital. Hlabisa Hospital reported that they only provide medical forensic examinations during the district session, and they do not provide the full package of post-violence care. A major barrier to accessing care is that many victims do not have the resources (money and transport) to travel to the hospital.

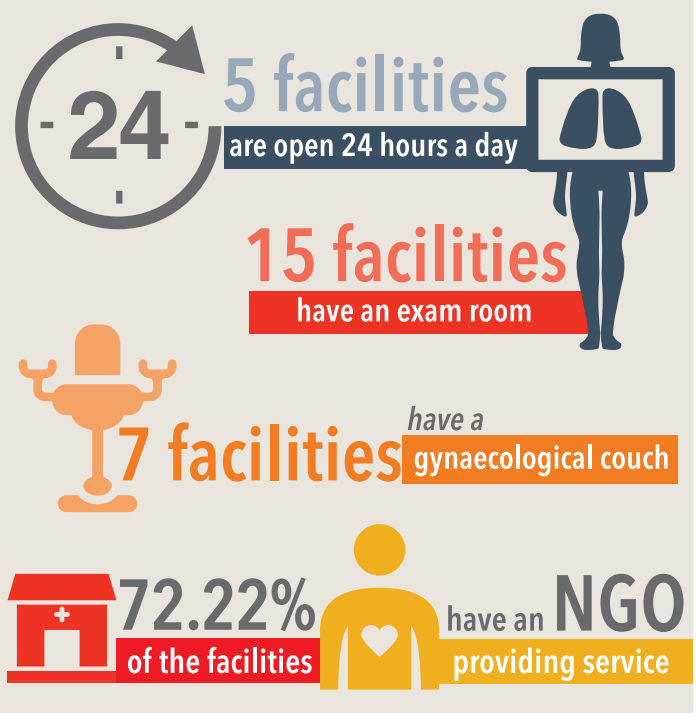
Although only five facilities (27.87%) are open 24 hours a day, nearly all are open 7 days a week, which shows potential for upscale as post-violence care should ideally be available to victims 24/7. Facilities are in need of additional space and there is a lack of adequate, private counselling space as well as private, separate examination rooms for victims of sexual assault. Seventeen (94.44%) facilities in Hlabisa and Mtubatuba have an HCT room and 15 (83.33%) have an exam room. Only seven (38.89%) have a waiting room with seating.

Facilities also need specific equipment to provide post-violence care such as anatomically correct dolls, comfort packs and clean clothes, colposcopes and examination lights to deliver post-violence care services according to the TCC Blueprint. Seventeen (94.44%) facilities have a speculum (or non-disposable speculums), three (16.67%) have a colposcope and seven (38.89%) have a gynaecological couch.

The data also illustrated staffing gaps in relation to forensic nurses, trauma counsellors and psychologists. There was also no indication of victims being tracked over time and being provided with the longer-term psychosocial support that they need.

Refresher training on the provision of post-violence care is necessary for all healthcare staff, and lack of training together with limitations of space and equipment affect the victim-friendliness of facilities.

Thirteen facilities (72.22%) reported that they have an NGO providing services. However, none of these relate directly to the provision of post-violence care. It is important to note that NGOs could be contributing to the continuum of care for victims of sexual assault and this potential relationship should be explored.




## Recommendations

The evaluation team made a number of recommendations to improve the delivery of post-violence care:

### General

Familiarise all healthcare staff at facilities with what is entailed in post-violence care.

Equip and allow all PHCs to provide post-violence care as distance from Hlabisa hospital is a barrier to care.

Identify facilities for upscaling and provide them with training, space and equipment.

The full package of post-violence care should be available 24/7 at one facility per sub-district, and facilities that are already open 24/7 could be considered for upscaling.

### Staffing

Staffing gaps identified relate to forensic nurses, trauma counsellors and psychologists.

It is necessary for facilities, NGOs and DSD to track referred clients to ensure they receive long-term psychosocial support.

## Space and equipment

Facilities have limited space inside the clinic, and do not have equipment such as a colposcope, gyneacological couch and lighting for forensic examinations and should be provided with this.

Facilities should have a private, separate examination room and counselling room to safeguard the privacy and confidentiality of victims.

## Community interventions

Awareness-raising around gender-based violence should be done in the community.

## Referral pathways

A system should be put in place for all health facilities to keep a record of the victims who have reported to the facility, where they have been referred and what service or treatment they received.

A directory of post-violence care service providers needs to be started for all stakeholders, including SAPS, to prevent people being referred to facilities that cannot help them.

## NGOs

Some NGOs at facility level already provide some form of counselling or psychological support in relation to HIV and how they can be drawn upon and equipped to provide psychological support to victims of sexual violence needs to be explored.

**There is a clear need for post-violence care services to be upscaled in Hlabisa and Mtubatuba. It is clear that some facilities have the potential for upscaling. The team believes that if the recommendations are adhered to all post-violence care services in the Hlabisa and Mtubatuba will be strengthened.**

# CHAPTER 1: INTRODUCTION AND OBJECTIVES

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

This rapid assessment and gap analysis of post-violence care services at public health facilities in UMkhanyakude (Hlabisa and Mtubatuba) is grounded in the DREAMS initiative. 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 (DREAMSa, n.d.).[2] 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 annually, which is the equivalent of around 1 000 girls daily (DREAMSa, n.d.). This means that nearly half of all new HIV infections in 2014 among adolescent girls and young women are found in the ten DREAMS countries (DREAMSa, n.d.).

The DREAMS Strategic Plan comments on some of the reasons behind these high levels of infection:

> *"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, and school drop-out all contribute to girls' vulnerability to HIV." (DREAMSb, n.d: 1)*

HIV-prevention among adolescent girls and young women has more general positive outcomes for their lives in terms of educational attainment, wellbeing and health and overall development. The DREAMS initiative draws on evidence-based approaches to HIV prevention and considers factors other than health that increase vulnerability to HIV infection. These include structural drivers such as poverty, gender inequality and sexual violence (DREAMSb, n.d.). DREAMS is implemented with support from the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill & Melinda Gates Foundation, and Girl Effect (DREAMSa, n.d.).

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[2] The other nine countries are Kenya, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

The core interventions are linking post-violence care services to clients, and training of professionals working with clients of gender-based violence (DREAMSb, n.d.).

This study focuses directly on one of the structural drivers, sexual violence, that increase young women's risk of HIV infection. The rapid assessment and gap analysis looks specifically at the post-violence care that women are able to access at public health facilities in UMkhanyakude: Hlabisa and Mtubatuba, as these are the areas that MatCH Systems works in and for which FPD has a mandate to conduct a rapid assessment.

## 2. Purpose of the rapid assessment and gap analysis

The purpose of this rapid assessment and gap analysis is 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 focuses on all the components related to the functioning of these services at public health facilities in UMkhanyakude: Hlabisa and Mtubatuba. It assess the quality of services provided, the equipment at facilities, the staffing and qualifications of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working within the facility.

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## 3. Objectives of the rapid assessment and gap analysis

- To assess all health facilities to identify where post-violence care services are available
- To assess the health facilities' care against a comprehensive package of post-violence care services as per the NACOSA minimum standards, or similar provincial standards
- To assess if the health facilities are adequately staffed according to the TCC Blueprint and whether staff have the correct qualifications
- To review if the health facilities offer youth-friendly sexual and reproductive health care services, including post-violence care
- To review if the health facilities offer a multi-sectoral approach with referral to other services such as psycho-social, legal, education and safety (SAPS)
- Identify lessons learned and make recommendations on areas of improvement in the way that health facilities deliver a comprehensive package of post-violence care services

The rapid assessment and gap analysis was conducted between September 2016 and February 2017 and included a survey of all 18 health facilities in Hlabisa and Mtubatuba.

As the services delivered are of a sensitive nature, information collected in this survey is confidential.

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

This rapid assessment and gap analysis was conducted to serve the needs of specific stakeholders and those who will use the findings and recommendations. Stakeholder participation is an integral component of the evaluation design and planning and is fundamental to its validity.

*Key stakeholders and use of the rapid assessment and gap analysis*



**UMKHANYAKUDE DISTRICT MUNICIPALITY AND HLABISA AND MTUBATUBA LOCAL MUNICIPALITIES**

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

**MatCH SYSTEMS AND OTHER IPs**

- 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 EDUCATION**

- Improved support to children who are victims of sexual assault

**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

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This desk review covers topics such as: gender-based violence and how it is defined; international and regional frameworks and policies that relate to gender-based violence; gender-based violence in South Africa – trends, institutional frameworks and quality of care; and gender-based violence with specific reference to the geographic scope of the review – KZN and UMkhanyakude: Hlabisa and Mtubatuba.

## 1. Defining gender-based violence and sexual violence

### 1.1. Gender based violence and human rights

Gender-based violence is a recognised violation of basic human rights (WHO, 2002a). The violence can 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 gender-based violence is a violation of women's human rights is evident in the human rights-focused definition in the Declaration on the Elimination of Violence Against Women adopted by 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 gender-based violence as:

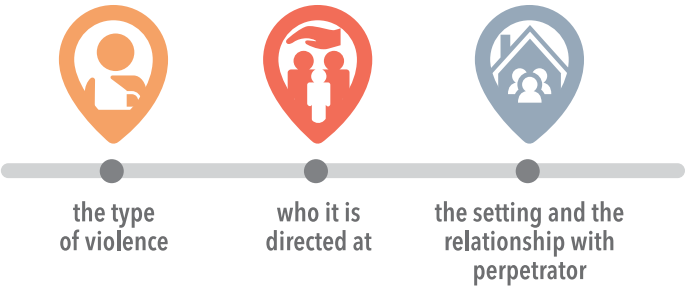
> *"the violation of women's human rights and a form of discrimination that prevents women from participating fully in society and fulfilling their potential as human beings." (WHO, 2002a:28).*

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

Understanding that gender-based violence 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 gender-based violence used by the United Nations Population Fund (UNPF) illustrates the wide spectrum that constitutes gender-based violence:

> *"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 gender-based violence is captured in the literature which at different times refer to various definitional subtypes that includes reference to: (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 gender-based violence is very important as it signifies the need for control or dominance. They argue that elements of gender-based violence are often overlooked or deemed to be less significant because the parties are adults in a close relationship.

The different dimensions or elements to gender-based violence 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

Sexual violence is a subtype of gender-based violence. Similar to the discussions on the definition of gender-based violence, 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).

**62%** of boys over 11
*believed that forcing someone to have sex*
**IS NOT AN ACT OF VIOLENCE**

## Gender inequality

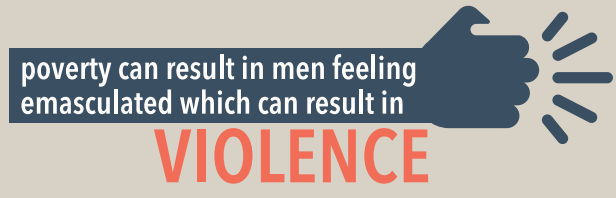
Many authors and institutions, including the WHO, have presented evidence in support of the argument that there is a relationship between the extent of gender inequality and the extent of GBV (WHO, 2002a; WHO, 2002b). Gender inequality is evident in the spheres of political and civil-society decision-making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




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).

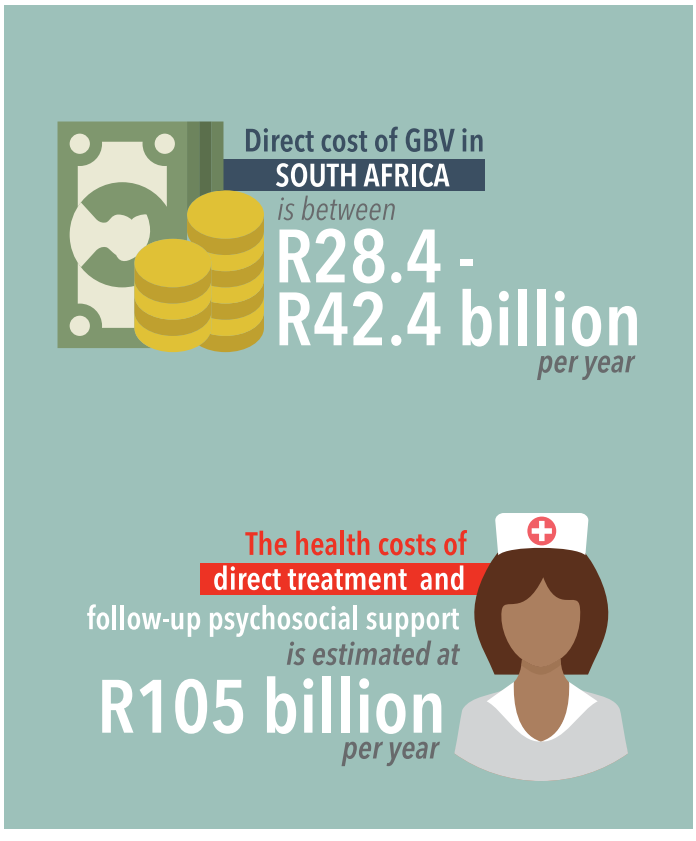

## Access to firearms

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.

### 1.5. 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; and 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).

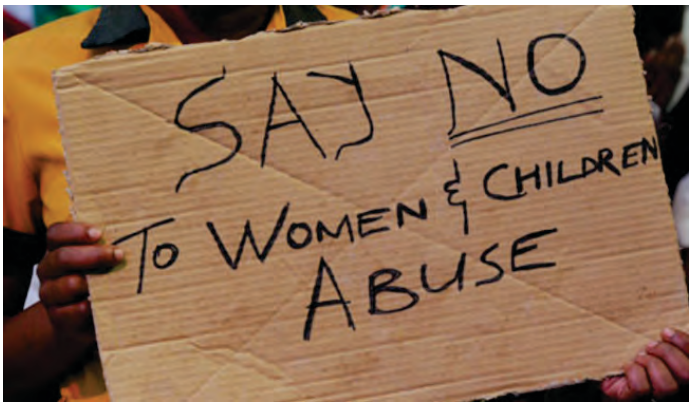
In addition to the impact of sexual violence on the health and wellbeing of survivors, some authors comment on the social and economic costs for society (Morrison and Orlando, 2004). This includes the erosion of social trust (WHO, 2002a) as well as economic costs for the country. The WHO (2002a) claims 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 follow-up 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 the light of the prevalence of gender-based and sexual violence 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 project women against discrimination and violence.




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

| INTERNATIONAL INSTRUMENT | OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS |
|---|---|
| **CEDAW**<br>**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**<br>**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.

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

| REGIONAL INSTRUMENT | OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS |
|---|---|
| **ACRWC**<br>**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, 1997**<br>*(Addendum on Prevention and Eradication of Violence against Women and Children, 2008)* | 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) |
| **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 rights 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 wide-ranging, 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 GBV 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.

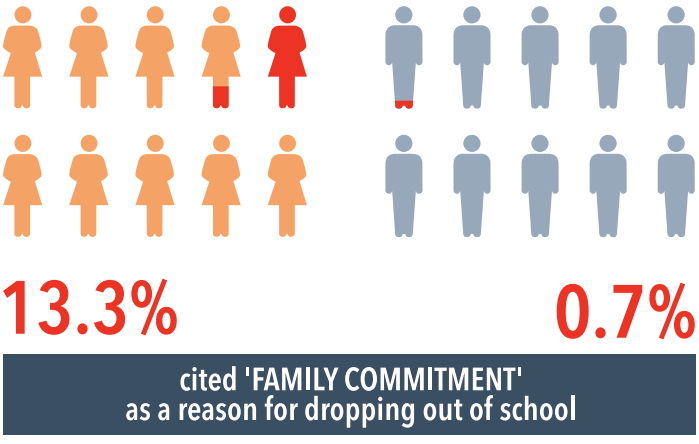
# 3. Gender-based violence in South Africa – trends, institutional frameworks and quality of care

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

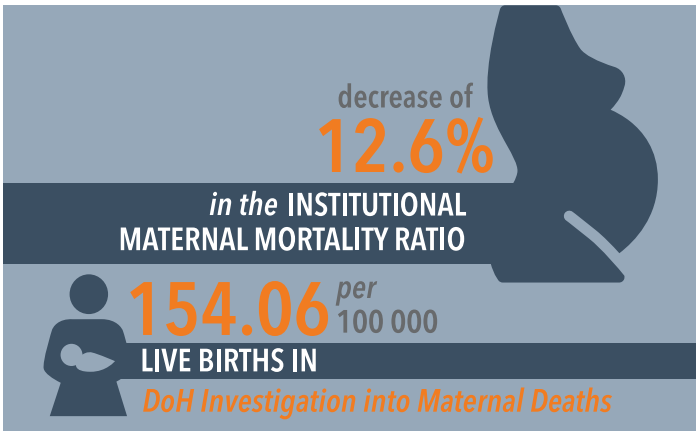
Although great strides have been made as far as women's inclusion in the political and economic sphere in South Africa, statistics indicate that there are many women's rights that remain unattained and that women often still hold a vulnerable position in society. The following description and statistics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




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 suboptimal 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).

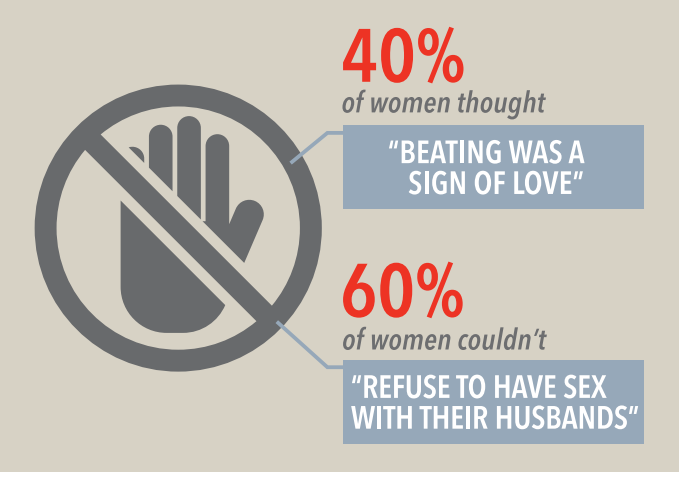



In South Africa (as elsewhere) continued inequity in employment practices, salaries, access to infrastructure and healthcare reduce female autonomy and contribute to the inappropriate societal norms and values discussed elsewhere in this report, in turn increasing women's vulnerability to GBV. (SAHRC,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



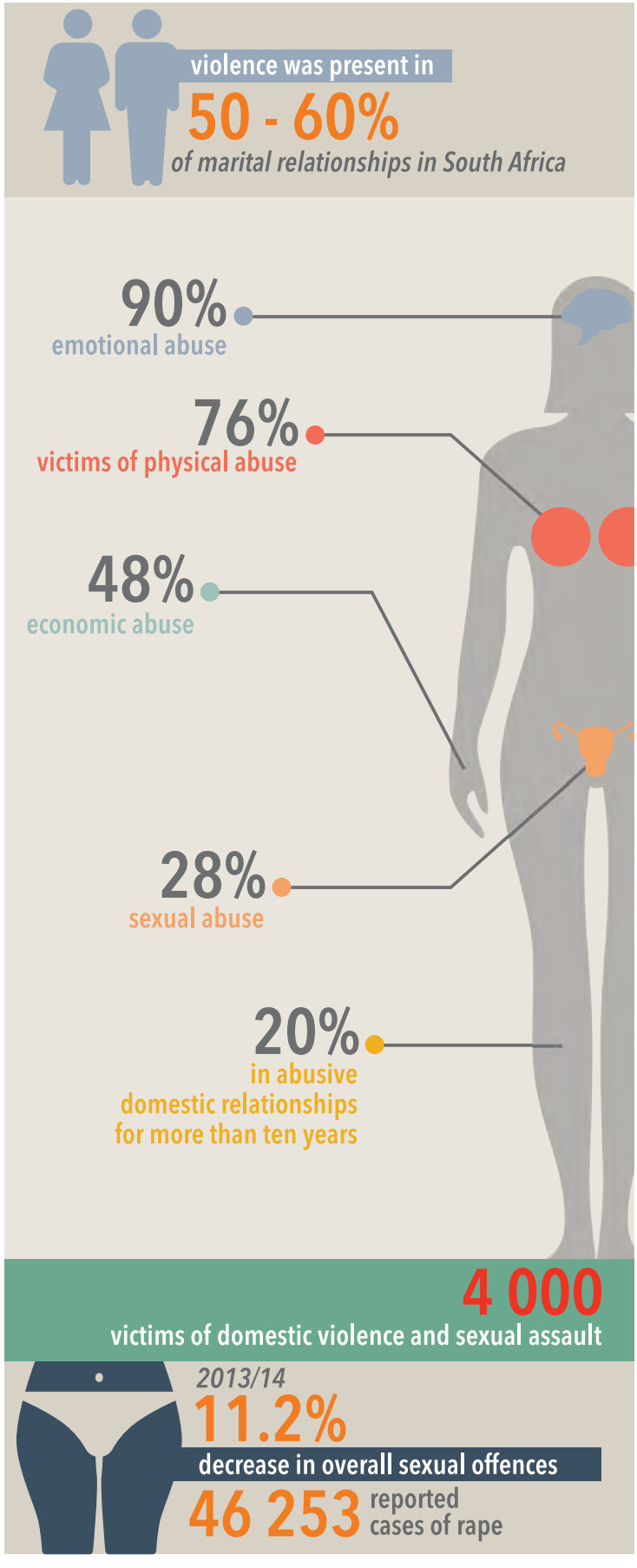
### 3.2.1 Intimate partner and domestic violence

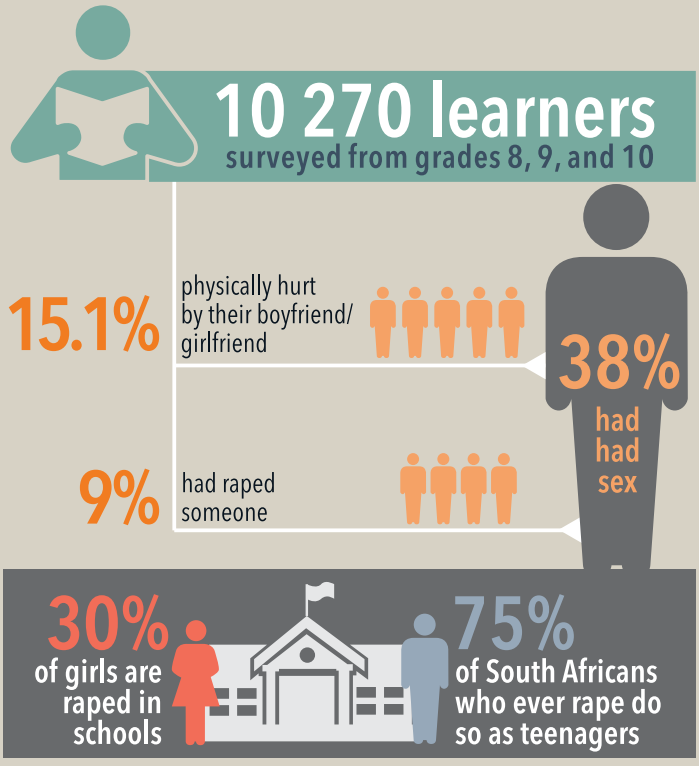
Literature on the prevalence of violence against women over time presents a bleak picture of consistently high rates. A 1991 study reported that violence was present in 50 - 60% of marital relationships in South Africa (Vogelman and Eagle, 1991). A 2002 community-based study of violence against women 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 was suffered over a longer period of time.

Another indication of the prevalence of violence against women is utilisation of the legal system in order 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), 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 women in South Africa who are murdered are murdered 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) report similarly 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 pre-teens and teens.

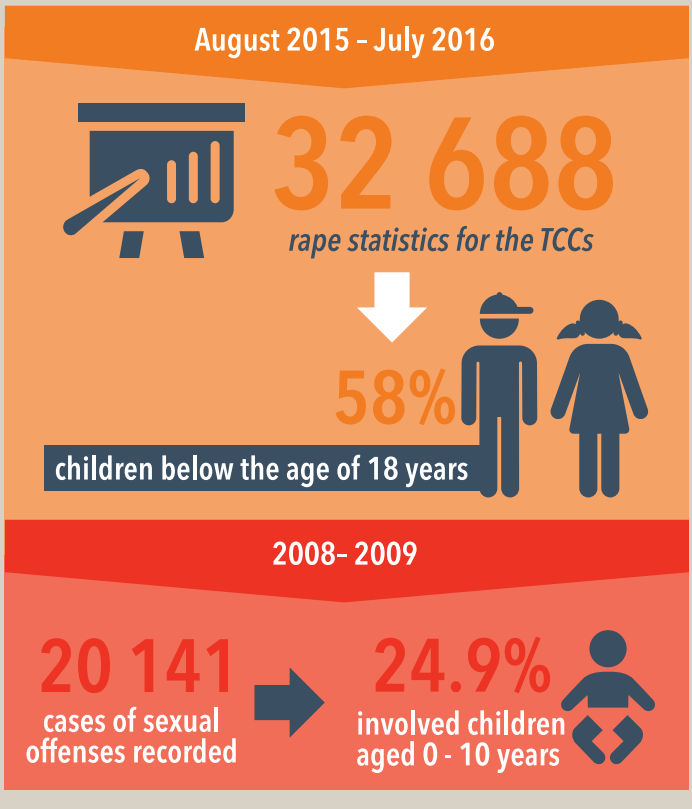
In many countries, including South Africa, Botswana and Namibia, both men and women are often targeted because of sexual identity (being gay or lesbian), (NACOSA, 2015). This is often called "corrective rape". Koraan and Geduld (2015) report that "corrective rape" refers to an instance when a woman is 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 incidence 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 offenses (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 offenses 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).[3]

The graphic on the following page summarises some of the laws and policies that are in place specifically in relation to gender-based violence. Some of the main legislation and policies are briefly explained below, 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)

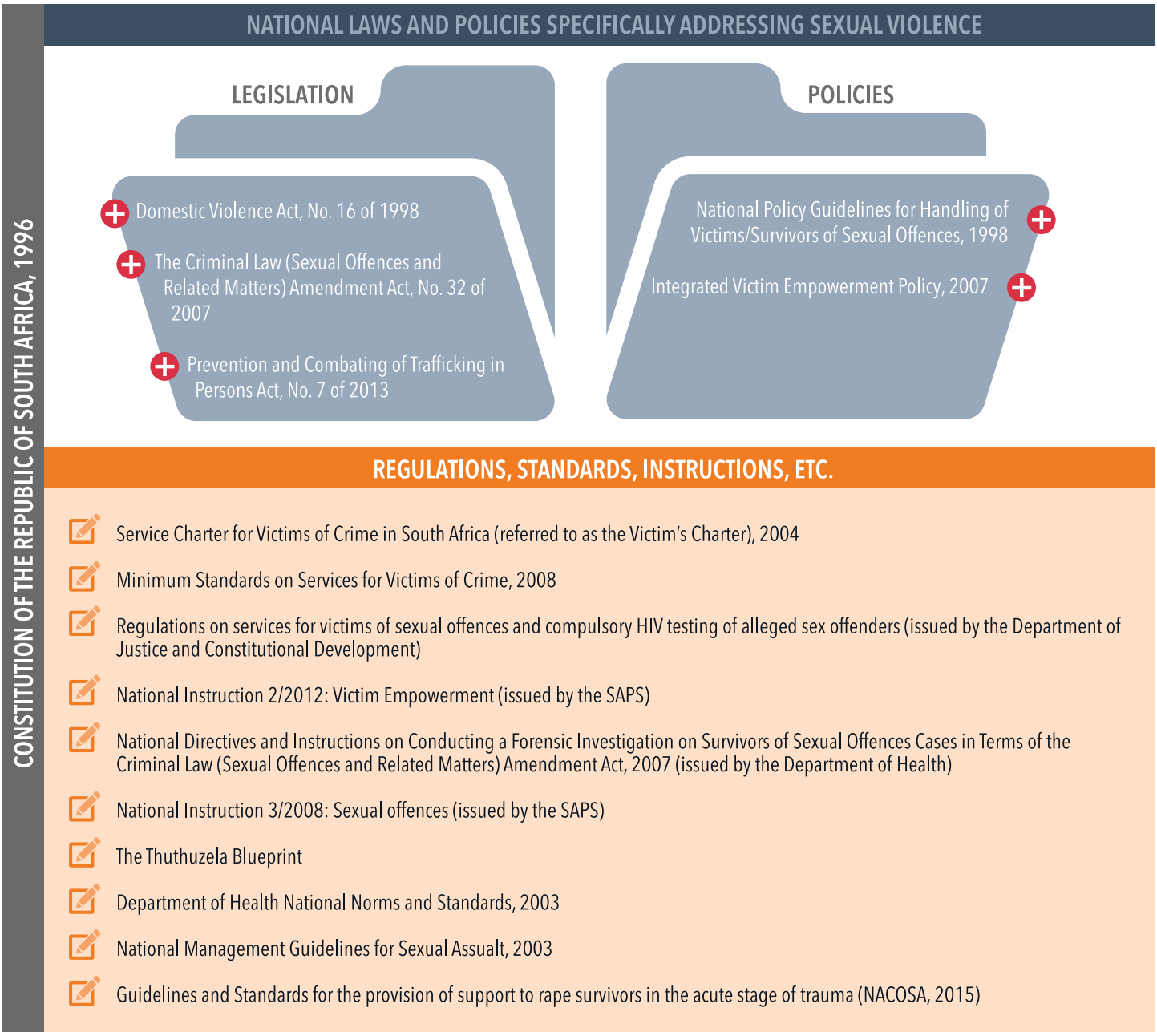
**The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007:**
The Act aims to incorporate all sexual crimes into one law and clearly defines sexual crimes and related matters. It also tries to ensure that victims receive adequate and appropriate services and assigns roles 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)

[3] 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 2015:0). 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).

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 SV (reproduced from Keesbury and Thompson (2010: 5))***

**Health**

- 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

**Police / Justice**

- 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

**Social Support**

- Assessment to determine need for psychosocial support
- 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 and 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 set 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:

"Detail the scope and content of services to be provided to victims of rape in the immediate aftermath of the attack.

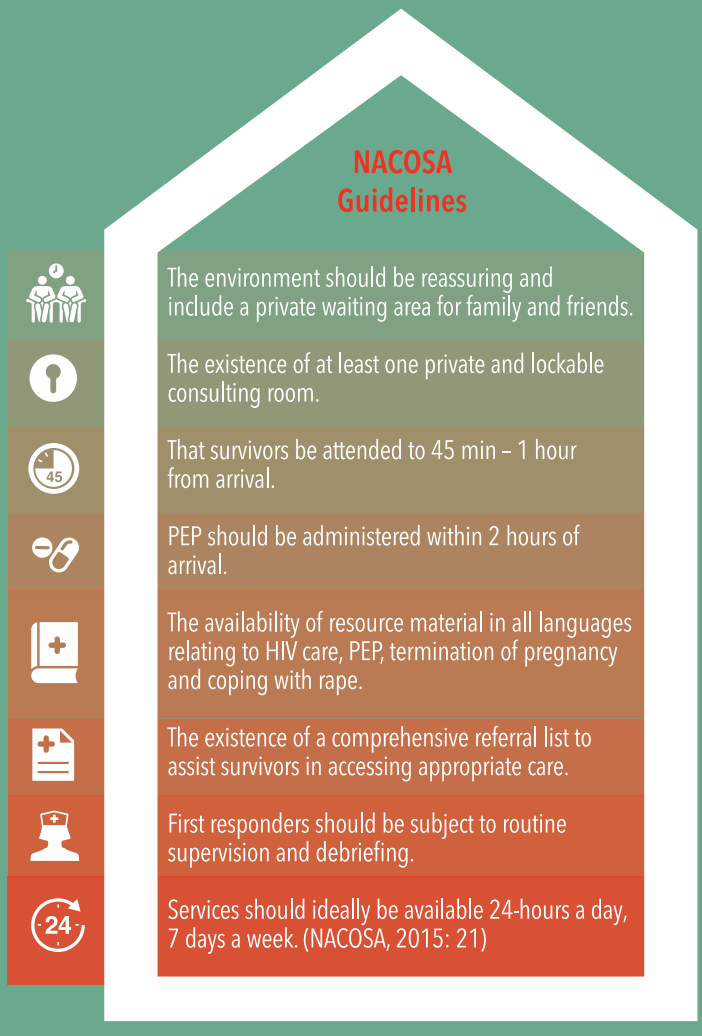
Outline the training and supervision needed to support first responders.

Ensure a high and consistent standard of care to rape survivors.

Help prevent secondary victimisation" (NACOSA, 2015: 9)

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:




**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:**
Although the first point of call often are the health facilities, sexual violence services are not always prioritised or regarded as a serious health issue (Christofides, et al., 2005) and are not institutionalised within plans and budgets (Kilonzo, 2013). This affects quality of care and could lead to secondary victimization (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).

**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 such as fear of the perpetrators when they are known to the survivor; acceptance or normalisation of such violence; feelings of 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)

**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 privacy in the provision of healthcare, which in the case of sexual violence includes not having a separate consultation room.

**Fragmented, uncoordinated care (only focusing on most immediate needs):**
Care might be of limited scope with most attention given to immediate needs with limited referrals to other services (e.g. legal or psychological) and follow-up (Christofides et al., 2003; Christofides et al., 2005).

**Cultural beliefs and societal responses:**
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)

# 4. Overview of KwaZulu-Natal province and UMkhanyakude district – socio-demographic and GBV profile

This section of the desk review and situational analysis relates to the geographic area (KZN more generally and UMkhanyakude district municipality specifically - with a focus on Hlabisa and Mtubatuba) that is also 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 gender-based violence (prevalence rates, services available and barriers to care).

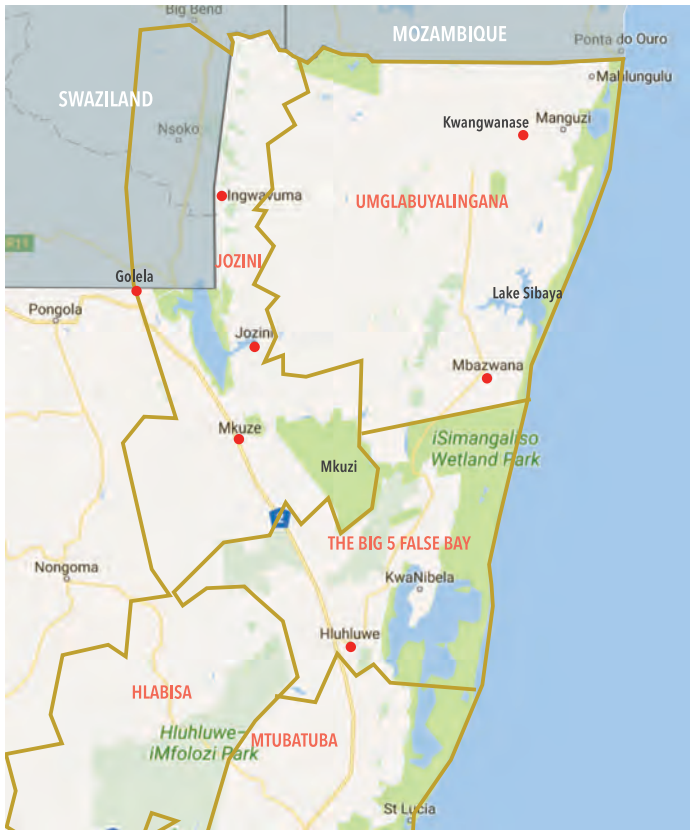
## 4.1. Demographic and socio-economic profile of KZN and UMkhanyakude

KZN is one of South Africa's nine provinces and is located on its east coast, bordering the Eastern Cape Province to the south, southern Mozambique to its north, and the Free State and Mpumalanga provinces to the west (KZN Tourism, n.d.). UMkhanyakude District Municipality is its northern-most district, and it is the second largest geographically (Local Government, n.d; UMkhanyakude, 2015).


Provincial map of South Africa, source: Google maps


District map of KZN province indicating UMkhanyakude, source: Google maps

The district of UMkhanyakude consists of five local municipalities: UMhlabuyalingana, Jozini, The Big 5 False Bay Municipality, Hlabisa, and Mtubatuba as depicted in the map below. (UMkhanyakude, 2015)




District map of UMkhanyakude indicating Hlabisa and Mtubatuba sub-districts, source: (UMkhanyakude, 2015: 14)

The district is predominantly rural with its economy drawing on sectors such as agriculture, services, tourism and retail. It has a number of tourist landmarks such as the Isimangaliso Wetland Park which is a World Heritage Site that comprise its eastern coastline of approximately 200 km, as well as the Hluhluwe-UMfolozi Game Reserve largely separating Hlabisa and Mtubatuba (UMkhanyakude, 2015; UMkhanyakude, n.d.)

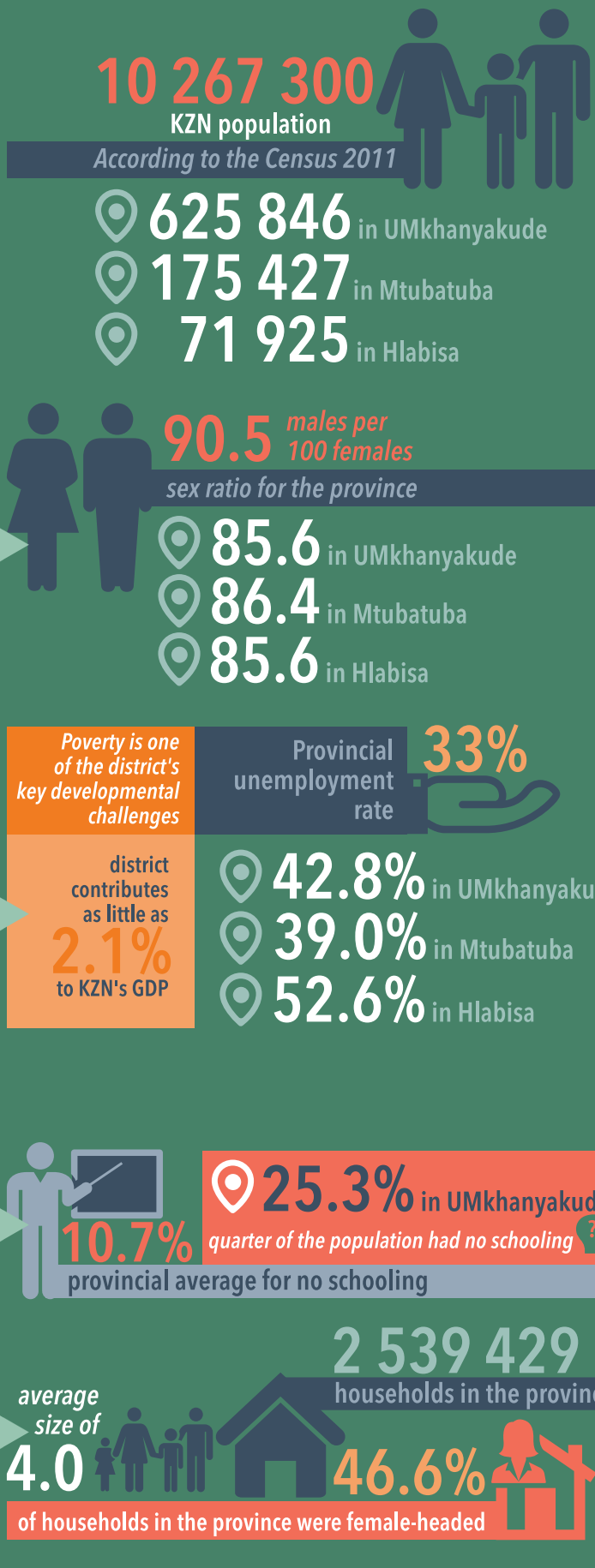
The district has undergone some changes to its internal boundaries – in 2011 Hlabisa Municipality was reduced from 19 wards to 8, while Mtubatuba grew in size (from 5 to 19 wards) by incorporating wards that were previously part of Hlabisa. It is envisaged that by 2016/2017 there will be a merger between Hlabisa and The Big 5 False Bay Municipality. (UMkhanyakude, 2015)

According to the Census 2011 report, KZN had a population of 10 267 300 of which just more than half a million (625 846) live in UMkhanyakude (175 427 in Mtubatuba and 71 925 in Hlabisa). By population, Mtubatuba is the second largest sub-district in UMkhanyakude and Hlabisa the second smallest. The provincial average for the population younger than 15 years of age is 31.9%, of which the average in UMkhanyakude is slightly higher at 40.3% (39.4% in Mtubatuba and 41.4% in Hlabisa). The sex ratio for the province (males per 100 females) is 90.5, while UMkhanyakude stood at 85.6 (Mtubatuba at 86.4 and Hlabisa at 85.6) (Stats SA, 2011).

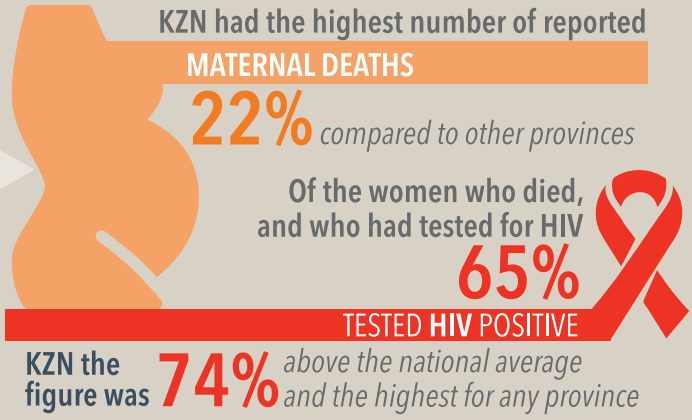
The province had an official unemployment rate of 33%, which was higher in UMkhanyakude at 42.8% (with Mtubatuba at 39.0% and Hlabisa much higher at 52.6%). The official youth (15 - 34 years) unemployment rate in UMkhanyakude was also higher than the provincial average (51.2% vs. 42.1% respectively) – and while youth unemployment in Mtubatuba was also above the provincial average at 46.9%, youth unemployment in Hlabisa surpassed both the provincial and the district average and was as high as 61.9%, although this was a decrease from 2001 levels that were reportedly 84.4% (Stats SA, 2011). Poverty is one of the district's key developmental challenges and estimates suggest that the district contributes as little as 2.1% to KZN's GDP (UMkhanyakude, 2015). It has been declared one of the Presidential Poverty Nodes which makes is the subject of special interventions in order to accelerate development (UMkhanyakude, 2015).

Statistics related to education were much worse for UMkhanyakude than the province as a whole, perhaps as a result of its more rural nature that poses challenges for the delivery of services. In UMkhanyakude a quarter of the population (25.3%) had no schooling, compared to the provincial average of 10.7%. The matric pass rate was also lower, at 25.5%, compared to the provincial average of 31.1%. (Stats SA, 2011)

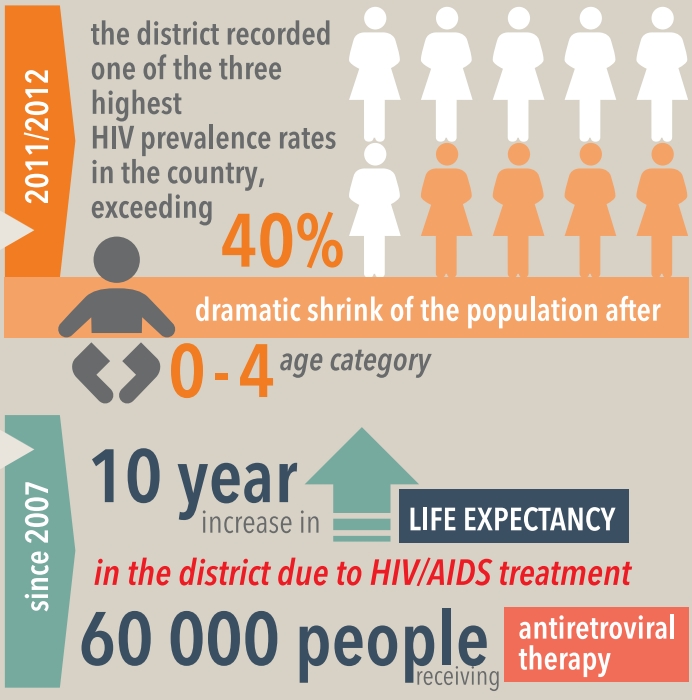
The province consisted of a total of 2 539 429 households (128 195 for UMkhanyakude as a whole, and only 12 586 for Hlabisa) with an average size of 4.0 (higher in UMkhanyakude at 4.9); while 46.6% of households in the province were female-headed (53.9% in UMkhanyakude) (Stats SA, 2011).



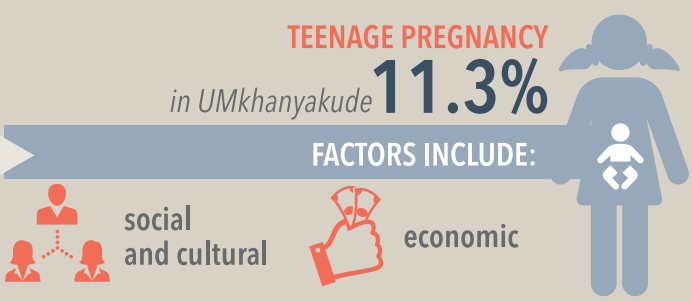
A 2014 Department of Health report on maternal mortality rates for 2011 - 2013 reported that KZN had the highest number of reported maternal deaths (964; or 22%) compared to other provinces, and that it is the province in which medical and surgical conditions are the second biggest cause of maternal 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% tested HIV positive (nationally). In KZN the figure was 74%, above the national average and the highest for any province (Department of Health, 2014).




HIV/AIDS are substantial health and developmental challenges that both KZN and UMkhanyakude face. KZN has higher than the national average numbers of HIV infections among those between 15 and 45 years – extrapolation of annual HIV sero-prevalence results to the general population puts the national average for this group at 17 - 18%, and KZN at 25% (eThekwini District Municipality, 2015). The biggest challenge that the health system in UMkhanyakude faces is HIV/AIDS (KZN DoH, 2016). For example, in 2011/2012 the district "recorded one of the three highest HIV prevalence rates in the country, exceeding 40% of its population, which is one of the factors contributing to the dramatic shrink of the population after 0 - 4 age category" (UMKhanyakude, 2015: 44). However, there have been successes in the fight against HIV/AIDS including a 10 year increase in life expectancy in the district since 2007 because of the introduction of HIV/AIDS treatment, with nearly 60 000 people receiving antiretroviral therapy (ART) (KZN DoH, 2015).

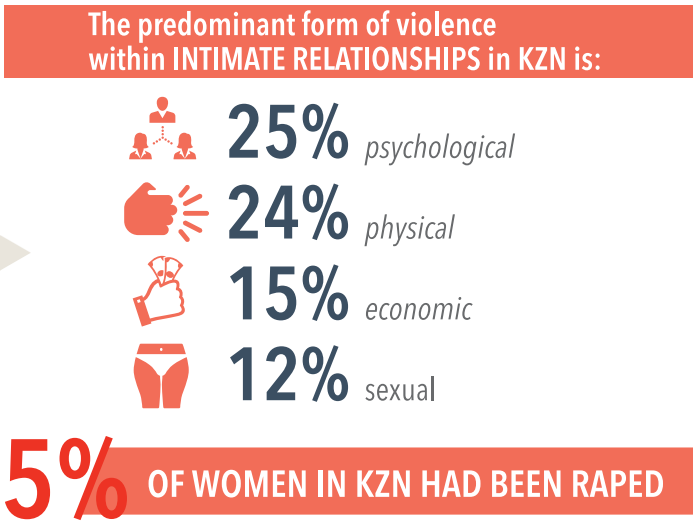



Teenage pregnancy remains a challenge for both the province and UMkhanyakude district. Factors associated with teenage pregnancy are social and cultural (e.g. living up to accepted gender norms, patriarchy, rites of passage) as well as economic (e.g. pregnancy as a means through which to secure economic stability) (eThekwini District Municipality, 2015). 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, large age differences between sexual partners, large number of partners in the past year, and a "high proportion of sexually active males with concurrent partners" (eThekwini District Municipality, 2015: 23). Teenage pregnancy remains a challenge in UMkhanyakude at 11.3% and requires multi-sectoral approaches and youth friendly services to address (KZN DoH, 2015).

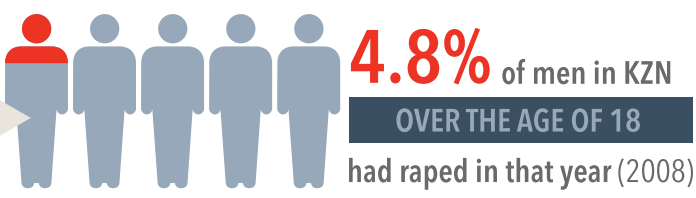


## 4.2. Gender-based violence in KZN and UMkhanyakude

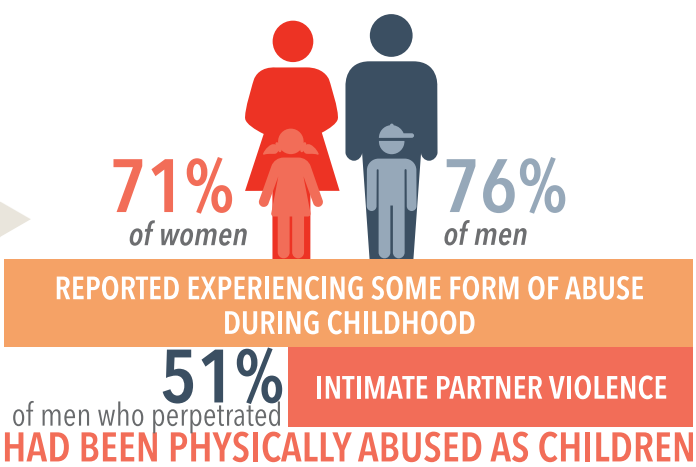
The rates of underreporting of sexual violence to the SAPS in KZN (as in other provinces) has been illustrated by statistically representative surveys on the nature and pervasiveness of gender-based violence. The research indicates that 36% of KZN women said that they had experienced gender-based violence (lower than the 51% in Gauteng and 45% in the Western Cape) (Machisa et al., 2011). A 2011 survey of KZN households indicated that 31% of women in KZN had been subjected to intimidate partner violence (Musariri et al., 2013). The predominant form of violence within intimate relationships in KZN is psychological (25%), followed by physical (24%), economic (15%) and sexual (12%) (Musariri et al., 2013: 7). Approximately 5% of women in KZN (compared to 12% in Gauteng 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: 13).



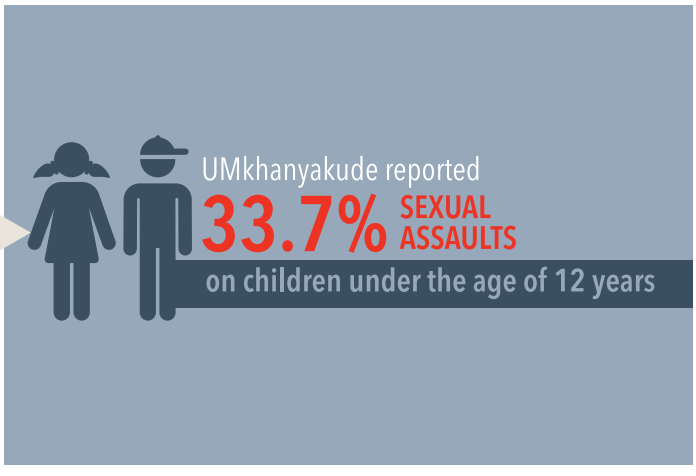

A study on the prevalence of perpetration showed that 4.8% of men in KZN over the age of 18 had raped in the past year (2008) (Jewkes, n.d.), while a much higher percentage of men in KZN (43%) admitted to researchers that they had perpetrated violence against women (Musariri et al., 2013). In the latter study 35% of men had admitted to perpetrating emotional inter-partner violence, 29% physical violence, 20% economic and 14% sexual (Musariri et al., 2013).




A very high proportion of men and women in KZN have been victims of child abuse (Musariri et al., 2013). The majority of women and men who took part in the study had been abused as children – 71% of women and 76% of men had reported experiencing some form of abuse during childhood (Musariri et al., 2013). As has been discussed earlier in this report, child physical abuse and child neglect can be linked to the perpetration of gender-based violence and Musariri et al. (2013) show a statistically significant difference in perpetration of intimate partner violence between survivors of child physical abuse and non-survivors. For example, 20% of men had committed intimate partner violence but had not been physically abused as children, against the 51% of men who had reported perpetrating intimate partner violence who had been physically abused as children (Musariri et al., 2013).

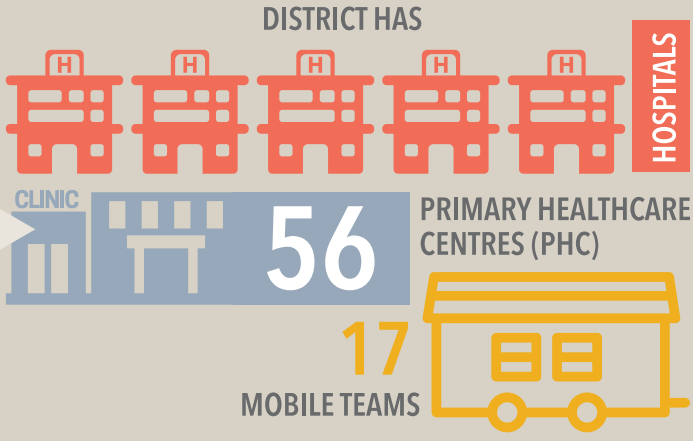



Data released in 2014 by the Office of the Premier compiled using SAPS and other data illustrate the prevalence of sexual and gender-based violence crimes for the 2013/14 financial year for the KZN province and for UMkhanyakude district. These only reflect reported incidents and the actual number is therefore likely to be higher. Of the 11 districts in KZN, UMkhanyakude ranked 8th highest in terms of the number of total sexual crimes (495) but was ranked 9th in the district ranking of total sexual crimes by ratio to the population (1:1264). UMkhanyakude had 2 areas in the top 31 highest number of total sexual crimes reported to the police – these areas/police stations and the number of reported crimes included KwaMsane (126) and Jozini (103) (Office of the Premier, 2014). With respect to sexual assaults on children under the age of 12 years, the report ranked UMkhanyakude 8th highest (out of 11) with a rate of 33.7% between April 2013 and March 2014 (Office of the Premier, 2014).



Various institutions and structures exist in the province to support survivors of gender-based and sexual violence. There are currently eight TCCs in the province: (1) Edendale TCC at Edendale Hospital, Pietermaritzburg; (2) Madadeni TCC at Madadeni Hospital, Newcastle; (3) Empangeni TCC at Ngwelezana Hospital, Empangeni; (4) Phoenix TCC at Mahatma Gandhi Memorial Hospital, Phoenix; (5) Port Shepstone TCC at Port Shepstone Regional Hospital, Port Shepstone; (6) RK Khan TCC at RK Khan Hospital, Durban; (7) Stanger TCC at Stanger Provincial Hospital, Stanger; and (8) Umlazi TCC at Prince Mshiyeni Memorial Hospital, Umlazi (UNICEF, n.d.; FPD, 2016). However, none of these are situated in UMkhanyakude with the closest being Empangeni TCC at Ngwelezana Hospital, Empangeni approximately 60 km from Mtubatuba.

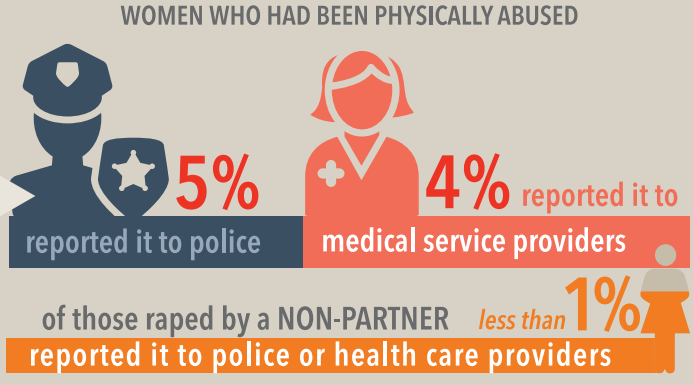

The rural nature of the district affects service delivery in general, and health services in particular. The district has 5 hospitals, 56 Primary Healthcare (PHC) centres (12 in Mtubatuba and 5 in Hlabisa) and 17 mobile teams (2 respectively in Hlabisa and Mtubatuba) (KZN DoH, 2015). However, resources have been allocated disproportionately as illustrated in the case of Mtubatuba which make up 28% of the population of the district, but does not have a hospital or Community Health Centre (CHC). Access to healthcare is inhibited by long distances to facilities, road infrastructure, transport frequency and cost, as well as quality of care as none of the facilities in the district comply with the National Core Standards, although they are striving to do so (KZN DoH, 2015).



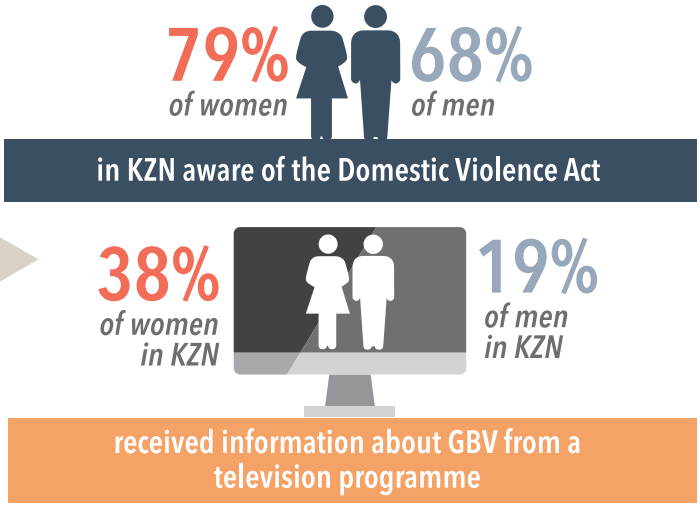

The SAPS has created 25 family violence, child protection and sexual offences (FCS) units in the province, as well as 142 Victim Friendly Rooms (VFCs) that provide a safe, private and comfortable space for victims of gender-based violence to be informed about their rights (Musariri et al., 2013).


Data from various directories, such as the 2011 Gender Based Violence 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 (CSVR, n.d.) show that there are some CBOs that provide various levels of assistance (such as counselling, legal assistance, shelters) to victims of gender-based and sexual violence in Mtubatuba and Hlabisa, although these are limited. Examples of some of these CSOs include: Child Welfare, Cotlands, Isidingo Community Caregivers, and the Siyonqoba home-based care organisation.

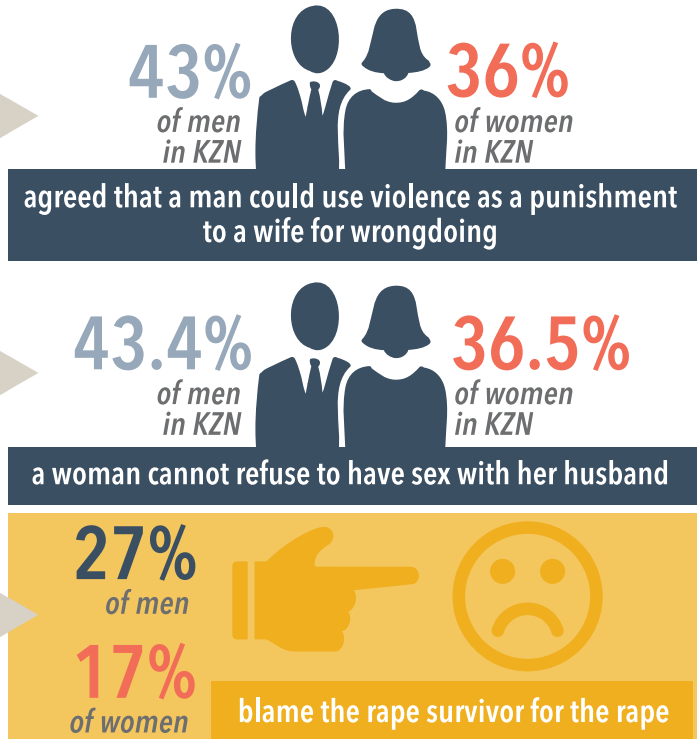
Despite the support services that are available, the under-reporting of the incidence of gender-based and sexual violence and accessing of services also holds true for KZN. Research has indicated that the majority of female victims do not report violence to police, seek medical attention or legal recourse. 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 health care providers (Musariri et al., 2013). Reasons for under-reporting and not accessing services in KZN are similar to reasons in South Africa more generally (mentioned earlier in this report), although it is worth highlighting research in KZN that specifically focuses on reporting and accessing of services:



**Awareness of legislation and rights:**
A 2013 study on gender-based violence in KZN (Musariri et al., 2013) highlighted that more women (79%) than men (68%) were aware of the Domestic Violence Act, but relatively low proportions of both men and women interviewed were aware of the Sexual Offences Act (23% women and 49% men). Fifty-eight percent of women and 64% of men had heard about protection orders (Musariri et al., 2013). Thirty-five percent of women, compared with 83% of men, had heard about the 16 Days of Activism campaign in the 12 months prior to the survey. Thirty-eight percent of women and nearly a quarter (19%) of men had received information about GBV from a television programme. More men (25%) than women (10%), received information about GBV from a newspaper (Musariri et al., 2013).




**Prevalence of inappropriate and harmful societal norms:**
Barriers to reporting violence and accessing care include the persistence of patriarchal views and the normalisation of violence. For example, in the 2011 cross-sectional survey of KZN households 43% of men and 36% of women who were surveyed agreed that a man could use violence as a punishment to a wife for wrongdoing. Further, 36.5% of women, and 43.4% of men said that a woman cannot refuse to have sex with her husband. Survivors of rape face stigmatisation – more than half of the men (56%) and nearly a quarter (23%) of women said rape survivors can often be seen as responsible because they are promiscuous. More than a quarter of men (27%) and 17% of women blame the rape survivor for the rape (Musariri et al., 2013). A 2013 qualitative study with survivors of sexual violence in KZN reported threats, fear, self-blame, and perceptions that the systems have failed them and others as some of the reasons for under-reporting (Curran et al., 2013).




**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 and the possibility of secondary victimisation by service providers (Musariri et al., 2013). Although not speaking about gender-based violence service provision specifically, challenges in relation to accessing care (long distances, road infrastructure, unequal distribution of resources across the district. etc.) and the quality of care in UMkhanyakude health care facilities have been acknowledged by the provincial department of health and attempts are being made to remedy these. (KZN DoH, 2015).

# 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 underlie 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 health care. These guidelines have been presented in this review. The rapid assessment and gap analysis of facilities in UMkhanyakude that follows will compare elements such as resources and skills against internationally accepted guidelines and identify areas where improvements can be made in the short- and longer-term.

# CHAPTER 3: METHODOLOGY

# CHAPTER 3: METHODOLOGY

The rapid assessment and gap analyses assessed the provision of post-violence care at all 18 public health facilities in Hlabisa and Mtubatuba.

The study was conducted in three phases. Phase one involved conducting a desk review to inform a situational analysis, the second phase was field work and data collection, and the third phase is reporting.

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

## 1. Approach

A mixed methods approach was followed, using both qualitative and quantitative data. It follows what Snape and Spencer (2003: 15) have called a "toolkit approach" to research, which is pragmatic and applies the methods that will enable the researcher to best answer the research questions (Silverman, 2006). Combining administering a check-list to facilities on elements such as the provision of post-violence care and the facility more generally (staffing, equipment, operating hours, etc.) with short qualitative interviews with facility managers to understand some of these findings better, was aimed at providing a more holistic picture. Key questions were selected for any qualitative interviews in order to reduce the burden on respondents after having completed the facility-specific survey. In addition, where possible and practical, the intention was to conduct interviews with NGOs working at facility-level, representatives from NGOs working on GBV more broadly, but not supporting a specific facility, and representatives from government.

## 2. Sample

All existing health facilities, including Primary Healthcare clinics (PHCs), Community Healthcare Centres (CHCs) and hospitals, in the public sector were selected to participate in the rapid assessment and gap analysis. A list of health facilities was compiled from a number of different sources, which were cross-referenced. These included lists of facilities available on the provincial department of health website and the National Health Research Database (NHRD). MatCH Systems also made available a list of facilities, and the researchers furthermore drew on other publicly available directories such as the 2011 Gender Based Violence Project by FPD, funded by Sida. Facilities were contacted before a site visit and an appointment made with the facility manager to administer the survey.

The exact number of NGOs linked to facilities was unknown, but would be established when the data collectors visited the facilities. This resulted in a convenience sample of potential respondents available on the day. This is discussed in greater detail in the limitations section of this chapter.

In the DREAMS Terms of Reference three categories of potential respondents were identified to conduct key informant interviews with:


Metropolitan/municipal managers


Managers from our implementing partner organisations


NGOs working in the field of GBV.

For all of these groups we sampled purposively, and after stakeholder consultation enhanced our efforts to, where possible, include an NGO working specifically with sex workers as this a group that might face particular challenges in accessing post-violence care.

## 3. Situational analysis and desk review

At the start of the project the team conducted a situational analysis and desk review drawing on international and local reports, academic papers and standards. Topics covered included: an introduction to gender-based violence and how it is defined; international and regional frameworks and policies that relate to gender-based violence; gender-based violence in South Africa – trends, institutional frameworks and quality of care; and gender-based violence with specific reference to the geographic scope of the review – KZN and UMkhanyakude: Hlabisa and Mtubatuba.

The desk review and situational analysis also informed the design of the data collection tools, such as the facility-specific survey and interview schedules.

# 4. Data collection methods, instruments and procedure

Data were collected through a number of different mechanisms.

***Study design***

**PART A (1)**

**FACILITY LEVEL**
Rapid assessment and gap analysis

The team developed check-lists to conduct the assessment and gap analysis. An electronic data collection tool was used to reduce data capturing time. This tool assessed the services provided in each facility, the facility and equipment needs and whether or not the staff have the necessary qualifications.

An Application (ODK App) and survey tool was developed in collaboration with Medical Practice Consulting that uses TRISCOMS cloud hosting technology, to allow the team to collect data electronically using tablets. 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. The initial survey tool (Gap Analysis 1.1) was developed and piloted during the first week of data collection and no changes were needed.

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 to validate the information given by the respondents.

**PART A (2)**

**FACILITY LEVEL**
Interviews with facility managers and NGOs working in facilities, where relevant

Interviews were conducted with each health facility manager and the NGOs working within the facility, where they consented. The interview schedule consisted of closed- and open-ended questions. Interviews were recorded, only when the interviewee agreed to be recorded, and supported with notes taken by the interviewer. The interview phase was voluntary and all interviewees were provided with an informed consent form explaining that they have the right to refuse or withdraw at any point and that their refusal or withdrawal would not have any negative repercussions for them.

Interviewees at facilities, as well as the NGOs working there, generally seemed reluctant to be recorded, and the researchers therefore took detailed notes in response to each question asked.

**PART B**

**KEY INFORMANT INTERVIEWS**
for broader context
Interviews with NGOs working in the GBV sector, key municipal staff, DREAMS stakeholders

Interviews were also conducted with NGOs working with the health facilities, other NGOs working in the field of sexual violence, key stakeholders in the DREAMS initiative, and relevant government sector leads. The interview schedules consisted of closed- and open-ended questions. Interviews were recorded, only when the interviewee agreed to be recorded, and supported with notes taken by the interviewer. The interview phase was voluntary – all interviewees were provided with an informed consent form explaining that they have the right to refuse or withdraw at any point and that their refusal or withdrawal would not have any negative repercussions for them.

Data from all of the interviews will remain anonymous to the readers of this report as far as possible. No names or identifying individual information are disclosed in the report or presentation of results.

# 5. Data analysis procedure

## 5.1. Quantitative data analysis

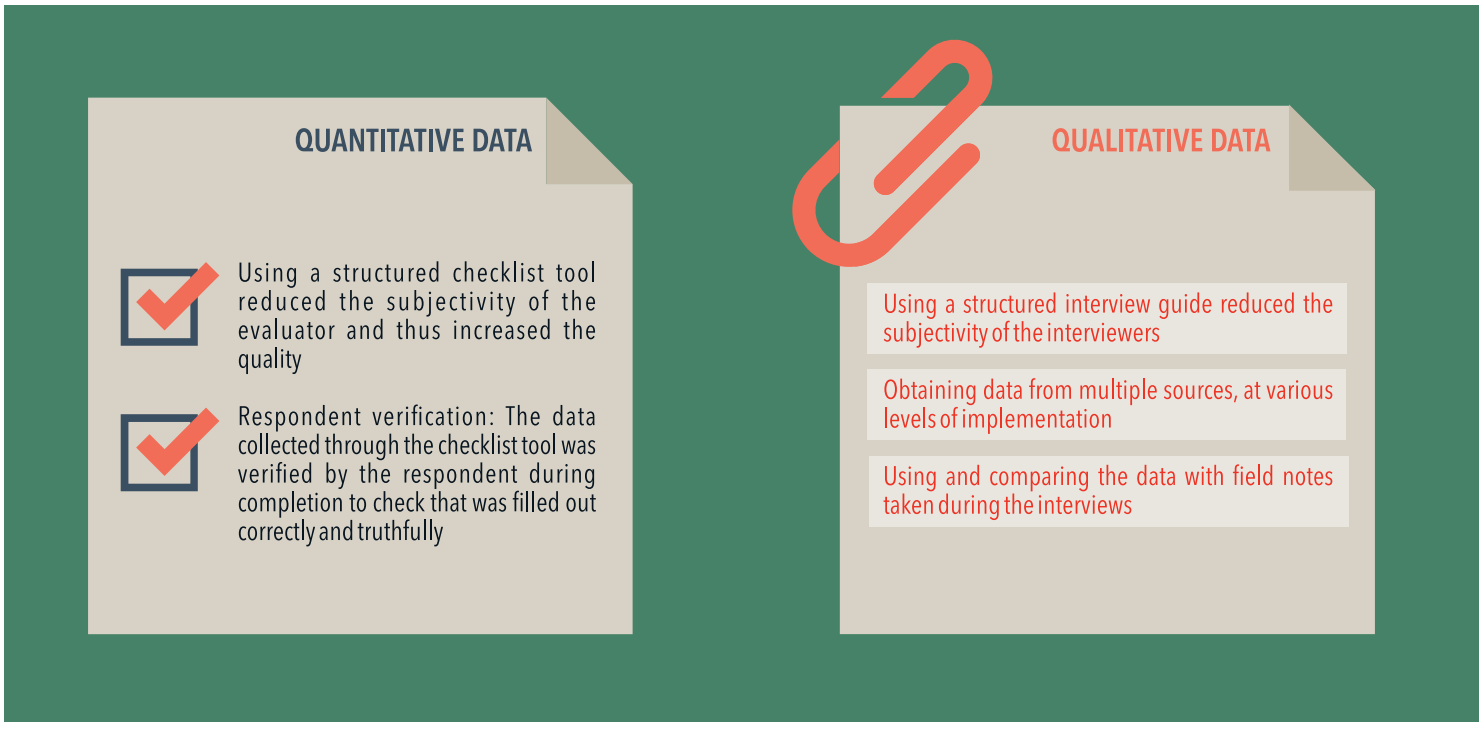
The quantitative data were exported from the database into MS Excel™, where it was cleaned, coded and analysed. In cases were paper-based surveys were used, the surveys were captured into MS Excel. Descriptive analyses were conducted and the data analysis output was displayed in graphs and tables.

## 5.2. Qualitative data analysis

Comprehensive field notes were taken during the interviews, which were then captured and thematically analysed taking care that all themes are grounded in the data (Ritchie et al., 2003).

# 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 and ensured that the data collection sessions only involved participants who volunteered to participate.

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.

# 7. Ethics

## 7.1. Ethical clearance and letters of support

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 gap analysis. The Evaluation 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 committee met on 14 June 2016 and requested a few small changes. This was implemented and the Committee approved the gap analysis component on the 28th of June 2016.

A further ethics approval process for the Provincial Department of Health was also followed. First, a letter of support for the research was obtained from the UMkhanyakude DoH District Office. This letter of support was then used to request approval for the study through the online NHRD service. Data collection only started once approval had been received.

## 7.2. Principles of ethical conduct

This compliance audit and gap analysis was conducted in accordance with the principles outlined in the United Nations Evaluation Group (UNEG) "Ethical Guidelines for Evaluation" and we adhered to the ethical standards described below.

### 7.2.1 Informed consent and right to withdraw

The evaluator explained the gap analysis 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 would not have any negative impact on them or their employment.

### 7.2.2 Anonymity

The team applied protocols to ensure anonymity of key informants as far as possible, such as allocating a unique identifier to each interviewee. It should, however, be recognised that although every attempt has been made to ensure the anonymity of key informants in the write-up of the findings, it might not be possible for certain key informants (such as key Department of Health staff members) to remain completely anonymous as someone working in their field might still recognise them in the report even if the data are anonymised. Audio files and transcripts from interviews did not have the name of the interviewee attached to them, only the unique identifier.

### 7.2.3 Confidentiality

Data collected during the interview phases, such as the audio files, transcripts and field notes are kept on a confidential location on FPD's private server, which only the researchers have access to. Any paper-based information will be kept in a locked filing cabinet on FPD premises that only the lead researcher will have access to.

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

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

Visits to the facilities took place on a day that was agreed to by the Facility Manager. They were responsible for notifying the staff in the facility/department that the compliance audit will be taking place on that day.

Facility Managers were asked to make clients presenting on that day aware that a researcher will be there, but that they are not there to talk or interact with them.

The researcher 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 made efforts to ensure that their presence did not infringe on the patients' care or privacy.

If it was necessary for the researcher to move through the facility, the researcher was accompanied by someone from the facility and only entered rooms that are not being used by clients at the time. Areas such as the waiting room and reception were avoided as much as possible.

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

### 7.2.5 Dissemination of information

The data from this Gap Analysis will be used to compile a National and Facility-Specific Report (this report). USAID may use the information from the report for various purposes 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.

# 8. Challenges and limitations

Every possible effort was made to administer the survey at facilities and conduct interviews with facility managers. A number of challenges were experienced which also relate to the limitations of this study:

A factor affecting the strength of the study design and report findings is that the data are self-reported. This introduces bias into the design as there is strong reliance on the honesty of respondents and their recall accuracy when answering certain questions. Where possible, the data collectors used their discretion to validate the responses given.

In drawing up the sample contact, details for the facilities were collated from different lists. Despite this cross-referencing, contact details for facilities were not always accurate which meant that data collectors had to visit a facility to make an appointment at a later date to administer the survey, rather than making such an appointment over the phone. This meant data collection took longer.

As NGOs working with a facility were only identified on the day of the site visit, many of the NGO staff were quite junior (e.g. data collectors) and not necessarily in a position to answer all questions in the interview schedule for NGOs.

Due to the sensitive nature of the research and due to the focus of the study on the ability of facilities to provide post-violence care, no victims of violence were interviewed. Although this is appropriate for the study design and focus, it has the implication that the perceptions of clients on the victim friendliness and appropriateness of the services provided was not tested.

When assessing the provision of post-violence care the study referred to the TCC Blueprint as well as the NACOSA 2015 guidelines. This didn't assess the alignment of facilities with other national policies, procedures and guidelines.

# CHAPTER 4: FINDINGS: RAPID ASSESSMENT AND GAP ANALYSIS

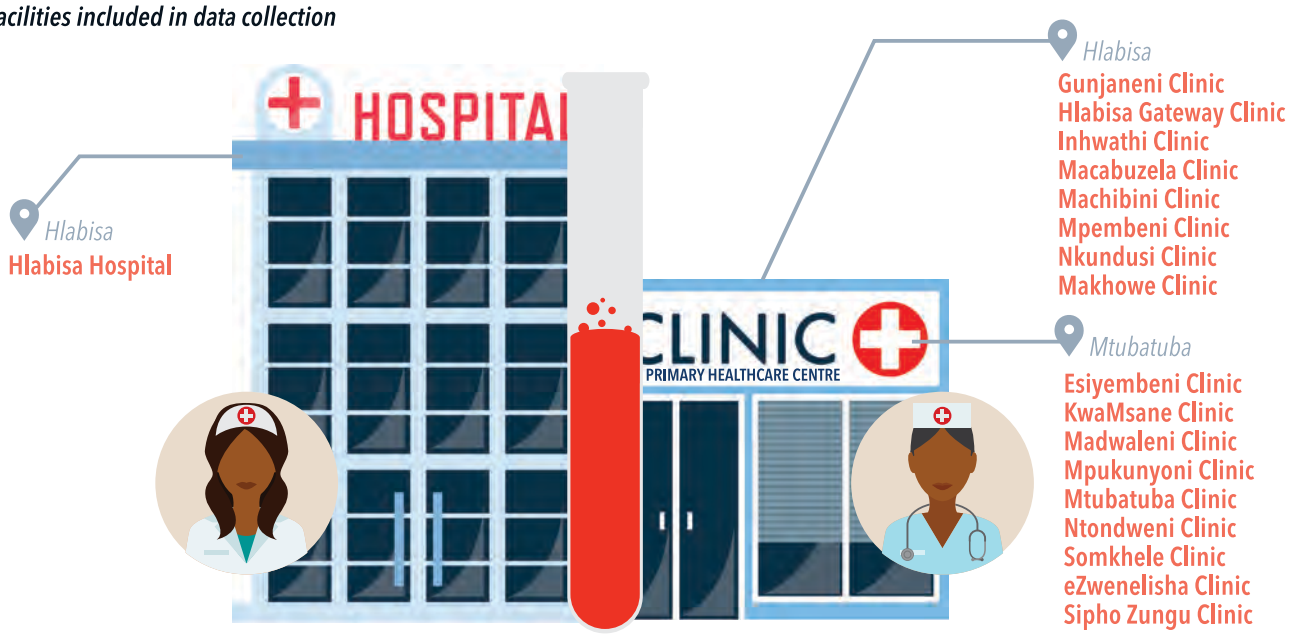
# CHAPTER 4:
# FINDINGS:
# RAPID ASSESSMENT AND GAP ANALYSIS

## 1. Overall findings

### 1.1. Facilities included in the data collection

There were 18 facilities included in data collection in Hlabisa and Mtubatuba of which 17 were Primary Healthcare Centres and 1 was a hospital.

***Facilities included in data collection***




We were not able to collect data from Dukuduku Sick Bay Clinic as it is a military clinic under the jurisdiction of the Department of Defence.

## 1.2. Summary of findings

| *Summary of findings* | *Out of 18 facilities* |
|---|---|
| Facility is open 24 hours a day | 27.87% |
| Facility is open 7 days a week | 77.78% |
| Facility is located in a permanent building | 83.33% |
| Average number of Sexual Offence cases per week | |
| Average waiting time of 45 minutes | 77.78% |
| **SERVICES PROVIDED** | |
| Medical Forensic Examination | 11.11% |
| Bath or shower facility | 44.44% |
| Provision of comfort packs and clean clothes | 33.33% |
| Statement taken by a SAPS investigating officer | 33.33% |
| Psychological services | 44.44% |
| HIV, STI and pregnancy testing | 94.44% |
| Provision of post-exposure prophylaxis | 94.44% |
| HIV treatment | 100% |
| Assistance with case reporting and court preparation | 22.22% |
| **FACILITIES AVAILABLE** | |
| Private ablutions | 33.33% |
| Disabled friendly ablutions | 50.00% |
| Private room for victims to rest in | 22.22% |
| Waiting room | 38.89% |
| Counselling office | 11.11% |
| SAPS office | 0.00% |
| HCT room | 94.44% |
| Examination room | 83.33% |
| NGO Room | 27.78% |
| Wheelchair ramp | 61.11% |
| **EQUIPMENT AVAILABLE** | |
| Computers | 77.78% |
| Telephones | 88.89% |
| Fax machines | 38.89% |

| | *Out of 18 facilities* |
|---|---|
| Photocopiers | 77.78% |
| Printers | 50.00% |
| Internet | 11.11% |
| Camera for evidence | 0.00% |
| Fans | 66.67% |
| Air conditioner | 72.22% |
| Heater | 33.33% |
| Fridges | 88.89% |
| Microwave ovens | 44.44% |
| Fire extinguishers | 100% |
| Lockable cabinet | 72.22% |
| Refreshments for victims | 0.00% |
| Clean clothing | 11.11% |
| Comfort packs | 0.00% |
| Toys | 5.56% |
| Anatomically correct dolls | 0.00% |
| IEC material | 16.67% |
| Adult height and weight measures | 100% |
| Children's scale | 94.44% |
| Children's measuring board | 77.78% |
| BP monitors | 100% |
| Syringes, needles, sterile swabs | 100% |
| Blood collection tubes | 100% |
| Examination gloves | 94.44% |
| Sharps container | 100% |
| Lighting for examination | 33.33% |
| Gynaecological couch | 38.89% |
| Speculums | 94.44% |
| Colposcope | 16.67% |
| Gown for victim | 88.89% |
| **STAFF** (FULL/PART TIME) | |
| Department/ Facility Manager | 72.22% |
| Professional Nurse | 100% |
| Forensic Nurse | 0.00% |
| Doctor | 33.33% |

*Out of 18 facilities*

| | |
|---|---|
| Administrative staff | 77.78% |
| Trauma Counsellor | 16.67% |
| HCT Counsellor | 88.89% |
| Psychologist | 0.00% |
| Pharmacist | 5.56% |

**TRAINING IN PROVIDING POST-VIOLENCE CARE**

| | |
|---|---|
| Healthcare Staff | 61.11% |
| Non-healthcare Staff | 27.78% |
| Auxiliary Staff | 11.11% |

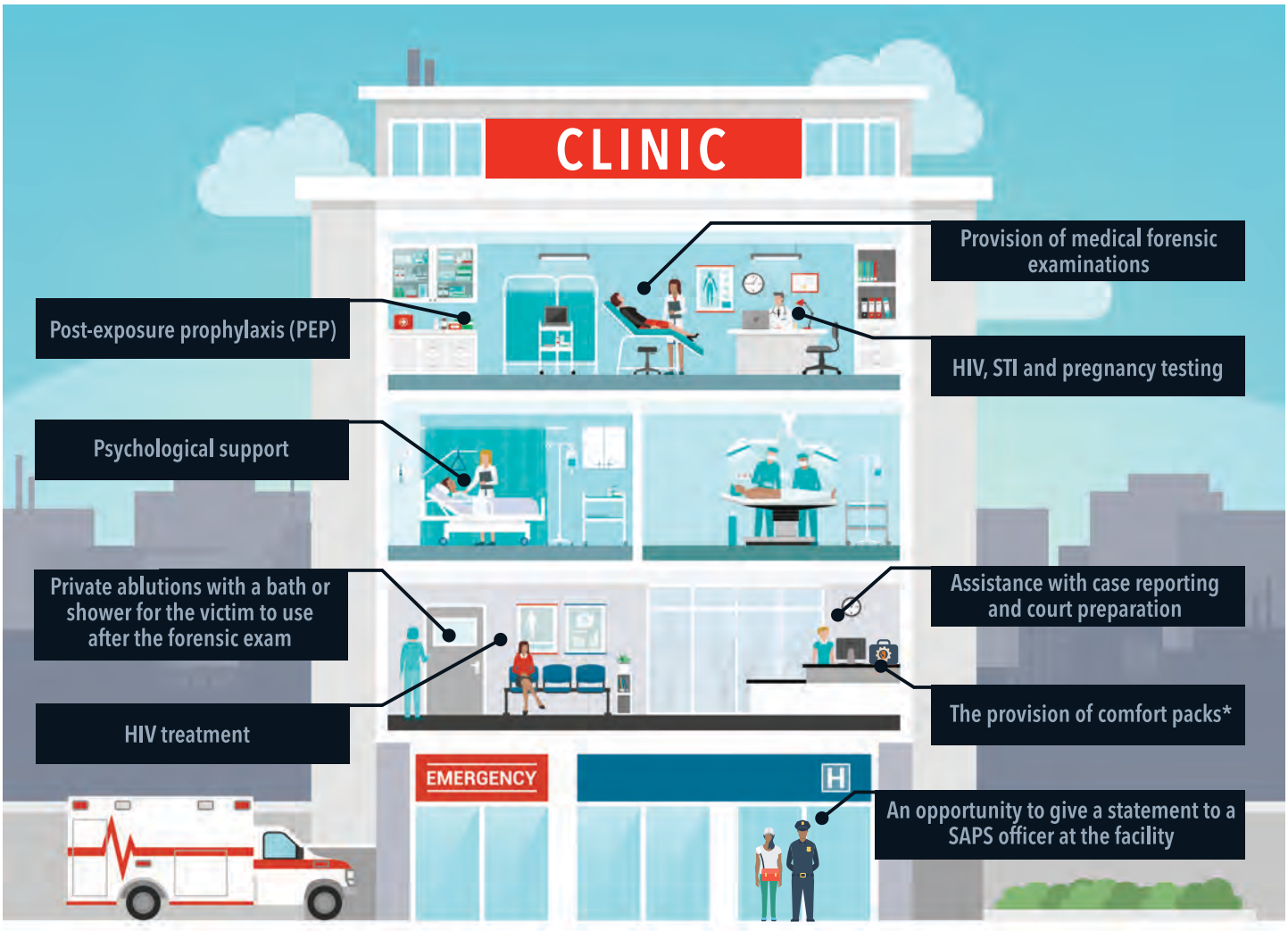
**FACILITIES WITH AN NGO**

| | |
|---|---|
| Facilities with an NGO | 72.22% |

## 2. Findings related to post-violence care

When asked the question 'do you provide post violence care?' 14 of the 18 facilities (77.78%) responded yes. However, when this was unpacked further it was found that facilities were using different assessments or definitions of 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, for example. Additionally, all the facilities in our sample are able to provide some services, such as HIV testing, but some don't provide this service to victims of sexual violence because their understanding is that they should refer victims in order not to interfere with the collection of evidence.

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




*A comfort pack is a small package or kit that is given to victims or survivors. It usually contains age and gender appropriate items such as underwear, sanitary pads for women and girls, toothbrush and toothpaste, soap, a facecloth and possibly a non-perishable snack.*

If a facility provides all of the above services, to victims of violence, they are said to provide post-violence care. It is an important finding that facilities responded positively to the question whether they provide post-violence care even if they do not provide the full package, as this might indicate that it is necessary to raise awareness of what the full package of care entails. This response also indicates that victims of violence are inconsistently cared for if they are referred by some facilities, but receive basic care at others. This points to a need to strengthen the referral pathways (further discussed below).

Two facilities reported that they perform medical forensic examinations – Mtubatuba Clinic and Hlabisa Hospital (during the district session). When asked for clarity on the meaning of the district session it was explained that a district surgeon comes to the hospital and does sessions periodically. In practice this could mean that a victim only receives a medical forensic examination and treatment after 72 hours. This was of concern firstly, because of the importance of victims accessing treatment such as PEP and secondly, because of the importance of timely evidence collection.

None of the facilities in Hlabisa and Mtubatuba provide the full package of post-violence care services.

All of the facilities provide HIV testing, and seventeen (94.44%) can provide PEP and HIV treatment, which means that these services are potentially available to victims sexual violence at all facilities irrespective of their ability to provide the full package of care.

*Services provided across facilities*


**22.22%**
Assistance with case reporting and court preparation

**94.44%**
HIV treatment

**94.44%**
Post-exposure prophylaxis (PEP)

**100%**
HIV testing

**44.44%**
Psychological services

**33.33%**
Opportunity to give a statement to SAPS

**33.33%**
Provision of comfort packs

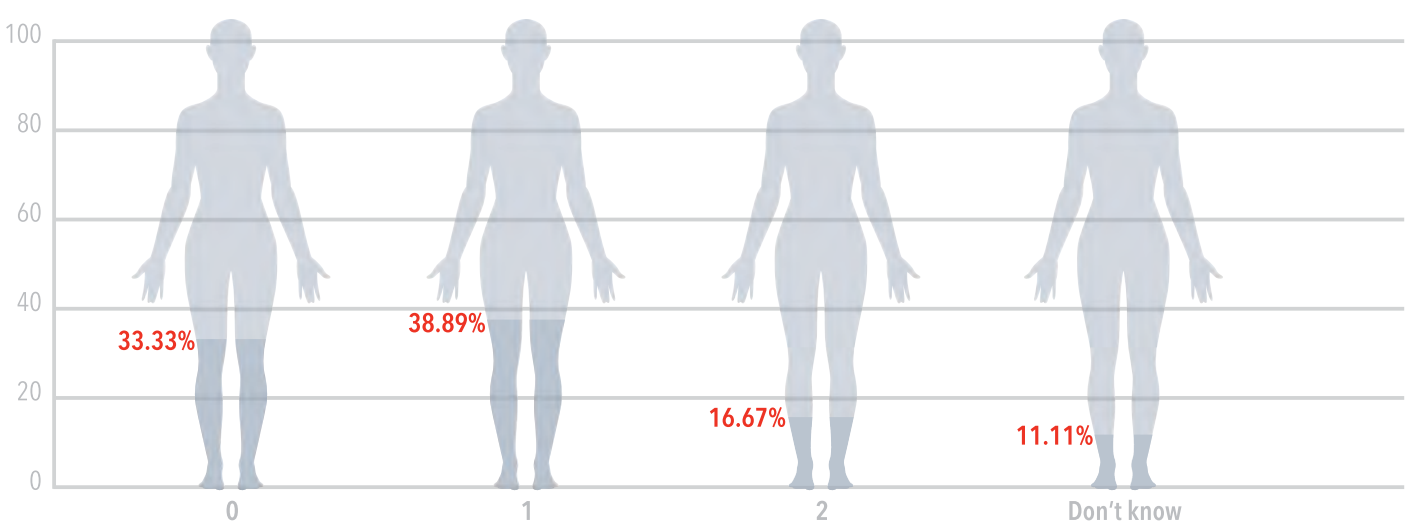
**44.44%**
Private ablutions with bath/shower and toilet

**11.11%**
Medical forensic exam

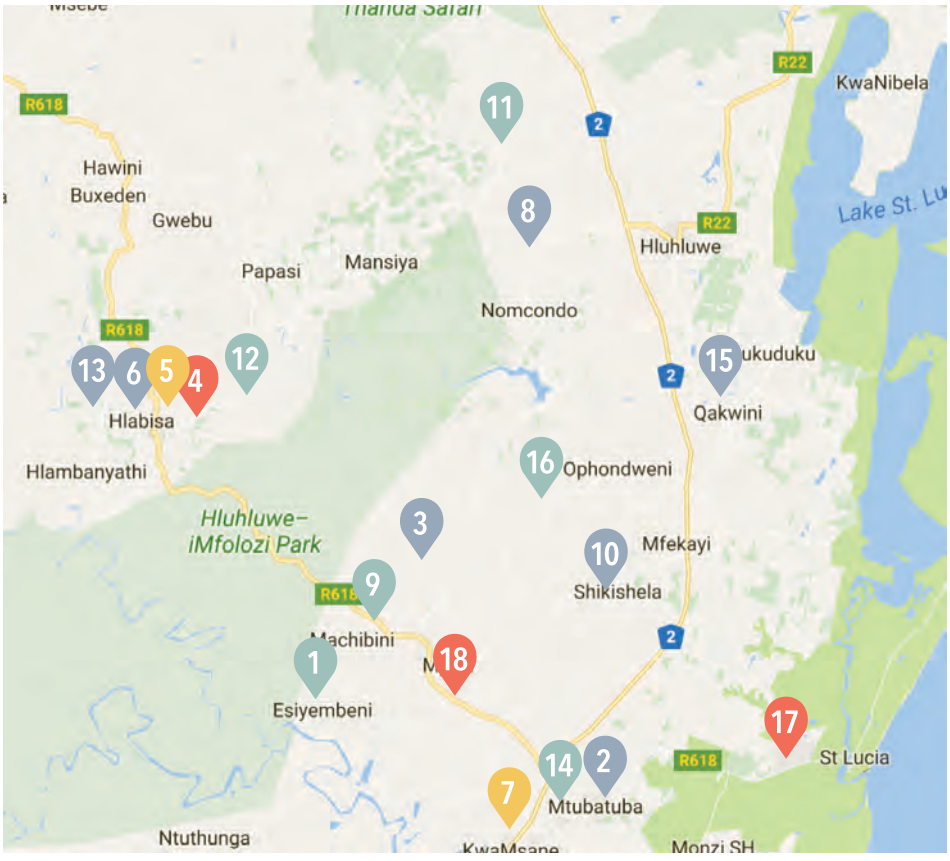
## 2.1 Number of sexual offence cases per week

Overall, facilities reported that they see between 0 and 2 cases of sexual assault per week. The highest number of cases reported was 2. The average number of cases of sexual assault seen by facilities per week is 0.81.


## AVERAGE NUMBER OF CASES OF SEXUAL ASSAULT SEEN PER WEEK BY FACILITIES IN HLABISA AND MTUBATUBA



*Facilities reporting receiving victims of sexual violence*




| MAP KEY | FACILITY |
|---|---|
| 1 | Esiyembeni Clinic |
| 2 | Zwenelisha Clinic |
| 3 | Gunjaneni Clinic |
| 4 | Hlabisa Gateway Clinic |
| 5 | Hlabisa Hospital |
| 6 | Inhlwathi Clinic |
| 7 | KwaMsane Clinic |
| 8 | Macabuzela Clinic |
| 9 | Machibini Clinic |
| 10 | Madwaleni Clinic |
| 11 | Makhowe Clinic |
| 12 | Mpembeni Clinic |
| 13 | Mpukunyoni clinic |
| 14 | Mtubatuba Clinic |
| 15 | Nkundusi Clinic |
| 16 | Ntondweni Clinic |
| 17 | Sipho Zungu Clinic |
| 18 | Somkhele Clinic |

2 cases per week
1 case per week
None
Don't Know

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. One week they would get no cases and the following week they could get four. Secondly, as PHCs do not record the victims of sexual violence that report at the clinic, it was challenging for them to report the true number of cases.

When asked for more detail about the victims reporting to the facilities and whether respondents had perceived an increase in sexual violence and reporting in the last five years, the majority of interviewees from facilities reported that they did not think that sexual violence has increased in the last five years. The reason they most often suggested was that victims don't report. Those that reported that sexual violence has increased suggested that the reasons included family's keeping sexual violence a secret, children walking long distances to school and family negligence. Lack of awareness on the community of what constitute gender-based violence was also mentioned as a barrier to people reporting. Some mentioned that they have seen the sexual assault statistics from the community rise every year and they hear about it on the news. Holidays and the festive season were mentioned as times when more victims of sexual violence were seen. When asked about the ages of victims that are most likely to report at their facility, adults were mentioned most often, followed by adolescents and children.

Lack of awareness of what gender-based violence is, combined with cultural factors that keep such cases hidden was mentioned in other key informant interviews with NGOs working in the area as important barriers to why more cases are not identified and reported. This might include some forms of violence being normalised as "the husband takes control" (interview with NGO), the practice of polygamy, it being seen as an infringement on people's private space if someone tries to intervene in the home environment, the use of other practices, such as the payment of a sheep to a family as compensation when abuse of a child had taken place, and women being financially dependent on abusive partners and therefore tolerating the abuse due to the lack of an alternative and asking "why do you want to take away my food, shelter, and children" (interview with NGO) when interventions are attempted.

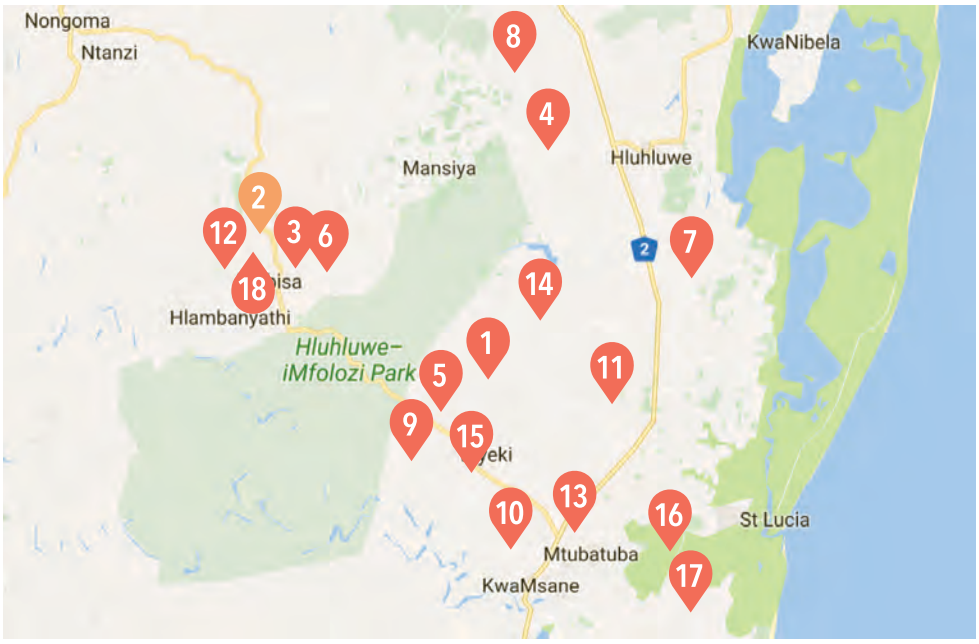
## 2.2 PVC referral pathways

All of the facilities in Hlabisa and Mtubatuba refer victims to Hlabisa hospital. Hlabisa hospital reported that they only provide medical forensic examinations during the district session. They don't provide a bath or shower facility, comfort packs and clean clothes, an opportunity to give a statement to SAPS or case reporting and court preparation. A challenge mentioned by interviewees in the provision of post-violence care is that the

district session is not always available over weekends, the hospital is far to travel to for some, and that there is not always timely access to an ambulance in emergencies.

It is important to consider the implications of these referral pathways for the ability of victims to be able to receive the full package of care, which none of the facilities currently provide, and to receive this care timeously. In addition, any referral pathway also needs to consider potential further trauma to victims in having to relay their experiences at multiple times if they have to report at multiple facilities. As the nearest TCC is approximately 60 km from Mtubatuaba – Empangeni TCC at Ngwelezana Hospital – it is important that victims in Hlabisa and Mtubatuba are able to access all of the elements of care in within these districts.

***Facilities and referral pathways***




| MAP KEY | FACILITY |
|---|---|
| 1 | Gunjaneni Clinic |
| 2 | Hlabisa Hospital |
| 3 | Inhlwathi Clinic |
| 4 | Macabuzela Clinic |
| 5 | Machibini Clinic |
| 6 | Mpembeni Clinic |
| 7 | Nkundusi Clinic |
| 8 | Makhowe Clinic |
| 9 | Esiyembeni Clinic |
| 10 | KwaMsane Clinic |
| 11 | Madwaleni Clinic |
| 12 | Mpukunyoni Clinic |
| 13 | Mtubatuba Clinic |
| 14 | Ntondweni Clinic |
| 15 | Somkhele Clinic |
| 16 | eZwenelisha Clinic |
| 17 | Sipho Zungu Clinic |
| 18 | Hlabisa Gateway Clinic |

It was also evident from interviews with other NGOs working in Hlabisa and Mtubabtuba that the rural nature of the district is important to consider as a design feature in referral pathways and in the upscaling of facilities to provide post-violence care, as one interviewee explains: *"Topographical it [the district] is rural, so providing healthcare is difficult. We talk about the catchment area of the population rather than the district, because of what the area looks like geographically"* (interview with NGO).

## 2.3 Willingness to provide post-violence care

All of the interviewees at facility-level thought that post-violence care is a service they should be providing at their facilities. The reasons included that Hlabisa hospital is too far for most victims to travel, there are a lot of abused and vulnerable people living in the community, and some people are uneducated regarding sexual abuse. For example there are still people living in the community who think that having sex with an infant cures HIV. It was also indicated that very often victims don't report, indicating the need for awareness and education in the community.

The large majority said that they would like to be equipped to provide post-violence care. PVC training; relevant staff such as forensic nurses, social workers and psychologists, sufficient space and private rooms, and equipment were recognised as essential to providing post-violence care services.

The majority of interviewees wanted their facility to be equipped sufficiently so that victims don't need to travel the distance to the hospital. However, facilities differed in relation to which services they wanted to provide – some wanted to be able to provide specific elements such as trauma counselling, social services, HIV testing, PEP, and assistance with case reporting; while others wanted to be able to provide all post-violence care services including forensic nurses, equipment and rooms so that they don't have to refer

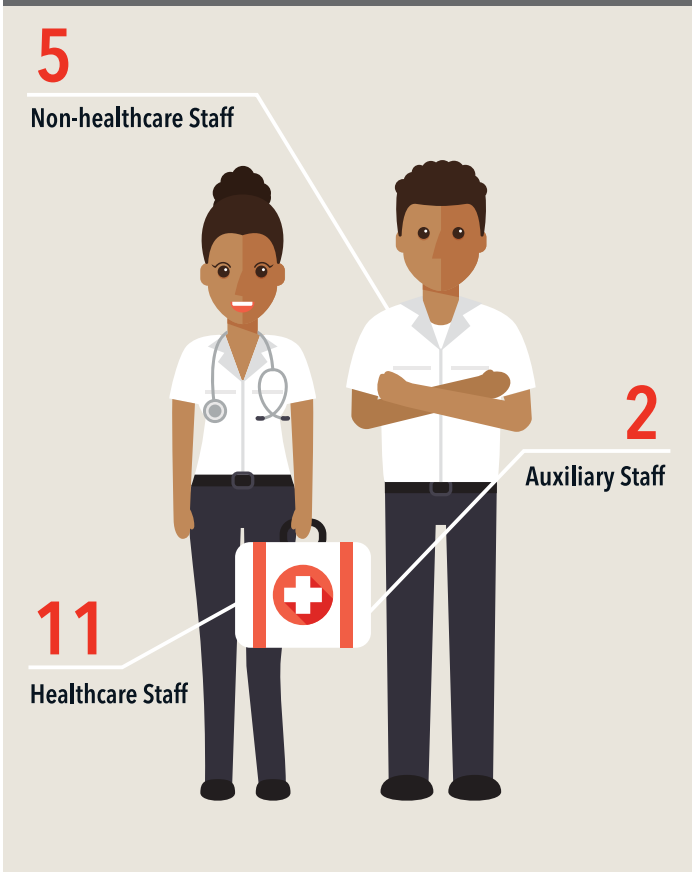
victims anywhere. But there was a majority view that facilities should be provided with more staff, facility space and private rooms, enough equipment as some equipment is absent or broken, and training to be able to better support victims of post-violence care.

Interviews with other NGOs working in Hlabisa and Mtubatuba confirmed the challenges outlined above: *"access to service points are inadequate and service time in the form of transport to hospital is also inadequate"* (interview with NGO). When asked what the most immediate things are that could be improved at facilities in relation to the provision of post-violence care, one interviewee answered that: *"all consulting rooms should have a safe space; there should be a proper triage system that identifies victims early; and there should be a separate waiting area in the clinic"* (interview with NGO).

### 2.4 Training on providing post-violence care

Interviewees spoke of the need for training on how to best care for victims of violence. Eleven (61.11%) facilities in Hlabisa and Mtubatuba reported that their healthcare staff had received refresher training in post-violence care in 2016. Five (27.78%) reported that their non-healthcare staff had received refresher training in 2016 and two (11.11%) reported that their auxiliary staff had received refresher training in 2016. The training was provided by FPD, MatCH Systems or the Department of Health.

**FACILITIES IN HLABISA AND MTUBATUBA THAT RECEIVED REFRESHER TRAINING IN POST-VIOLENCE CARE IN 2016**




Even if the full package of care is not available to victims, basic sensitisation on how to approach and support victims, awareness of the different types of care they need and where to refer them affects how victim-friendly facilities are. In terms of improving client/victim-friendliness interviewees recommended that staff be trained in client-friendliness, have waiting areas that are comfortable, have enough consultation and examination rooms for privacy and increase their youth- and child-friendliness.

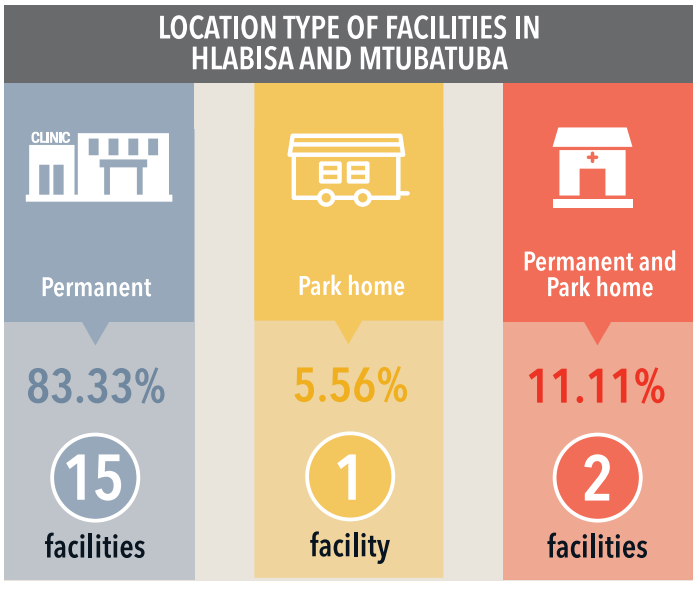
Interviews with other NGOs working in Hlabisa and Mtubatuba indicated the importance of nurses being trained to be able to identify cases of possible abuse and violence as victims do not always openly declare this when they present at the clinic. There was a sense that nurses sometimes "treat what you see" (interview with NGO) and might therefore not identify all relevant cases and know how to treat them. On the other hand another key informant commented that, *"the smaller PHCs are staffed by nurses who know the community. The benefit of this is that they take things more personally, and this familiarity is more of a positive than a negative. These nurses have a finger on the pulse of the catchment area. This is the rural model of health"* (interview with NGO). Although these perspectives are slightly different, they point to the important role that nurses can play in the identification of and provision of support to victims of abuse and sexual violence.

## 3. Facilities and sites

### 3.1. Location type

The majority (83.33%) of facilities in Hlabisa and Mtubatuba are located in permanent buildings (15 facilities). The remaining facilities are either located only in a park home (1 facility) or in both a permanent building and park home (2 facilities).

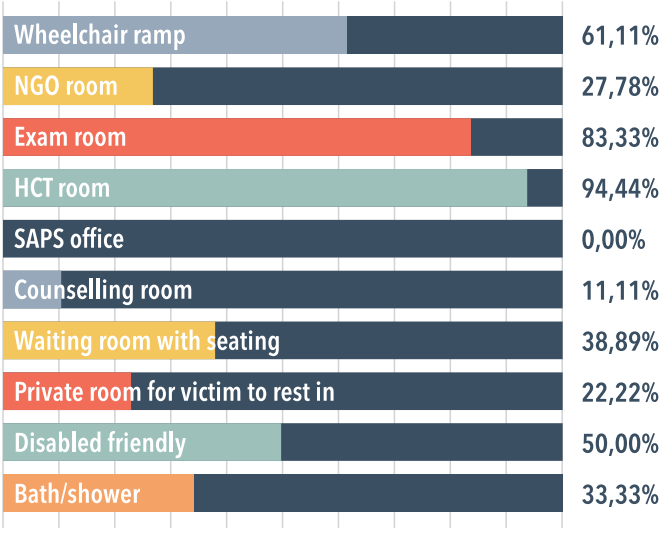
**LOCATION TYPE OF FACILITIES IN HLABISA AND MTUBATUBA**



## 3.2. Space and accessibility

Half of the facilities in Hlabisa and Mtubatuba have disabled-friendly toilets and eleven (61.11%) have a wheelchair ramp. Seventeen (94.44%) have an HCT room and 15 (83.33%) have an exam room. Only seven (38.89%) have a waiting room with seating .


### SPACE AND ACCESSIBILITY IN FACILITIES




## 3.3. Equipment and supplies

**General equipment**

Fourteen facilities have computers (77.78%), 16 have telephones (88.89%), 14 have photocopiers (77.78%), and all have fire extinguishers (100%). Two facilities have access to the internet (11.11%), three have IEC material (17.67%) and one toys for children (5.56%) .

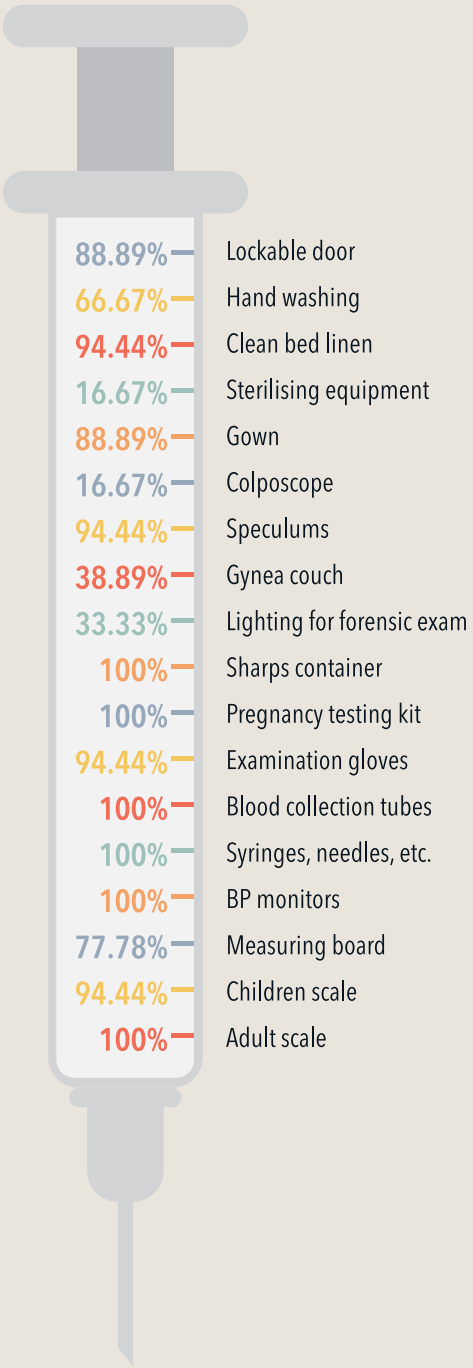
### GENERAL EQUIPMENT AVAILABLE ACROSS FACILITIES

| | | |
|---|---|---|
| 16.67% IEC material | 0.00% Anatomically correct dolls | 5.56% Toys |
| 0.00% Comfort packs | 11.11% Clean clothes | 0.00% Refreshments |
| 72.22% Lockable cabinet | 100% Fire extinguisher | 44.44% Microwave |
| 88.89% Fridges | 33.33% Heaters | 72.22% Aircon |
| 66.67% Fans | 0.00% Cameras for evidence | 11.11% Email/Internet |
| 50.00% Printer | 77.78% Photocopier | 38.89% Fax machine |
| 88.89% Telephone | 77.78% Computer | |

**Medical equipment**

All of the facilities in Hlabisa and Mtubatuba have sharps containers, pregnancy testing kits, blood collection tubes, syringes, needles, sterile swabs and BP monitors. Seventeen (94.44%) facilities have a speculum (or non-disposable speculums), three (16.67%) have a colposcope and seven (38.89%) have a gynaecological couch.

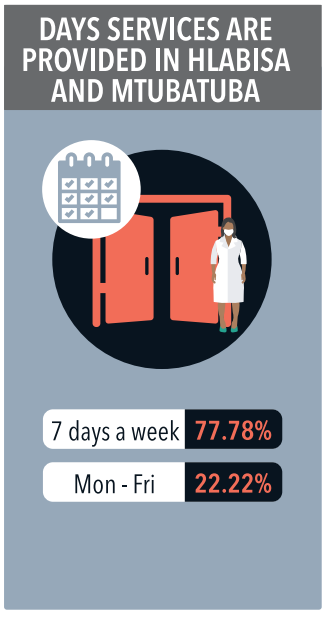
## MEDICAL EQUIPMENT AVAILABLE ACROSS FACILITIES

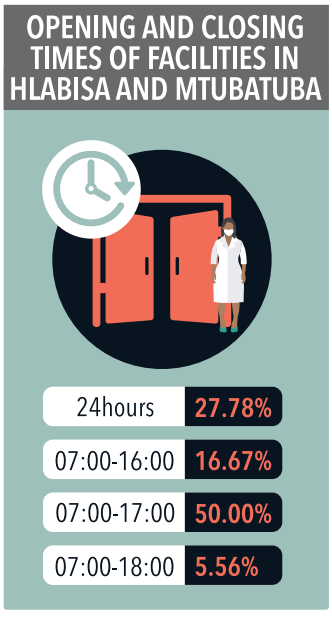



# 4. Services delivered

## 4.1. Days and hours of service

The majority of facilities in Hlabisa and Mtubatuba are open 7 days a week (77.78%; 14 facilities), from 7:00 to 17:00 (50.00%). Hlabisa hospital and four clinics reported that they are open 24 hours a day (Makhowe Clinic, KwaMsane Clinic, Sipho Zungu Clinic and Ntondweni Clinic).


## 4.2. Waiting time

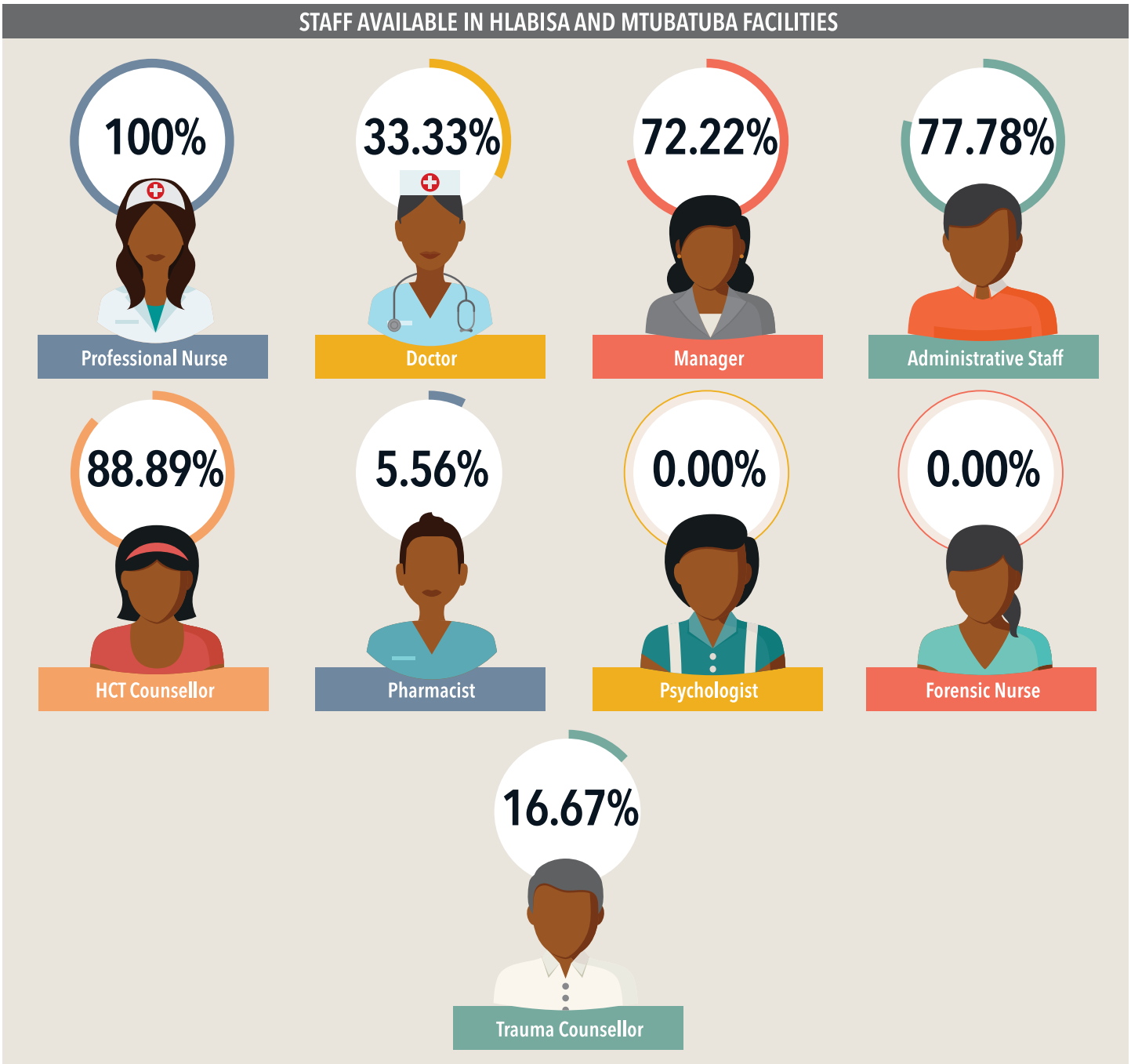
Overall, fourteen (77.78%) facilities reported that patients don't wait longer than 45 minutes to receive care.

# 5. Human resources

## 5.1. Staffing

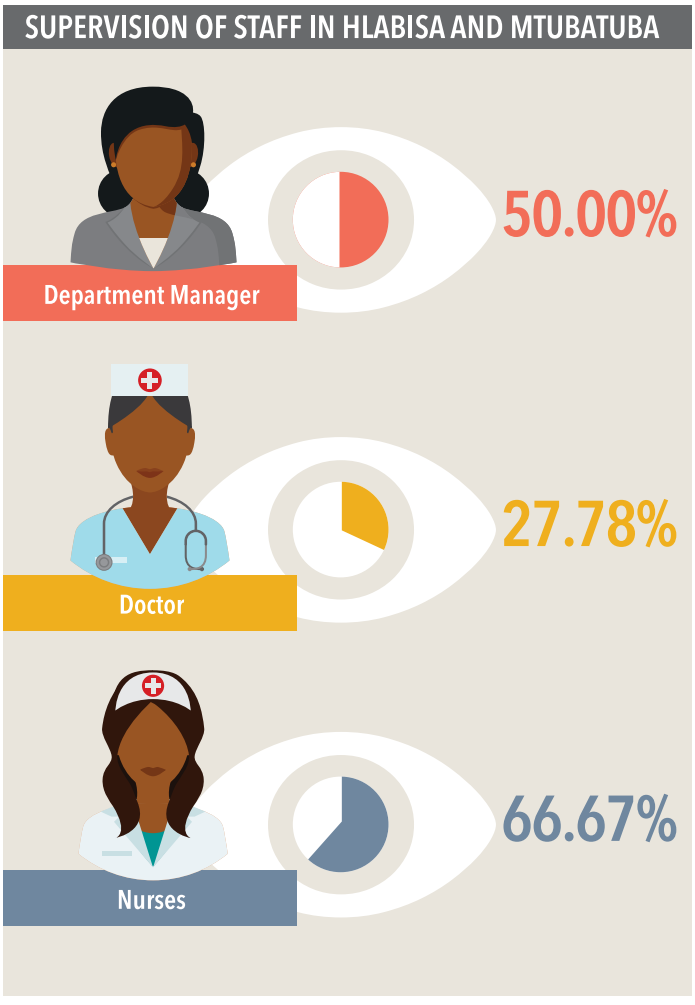
### 5.1.1 Staff available in facilities (full and part time)

All of the facilities in Hlabisa and Mtubatuba have at least one professional nurse, six facilities (33.33%) have a Doctor. Thirteen (72.22%) have a facility or department manager, and fourteen (77.78%) have administrative staff.

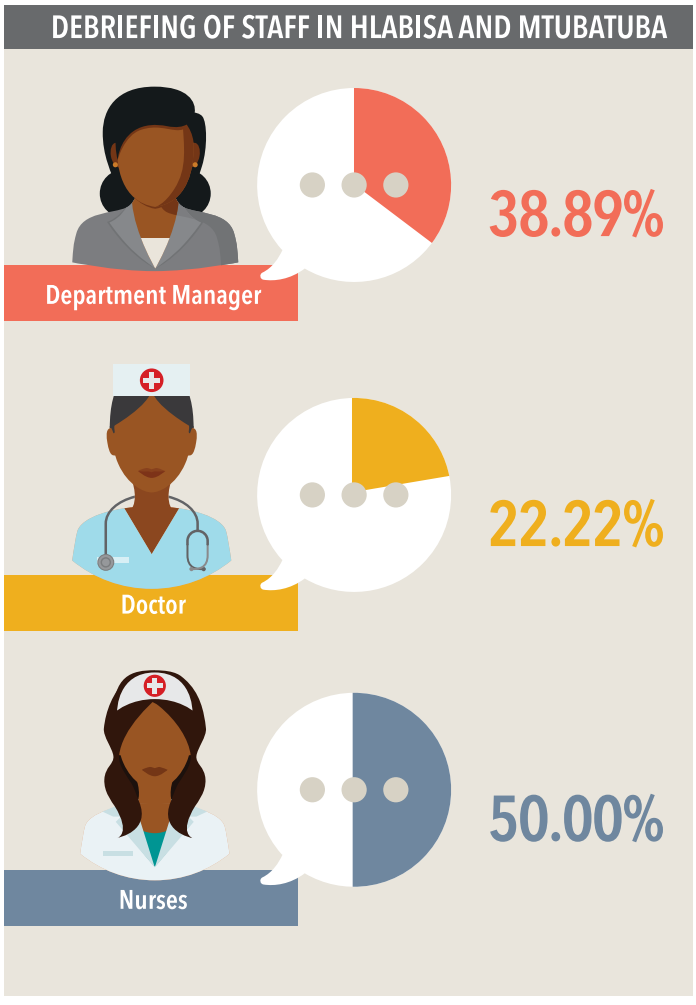
### 5.1.2 Staff supervision

Half of the facilities reported that their managers are supervised, five (27.78%) that their doctors are supervised and 12 (66.67%) that their nurses are supervised.




### 5.1.3 Staff debriefing

Half of the facilities reported that their nurses receive debriefing, seven (38.89%) that their department manager is debriefed and four (22.22%) that their doctors are debriefed.




# 6. NGOs as service providers

Thirteen facilities (72.22%) reported that they have an NGO providing services.

***NGOs supporting facilities***

**MatCH Systems**

Support the provision of PVC services

Provide training

Support HIV programme

Support HCT

Condom distribution

Data capturing

Provision of nurses

Youth-friendly services

FACILITIES PROVIDED SERVICES IN

10

**Humana People to People SA**

Community-based services

FACILITIES PROVIDED SERVICES IN

1

**UNYEZI**

Social Services

FACILITIES PROVIDED SERVICES IN

1

**AHRI Africa Health Research Institute**

Community-based HCT

Support HIV programme

Support HCT

Condom distribution

Training

*formerly Africa Centre for Population Health*

FACILITIES PROVIDED SERVICES IN

9

# CHAPTER 5: SUB-DISTRICT FINDINGS: HLABISA

# CHAPTER 5: SUB-DISTRICT FINDINGS: HLABISA

Data were collected from 9 facilities in Hlabisa, 1 hospital and 8 PHCs.

## 1. Findings related to PVC

Hlabisa hospital is the only facility in Hlabisa to provide medical forensic examinations. All provide HIV testing, PEP and HIV treatment.

***Services provided in Hlabisa facilities***


**22.22%**
Assistance with case reporting and court preparation

**100%**
HIV treatment

**100%**
Post-exposure prophylaxis (PEP)

**100%**
HIV testing

**55.56%**
Psychological services

**44.44%**
Opportunity to give a statement to SAPS

**55.56%**
Provision of comfort packs

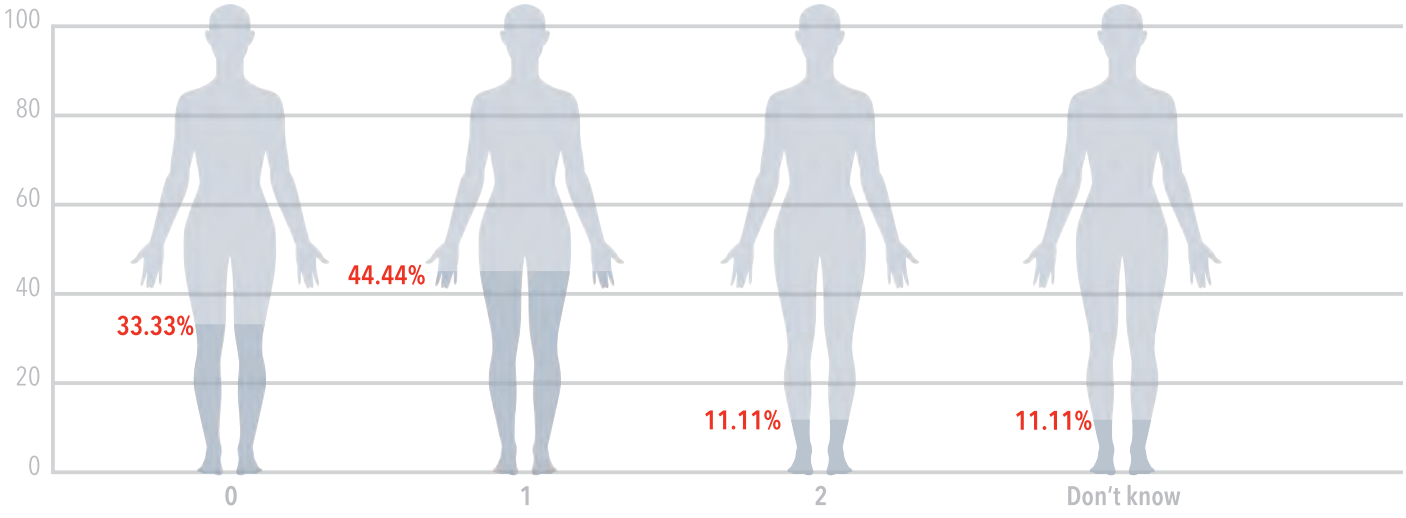
**55.56%**
Private ablutions with bath/shower and toilet

**11.11%**
Medical forensic exam

### 1.1. Number of sexual offence cases per week

The average number of sexual assault cases across facilities in Hlabisa is 0.75. Four (44.44%) facilities reported seeing an average of 1 case of sexual violence per week.


## AVERAGE NUMBER OF CASES OF SEXUAL ASSAULT SEEN PER WEEK BY FACILITIES IN HLABISA




### 1.2. PVC referral pathways

All of the facilities in Hlabisa refer victims to Hlabisa hospital. Hlabisa hospital reported that they only provide medical forensic examinations during the District Session.

### 1.3 Training on providing post-violence care

Six (66.67%) facilities reported that their healthcare staff had received refresher training in 2016. Four (44%) reported that their non-healthcare staff had received refresher training in 2016. Two (22.22%) reported that their auxiliary staff had received refresher training in 2016.

# 2. Facilities and sites

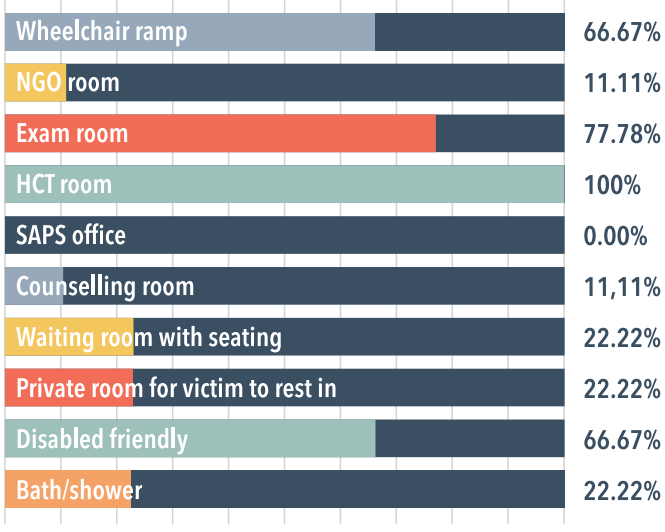
### 2.1. Type of buildings

All of the facilities in Hlabisa are located in a permanent building.

### 2.2. Space and accessibility

Six facilities have disabled friendly toilets (66.67%), all have an HCT room (100%), seven have an examination room (77.78%) and six have a wheelchair ramp (66.67%).

## SPACE AND ACCESSIBILITY IN HLABISA FACILITIES



## 2.3. Equipment and supplies

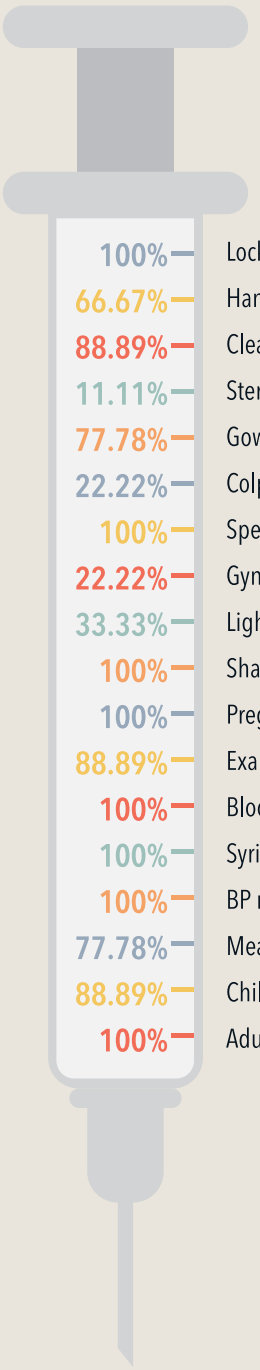
Six facilities in Hlabisa have computers (66.67%), eight have telephones (88.89%), seven have photocopiers (77.78%), all have fire extinguishers (100%) and six have lockable cabinets (66.67%).

### GENERAL EQUIPMENT AVAILABLE IN HLABISA FACILITIES

- 22.22% IEC material
- 0.00% Anatomically correct dolls
- 11.11% Toys
- 0.00% Comfort packs
- 11.11% Clean clothes
- 0.00% Refreshments
- 66.67% Lockable cabinet
- 100% Fire extinguisher
- 33.33% Microwave
- 77.78% Fridges
- 22.22% Heaters
- 66.67% Aircon
- 66.67% Fans
- 0.00% Cameras for evidence
- 11.11% Email/Internet
- 44.44% Printer
- 77.78% Photocopier
- 44.44% Fax machine
- 88.89% Telephone
- 66.67% Computer

All facilities in Hlabisa have adult scales, BP monitors, speculums, syringes, needles, sterile swabs, blood collection tubes, pregnancy testing kits, and sharps containers.

### MEDICAL EQUIPMENT AVAILABLE IN HLABISA FACILITIES

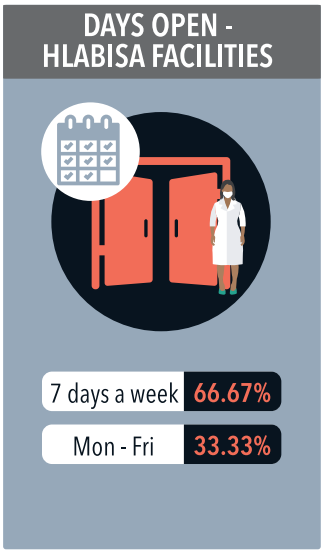


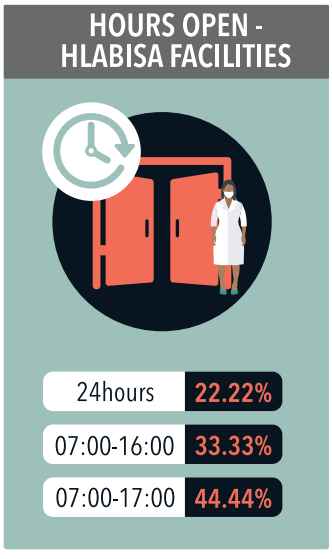
- 100% Lockable door
- 66.67% Hand washing
- 88.89% Clean bed linen
- 11.11% Sterilising equipment
- 77.78% Gown
- 22.22% Colposcope
- 100% Speculums
- 22.22% Gynea couch
- 33.33% Lighting for forensic exam
- 100% Sharps container
- 100% Pregnancy testing kit
- 88.89% Examination gloves
- 100% Blood collection tubes
- 100% Syringes, needles, etc.
- 100% BP monitors
- 77.78% Measuring board
- 88.89% Children scale
- 100% Adult scale

# 3. Services delivered

## 3.1. Days and hours of service

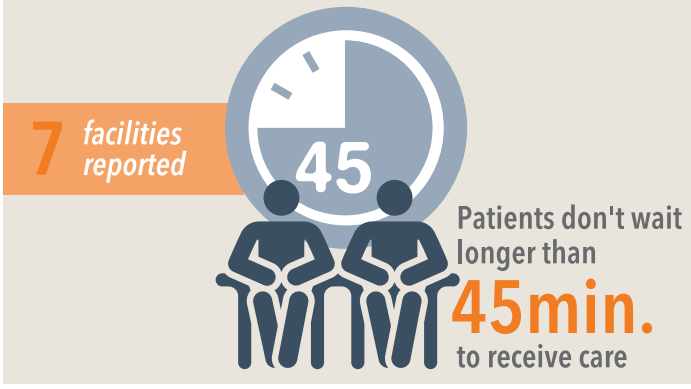
Six facilities (66.67%) are open 7 days a week and four from 7:00 to 17:00 (44.44%).


## 3.2. Waiting time

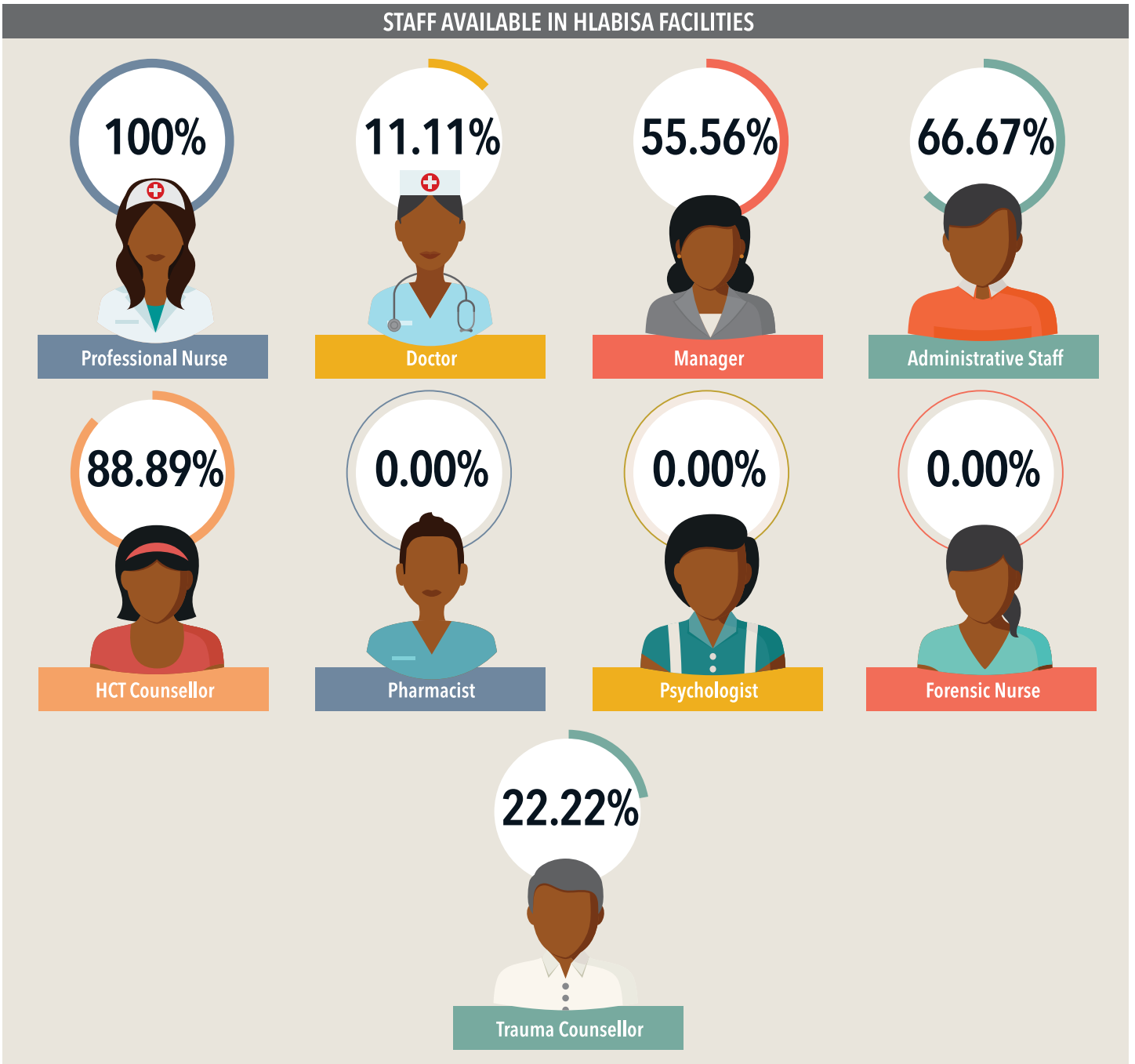
Seven facilities (77.78%) report that that they have a waiting time of 45 minutes or less.




# 4. Human resources

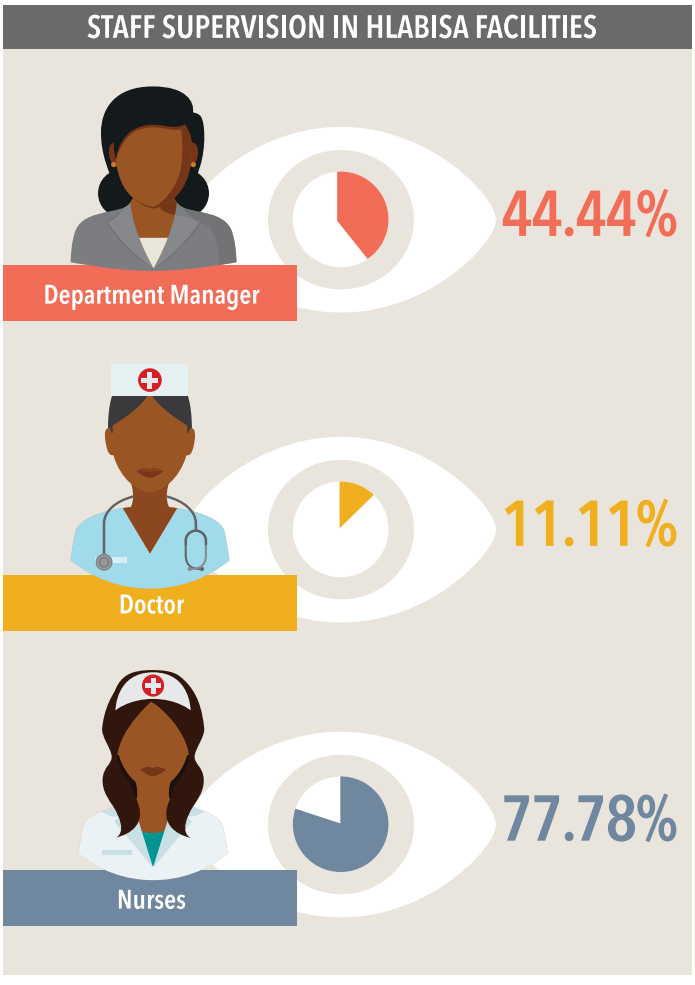
## 4.1. Staffing

All of the facilities in Hlabisa have at least one professional nurse. Five have a manager (55.56%), eight an HCT counsellor (88.89%) and six have administrative staff (66.67%).

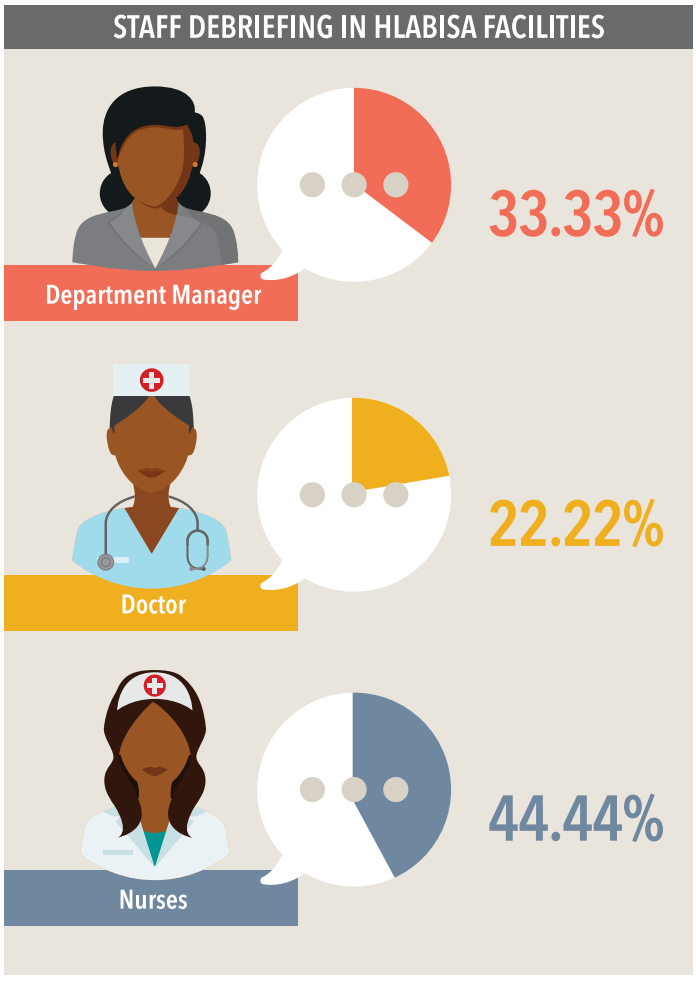
## 4.2. Supervision

Four facilities (44.44%) in Hlabisa reported that the Department Manager is supervised, seven facilities (77.78%) reported that their nurses are supervised and one facility (1.11%) reported that their doctors are supervised.




## 4.3. Debriefing

Three facilities (33.33%) in Hlabisa reported that the Facility Manager receives debriefing, four (44.44%) reported that their nurses receive debriefing and two (22.22%) that their doctors receive debriefing.




# 5. NGOs as service providers

Five facilities (55.56%) have an NGO working in them.

***NGOs in Hlabisa***

**MatCH Systems**

Support the provision of PVC services

Provide training

FACILITIES PROVIDED SERVICES IN

4

**Humana People to People SA**

Community-based services

FACILITIES PROVIDED SERVICES IN

1

**UNYEZI**

Social Services

FACILITIES PROVIDED SERVICES IN

1

**AHRI Africa Health Research Institute**

Community-based HCT

Support HIV programme

Support HCT

Condom distribution

Training

*formerly Africa Centre for Population Health*

FACILITIES PROVIDED SERVICES IN

1

# CHAPTER 6: SUB-DISTRICT FINDINGS: MTUBATUBA

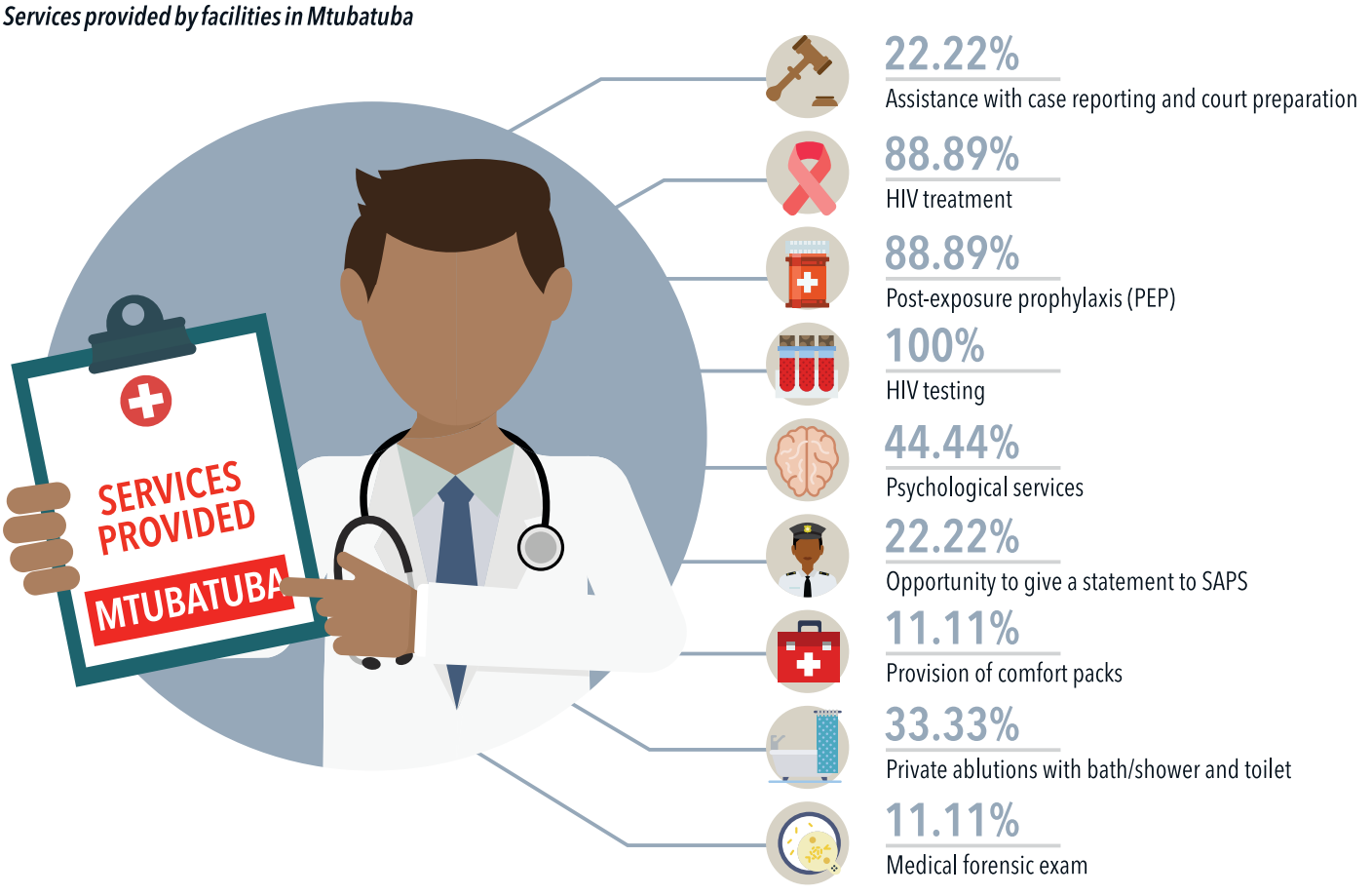
# CHAPTER 6: SUB-DISTRICT FINDINGS: MTUBATUBA

Data were collected from 9 facilities in Mtubatuba, all of which are PHCs.

## 1. Findings related to PVC

Only one facility in Mtubatuba provide medical forensic examinations, Mtubatuba Clinic. They don't offer the full package of post-violence care, but can provide psychological services, HIV testing, PEP and HIV treatment. All facilities offer HIV testing, eight (88.89%) provide PEP and HIV treatment.

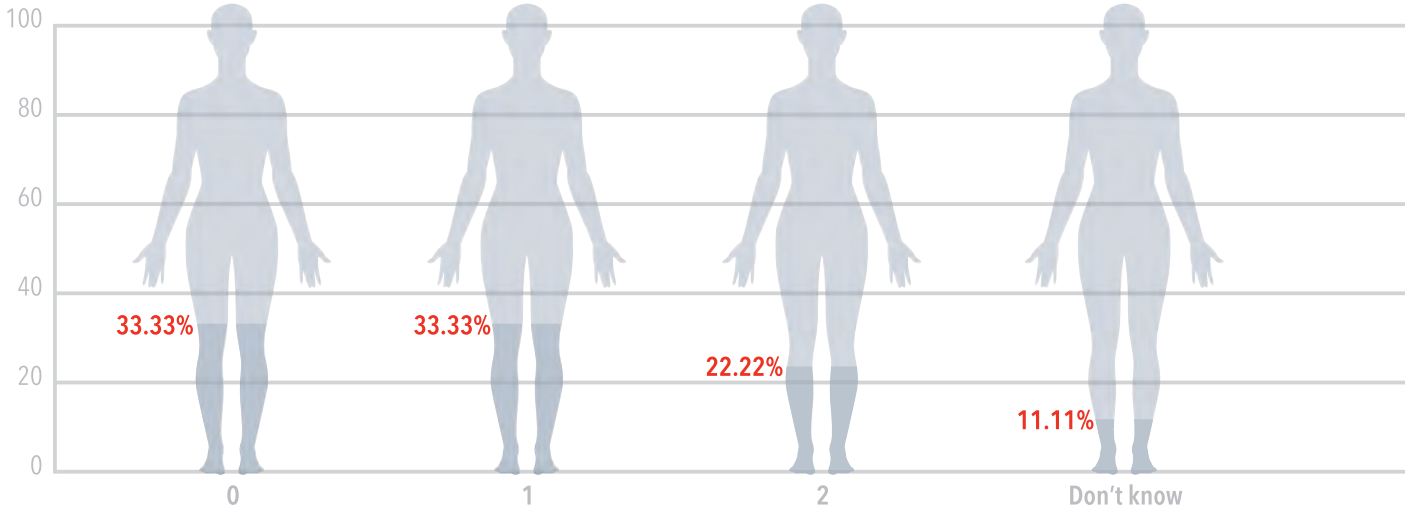
***Services provided by facilities in Mtubatuba***




### 1.1. Number of sexual offence cases per week

The average number of cases of sexual assault seen by facilities in Mtubatuba is 0.87, slightly higher than Hlabisa where the average in 0.75.


## AVERAGE NUMBER OF CASES OF SEXUAL ASSAULT SEEN PER WEEK IN MTUBATUBA FACILITIES




### 1.2. PVC referral pathways

All facilities refer victims to Hlabisa hospital. Although Mtubatuba Clinic reported that they do provide post-violence care including medical forensic examinations, no facilities refer victims here.

### 1.3. Training on providing post-violence care

Five facilities reported that their healthcare staff had received training in post-violence care in 2016, either by the Department of Health or MatCH Systems. One reported that their non-healthcare staff had received refresher training in 2016 by a Sister in the facility.

# 2. Facilities and sites

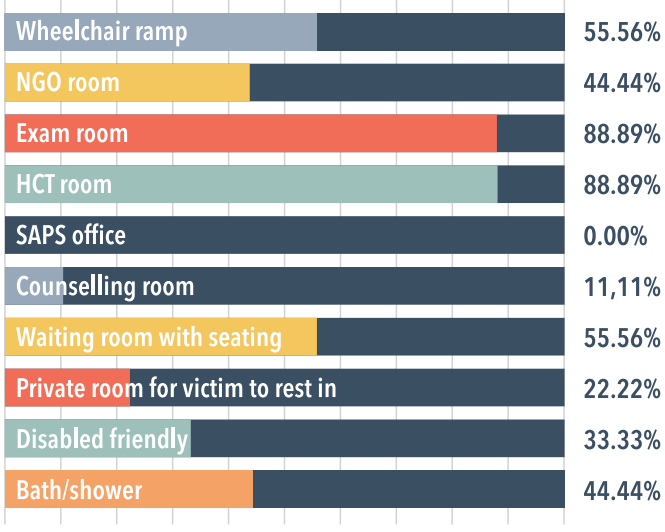
### 2.1. Type of buildings

All except one facility in Mtubatuba are located in permanent buildings.

### 2.2. Space and accessibility

Five facilities in Mtubatuba have waiting rooms with seating (55.56%), eight an HCT room and examination room (88.89%), and five have wheelchair ramps (55.56%).

## SPACE AND ACCESSIBILITY IN MTUBATUBA FACILITIES



## 2.3. Equipment and supplies

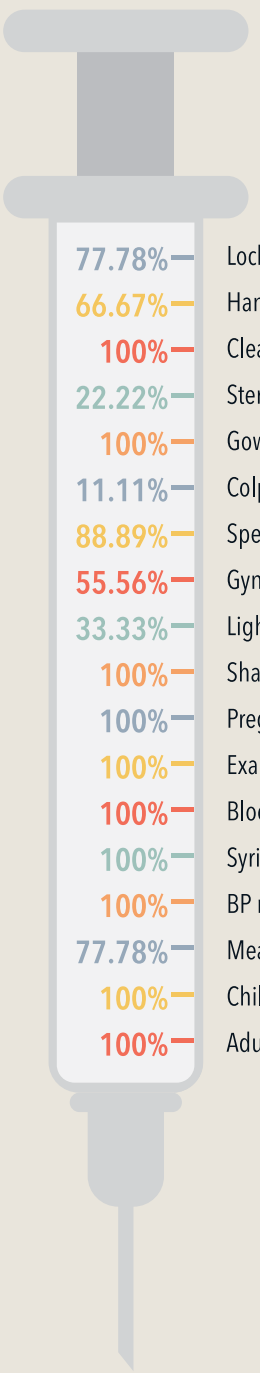
Eight facilities in Mtubatuba have computers and telephones (88.89%), seven have a photocopier (77.78%), and all have fire extinguishers (100%). Only one clinic has access to the internet (11.11%).

### GENERAL EQUIPMENT AVAILABLE IN MTUBATUBA FACILITIES

- 11.11% IEC material
- 0.00% Anatomically correct dolls
- 0.00% Toys
- 0.00% Comfort packs
- 11.11% Clean clothes
- 0.00% Refreshments
- 77.78% Lockable cabinet
- 100% Fire extinguisher
- 55.56% Microwave
- 100% Fridges
- 44.44% Heaters
- 77.78% Aircon
- 66.67% Fans
- 0.00% Cameras for evidence
- 11.11% Email/Internet
- 55.56% Printer
- 77.78% Photocopier
- 33.33% Fax machine
- 88.89% Telephone
- 88.89% Computer

All of the facilities in Mtubatuba have adult scales, children's scales, BP monitors, clean bed linen and gowns, syringes, needles, sterile swabs, blood collection tubes, examination gloves, pregnancy testing kits and sharps containers. Only one facility has a colposcope (11.11%), five have a gynaecological couch (55.56%) and eight have speculums (88.89%).

### MEDICAL EQUIPMENT AVAILABLE IN MTUBATUBA FACILITIES

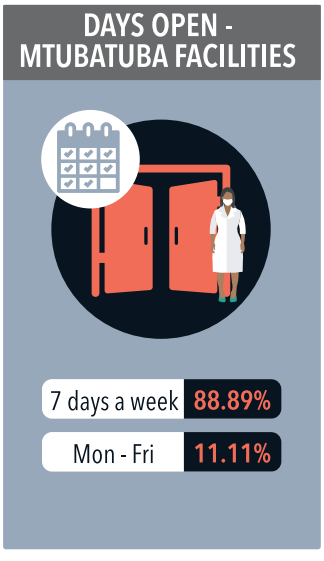


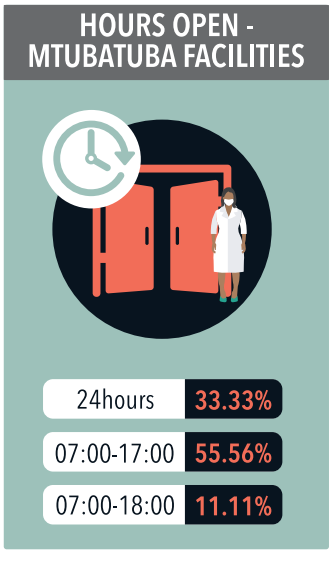
- 77.78% Lockable door
- 66.67% Hand washing
- 100% Clean bed linen
- 22.22% Sterilising equipment
- 100% Gown
- 11.11% Colposcope
- 88.89% Specula
- 55.56% Gynea couch
- 33.33% Lighting for forensic exam
- 100% Sharps container
- 100% Pregnancy testing kit
- 100% Examination gloves
- 100% Blood collection tubes
- 100% Syringes, needles, etc.
- 100% BP monitors
- 77.78% Measuring board
- 100% Children scale
- 100% Adult scale

# 3. Services delivered

## 3.1. Days and hours of service

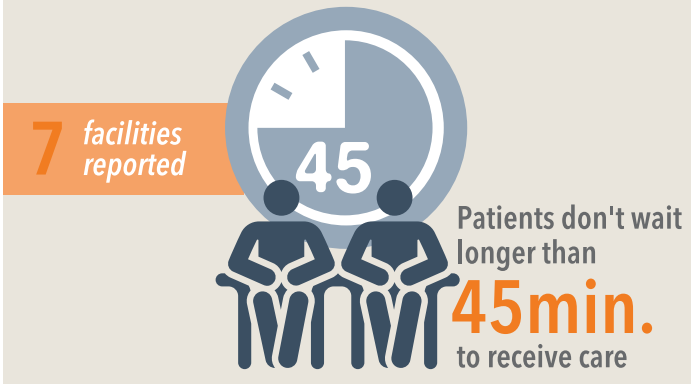
Eight facilities in Mtubatuba are open 7 days a week (88.9%), and five are open from 7:00 to 17:00 (55.56%).

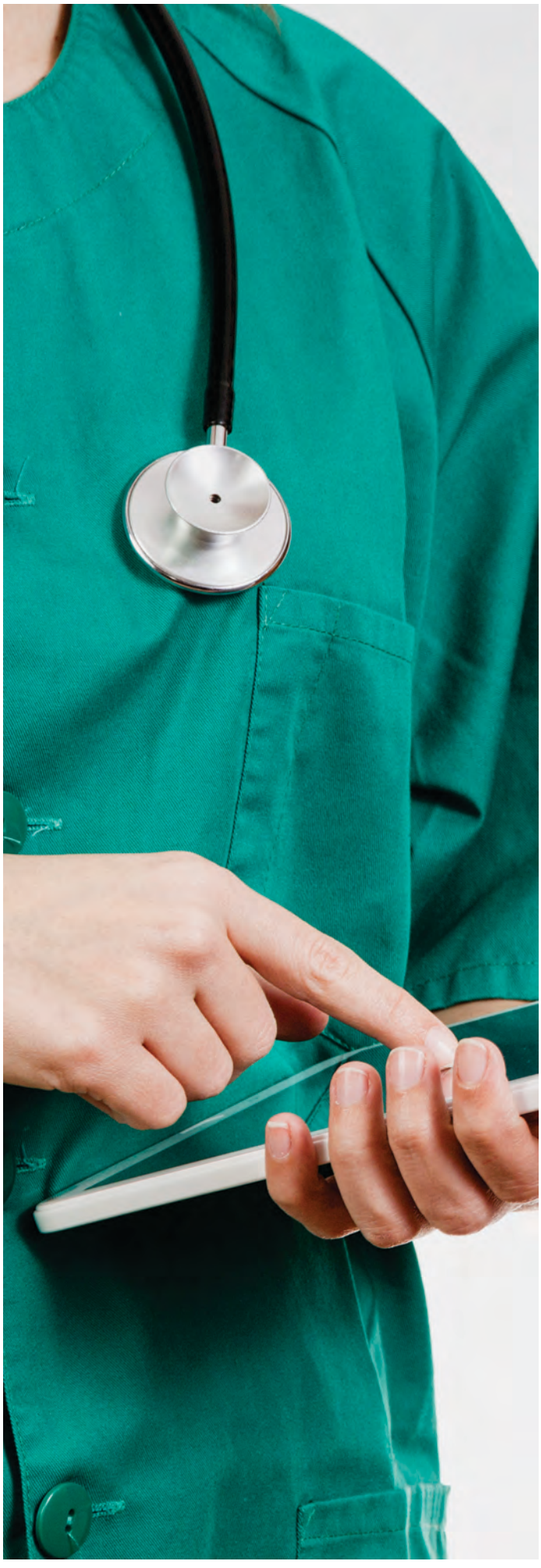




## 3.2. Waiting time

Seven (77.87%) facilities reported a waiting time of 45 minutes or less.

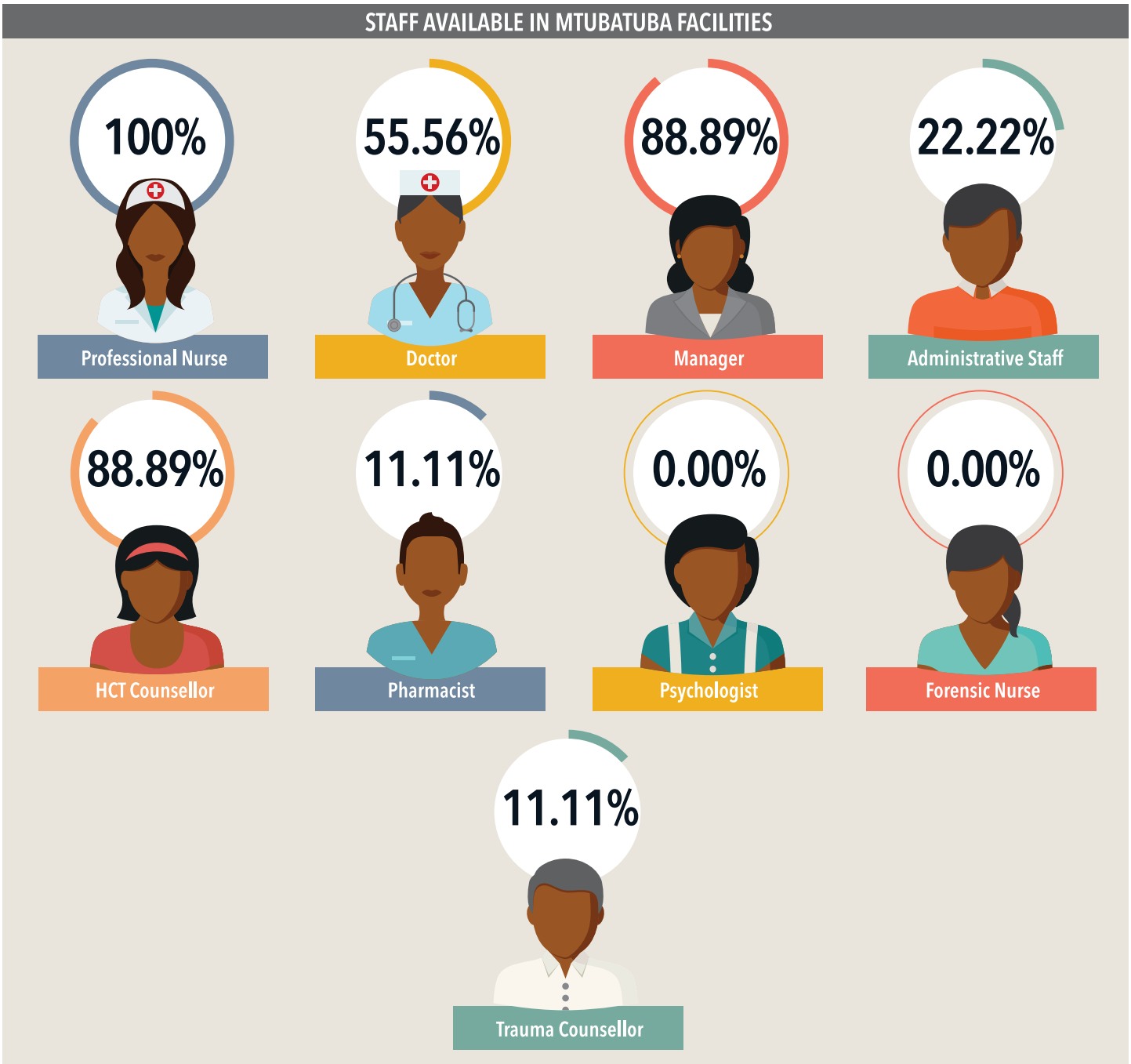


# 4. Human resources

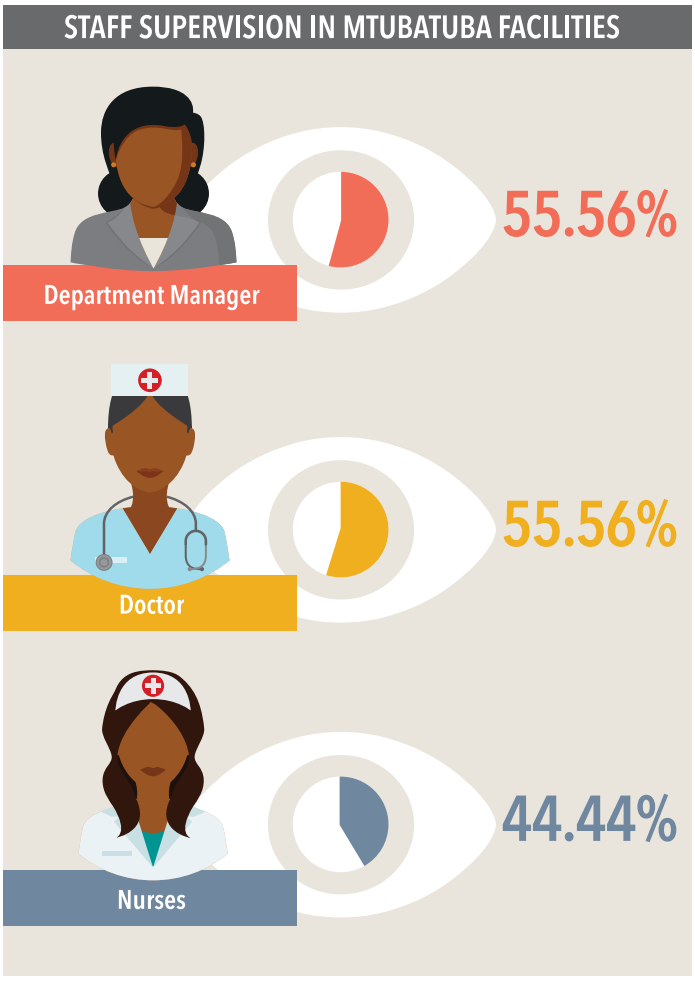
## 4.1. Staffing

All facilities in Mtubatuba have at least one professional nurse. Eight have HCT counsellors (88.89%), a manager (88.89%) and five have a doctor (55.56%). Only two have administrative staff (22.22%), one has a trauma counsellor and one has a pharmacist (11.11%). None have a psychologist of forensic nurses.

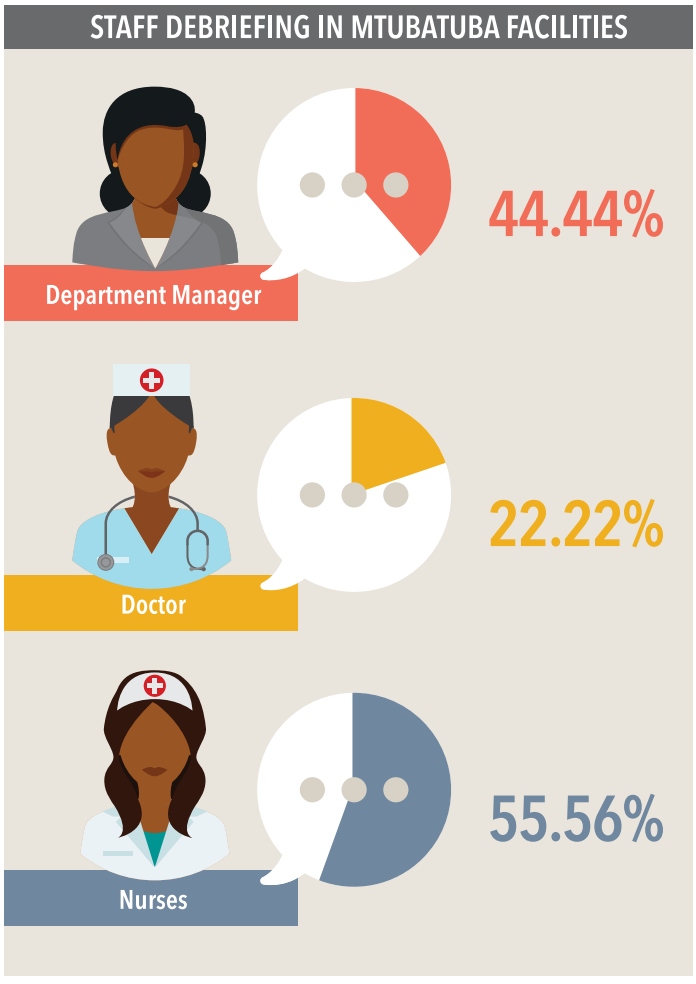
## 4.2. Supervision

Five facilities (55.56%) reported that the Department Manager and nurses is supervised. Four facilities (44.44%) reported that the doctors is supervised.




## 4.3. Debriefing

Four facilities (44.44%) reported that the Department Manager receives debriefing, five (55.55%) that their nurses receive debriefing and two (22.22%) that their doctors receive debriefing.




# 5. NGOs as service providers

Eight facilities in Mtubatuba have an NGO working with them.

***NGOs in Mtubatuba***

**MatCH Systems**

Support the provision of PVC services

Provide training

Support HIV programme

Support HCT

Condom distribution

Data capturing

Provision of nurses

Youth-friendly services

FACILITIES PROVIDED SERVICES IN

6

**AHRI**
**Africa Health Research Institute**

Community-based HCT

Support HIV programme

Support HCT

Condom distribution

Training

*formerly Africa Centre for Population Health*

FACILITIES PROVIDED SERVICES IN

8

# CHAPTER 7: RECOMMENDATIONS

# CHAPTER 7: RECOMMENDATIONS

Throughout, interviewees expressed a willingness to support victims of post-violence care who report to facilities. It is recommended that this willingness be supported by equipping staff better to provide this care. Based on the findings of the rapid assessment and gap analysis in Hlabisa and Mtubatuba the following recommendations are therefore made.

## 1. Recommendations on post-violence care services

### 1.1. General

Healthcare workers and facilities all have different definitions of what post-violence care is and what it entails.

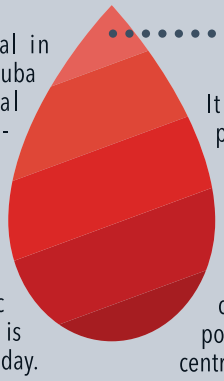

It is strongly recommended that all healthcare workers be familiarised with post-violence care, so that at the very least they are able to provide victims with accurate information and refer them to the correct facility.

A major challenge that was consistently reported by facilities was that often victims don't end up reporting at the referred hospital (Hlabisa Hospital) due to a lack of transport and money as the hospital is far away.

It is therefore strongly recommended that PHCs be equipped and allowed to provide comprehensive post-violence care services as they are closer to the communities they serve.


It is recommended that facilities that could possibly be scaled-up to provide post-violence care are identified and provided with staff training, facility space and equipment.

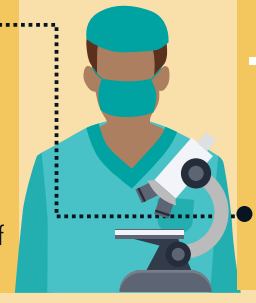
Only one hospital in Hlabisa and Mtubatuba provides medical forensic examinations, and only during the district session. Mtubatuba clinic is also able to provide medical forensic examinations, but is not open 24 hours a day.



It is recommended that post-violence care be available in at least one healthcare facility 24 hours a day, seven days a week. As five facilities are already open 24/7, these could serve as points to potentially upscale into crisis centres.

### 1.2. Staffing

There was a big gap with regards to forensic nursing and training to manage victims of sexual violence.

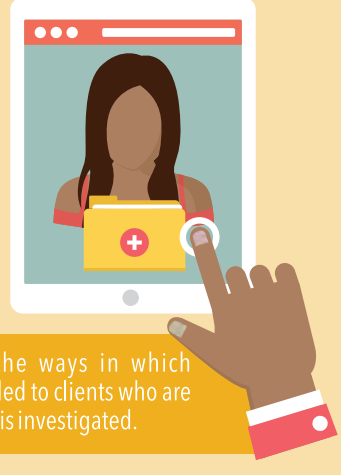


It is recommended that training be scaled up to include all facilities in Hlabisa and Mtubatuba.

Although self-reported, the data indicate a shortage of trauma counsellors and psychologists to support victims of violence.

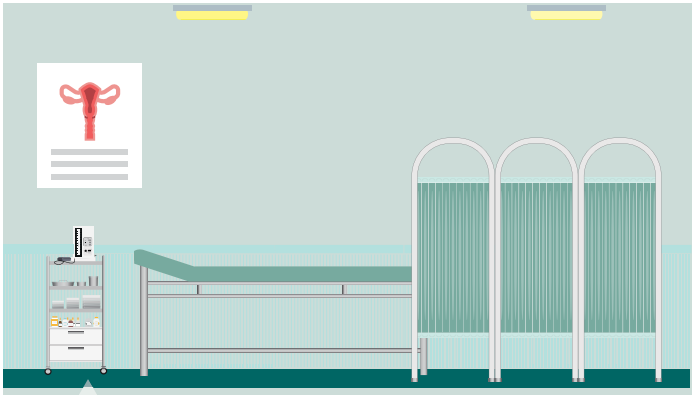
It is recommended that the Department of Social Development scales up their placement of psychological support staff. In addition, it could be explored how NGOs supporting facilities could assist in providing this service to victims.

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



It is recommended that the ways in which psychosocial support is provided to clients who are far removed from the facilities is investigated.

## 1.3. Space and equipment



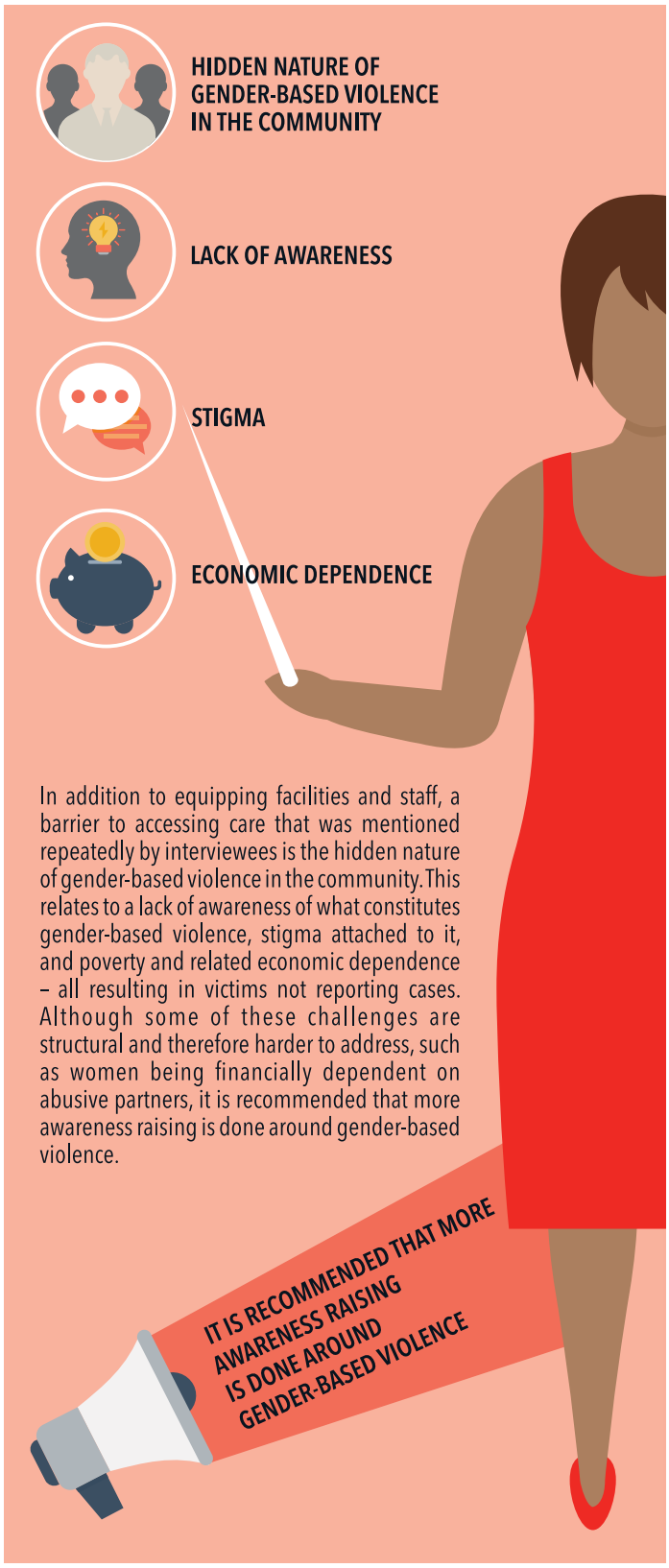
The majority of facilities reported that they have very limited space inside the clinic and they often did not have medical equipment specific to post-violence care such as a colposcope, gyneacological couch and lighting for forensic examinations.

Some interviewees particularly mentioned children as victims of sexual violence.

Although the researchers were not able to confirm this, one interview suggested that improvements can be made to how children are cared for as mention was made of children being removed from families and placed in Hlabisa hospital because of lack of an alternative place of care.

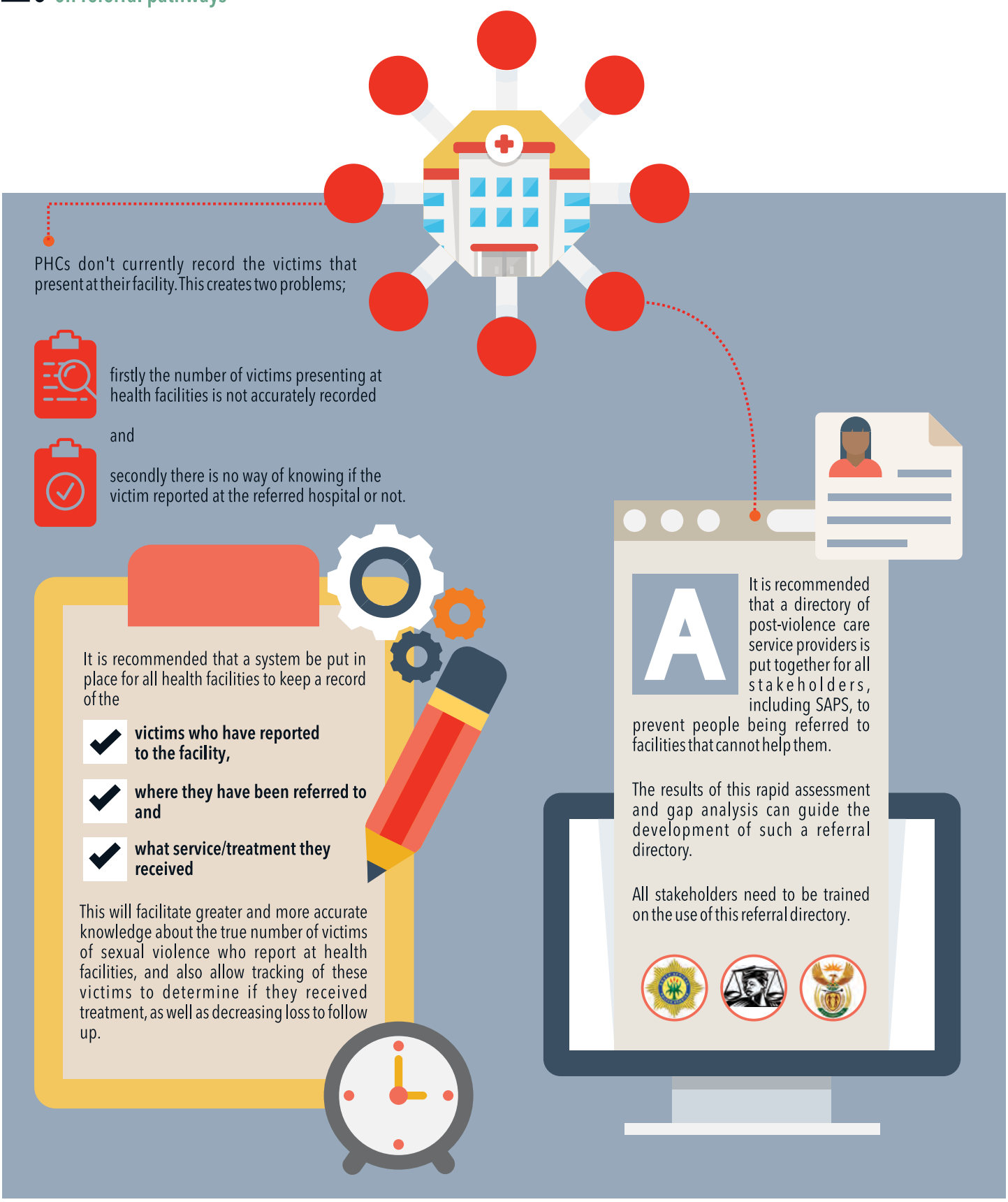
It is important that all facilities have adequate space to safeguard the privacy and confidentiality of victims. It is preferable to have a private, separate examination room, as well as a counselling room that is used exclusively for sexual assault victims.

## 1.4. Community interventions




In addition to equipping facilities and staff, a barrier to accessing care that was mentioned repeatedly by interviewees is the hidden nature of gender-based violence in the community. This relates to a lack of awareness of what constitutes gender-based violence, stigma attached to it, and poverty and related economic dependence – all resulting in victims not reporting cases. Although some of these challenges are structural and therefore harder to address, such as women being financially dependent on abusive partners, it is recommended that more awareness raising is done around gender-based violence.

# 2. Recommendations on referral pathways



# 3. Recommendations on NGOs

From the data MatCH appears to be the only NGO that has been providing support to facilities in relation to post-violence care as the organisation's name was mentioned in relation to refresher training. Some NGOs at facility level already provide some form of counselling or psychological support in relation to HIV.

It could be explored how to upskill these staff to provide counselling to victims of violence.

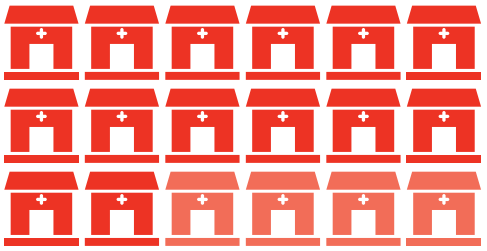
Before the NGOs would be able to take on this task some general orientation of the NGOs on gender-based violence would also be needed.

# CHAPTER 8: CONCLUSIONS

# CHAPTER 8: CONCLUSIONS

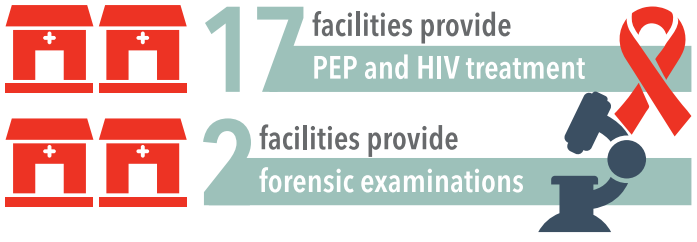
The rapid assessment and gap analyses assessed the provision of post-violence care at all 18 public health facilities in Hlabisa and Mtubatuba. The study was conducted in three phases. Phase one involved conducting a desk review to inform a situational analysis, the second phase was field work and data collection, and the third phase is reporting. The rapid assessment and gap analysis used a mixed methods approach consisting of a check-list administered at facilities as well as key informant interviews. The study was conducted between September 2016 and February 2017.

The data illustrate that interviewees at facilities had different assessments or definitions of what post-violence care entails and who they should be providing these services to. Although 14 of the 18 facilities (77.78%) answered 'yes' when asked whether the facility provides post-violence care, some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations, for example. Additionally, all of the facilities in our sample are able to provide some services, such as HIV testing, but some don't provide this service to victims of sexual violence because their understanding is that they should refer victims in order not to interfere with the collection of evidence.




**answered 'yes' when asked whether the facility provides post-violence care, BUT CARE IS INCONSISTENT**

Two facilities reported that they perform medical forensic examinations - Mtubatuba Clinic and Hlabisa Hospital (during the district session). None of the facilities in Hlabisa and Mtubatuba provide the full package of post-violence care services. All of the facilities provide HIV testing, and seventeen (94.44%) can provide PEP and HIV treatment, which means that these services are potentially available to victims sexual violence at all facilities, irrespective of their ability to provide the full package of care.




All of the facilities in Hlabisa and Mtubatuba refer victims to Hlabisa hospital. Hlabisa Hospital reported that they only provide medical forensic examinations during the district session, and they do not provide the full package of post-violence care. A major barrier to accessing care is that many victims do not have the resources (money and transport) to travel to the hospital.

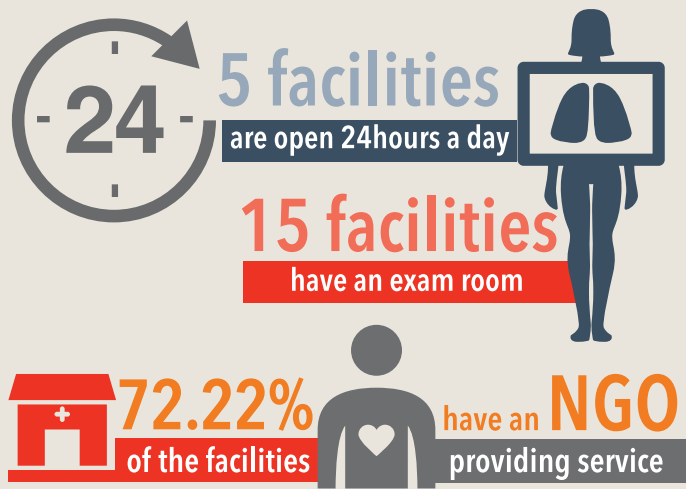
Although only five facilities (27.87%) are open 24 hours a day, nearly all are open 7 days a week, which shows potential for upscale as post-violence care should ideally be available to victims 24/7. Facilities need additional space and lack adequate, private counselling space as well as private, separate examination rooms for victims of sexual assault. Seventeen (94.44%) facilities in Hlabisa and Mtubatuba have an HCT room and 15 (83.33%) have an exam room. Only seven (38.89%) have a waiting room with seating.

Facilities also need specific equipment to provide post-violence care such as anatomically-correct dolls, comfort packs and clean clothes, colposcopes and examination lights to deliver post-violence care services according to the TCC Blueprint. Seventeen (94.44%) facilities have a speculum (or non-disposable speculums), three (16.67%) have a colposcope and seven (38.89%) have a gynaecological couch.

The data also illustrated staffing gaps, particularly forensic nurses, trauma counsellors and psychologists. There was also no indication of victims being tracked over time and being provided with the longer-term psychosocial support that they need.

Refresher training on the provision of post-violence care is necessary for all healthcare staff, and lack of training together with limitations of space and equipment affect the victim-friendliness of facilities.

Thirteen facilities (72.22%) reported that they have an NGO providing services. However, none of these relate directly to the provision of post-violence care. It is important to note that the NGOs are contributing to the continuum of care for victims of sexual assault, so further involvement by these NGOs in the provision of post-violence care needs to be explored.



The evaluation team made a number of recommendations to improve the delivery of post-violence care, which can be summarised as follows:

## General

Familiarise all healthcare staff at facilities with what post-violence care entails.

Equip and allow all PHCs to provide post-violence care as distance from Hlabisa hospital is a barrier to care.

Identify facilities for upscaling and provide them with training, space and equipment.

The full package of post-violence care should be available 24/7 at one facility per sub-district, and facilities that are already open 24/7 could be considered for upscaling.

## Staffing

Staffing gaps identified relate to forensic nurses, trauma counsellors and psychologists.

Facilities, NGOs and DSD need to track referred clients to ensure that they receive long-term psychosocial support.

## Space and equipment

Facilities have limited space inside the clinic, and lack the necessary equipment such as a colposcope, gyneacological couch and lighting for forensic examinations and should be provided with this.

Facilities should have a private, separate examination room and counselling room to safeguard the privacy and confidentiality of victims.

## Community interventions

Awareness-raising around gender-based violence should be done in the community.

## Referral pathways

A system should be put in place for all health facilities to keep a record of the victims who have reported at the facility, where they have been referred to and what service or treatment they received.

It is recommended that a directory of post-violence care service providers is put together for all stakeholders, including SAPS, to prevent people being referred to facilities that cannot help them.

## NGOs

Some NGOs at facility level already provide some form of counselling or psychological support in relation to HIV and how they can be drawn upon and equipped to provide psychological support to victims of sexual violence needs to be explored.

**There is a clear need for post-violence care services to be upscaled in Hlabisa and Mtubatuba. It is clear that some facilities have the potential for upscaling. The team believes that if the recommendations are adhered to all post-violence care services in the Hlabisa and Mtubatuba will be strengthened.**

# REFERENCES

# 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. 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*
6. 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.
7. Commission for Employment Equity. (2014). 14th Commission for Employment Equity. **Annual Report 2013-2014**. South Africa. Department of Labour, Chief Directorate of Communication.
8. Christofides, N., Webster, N., Jewkes, R., Penn-Kekana, L., Martin, L., Abrahams, N., and Kim, J. (2003). **The state of sexual assault services: Findings from a situation analysis of services in South Africa**. The South African Gender-based Violence and Health Initiative.
9. 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.
10. 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.
11. 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/*
12. Department of Health (DoH) (2003). **National Management Guidelines for Sexual Assault**.
13. 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.
14. 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*
15. 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*
16. Department of Social Development, 2014. **South African integrated programme of action: Addressing Violence Against Women and Children (2013-2018)**. Department of Social Development: Pretoria
17. 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.
18. DREAMSa, n.d. **Innovation challenge brochure**. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
19. DREAMSb, n.d. **Strategic Plan**: DREAMS.
20. eThekwini District Municipality (2015) **Annual Review 2014/15 of the Integrated Development Plan for 2012/13 to 2016/17**.
21. Foundation for Professional Development (FPD). (2016). **Thuthuzela Care Centres Compliance Audit and Gap Analysis**. FPD, Pretoria.
22. Gauteng Government, n.d. **Victim Empowerment**. *http://www.gautengonline.gov.za/Residents/Documents/victim_empowerment_booklet.pdf*
23. 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
24. Institute for Security Studies. (2011). **South African Police Services, Crime Report for 2010/11**. Pretoria
25. ISS Crime Hub. (19 September 2014). **Explaining the official crime statistics for 2013/14**. [Online]. Available at: *http://www.issafrica.org/uploads/ISS-crime-statistics-factsheet-2013-2014.pdf*
26. Jewkes R. (not-dated). **GBV prevention: are we getting any closer?**, Gender and Health Research Unit, Medical Research Council. Pretoria.
27. 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.
28. Jewkes, R. (2012). **Rape perpetration: A review**. Pretoria, Sexual Violence Research Initiative.
29. Johnston, H. (2014). **Voting for Change? Women and Gender Equality in the 2014 South African Elections**. Johannesburg: Heinrich Böll Stiftung, Southern Africa.
30. Keesbury, J. and Askew. I. (2010). **Comprehensive responses to gender based violence in low-resource settings: Lessons learned from implementation**. Lusaka: Population Council.
31. Keesbury, J. and Elson, L. (2010). **PEPFAR special initiative on sexual and gender-based violence: Final evaluation**. Lusaka: Population Council
32. 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.

33. Kilonzo, N., NdungGÇÖu, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., and Theobald, S. (2009) **Sexual violence legislation in sub-Saharan Africa: the need for strengthened medicolegal linkages** Reproductive Health Matters 2009; 17(34):10-19.
34. 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.
35. 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. *www.elsevier.com/locate/socscimed.*
36. 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
37. 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
38. KwaZulu-Natal Department of Health (2015). **UMkhanyakude District Health Plan 2015/2016**.
39. KwaZulu-Natal Department of Health (2016). **Hospitals, CHCs and clinics**. *http://www.kznhealth.gov.za/health_institutions.htm*
40. KZN Tourism (n.d.) **KwaZulu-Natal travel and tourism guide**. *http://www.zulu.org.za/files/useruploads/user_1/files/12061113_Travel%20Guide%20brochure_R1.pdf*
41. Local Government. n.d. **The Local Government Handbook: A complete guide to municipalities in South Africa**. *http://www.localgovernment.co.za/districts/view/21/umkhanyakude-district-municipality*
42. Machisa, M., Jewkes, R., Lowe-Morna, C., and Rama K. (August 2011). **The war at home: Gender Based Violence Indicators Projec**t, Gender Links. *www.genderlinks.org.za*
43. Matthews S. (December, 2013). **Presentation to the FNB Roundtable Discussion**. Johannesburg.
44. 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.
45. Medical Research Council (MRC). (2010). **The 2nd South African National Youth Risk Behaviour Survey**, 2008
46. National Prosecuting Authority (NPA) n.d. **Thuthuzela Care Centres**. Revised Blueprint.
47. RAPCAN and MRC. (not-dated). **Service responses to the co-victimisation of mother and child: missed opportunities in the prevention of domestic violence, Cape Town**, not dated, ISBN 978-0-9814341-3-1
48. Morrison, AR., and Orlando, MB. (2004). **The costs and impacts of gender-based violence in developing countries: Methodological considerations and new evidence**.
49. Musariri L., Nyambo V., Machisa M. (2013). **The Gender Based Violence Indicator Study. KwaZulu-Natal**. Gender Links. South Africa.
50. 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.
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. Compiled by Lisa Vetten, Wits Institute for Social and Economic Research (WiSER)
52. National Planning Commission (NPC). (2010). **Development Indicators**. 2010
53. National Planning Commission (NPC). (2011). **Diagnostic report**. Pretoria.
54. Nxumalo, M. (13 October 2016). **Rape victim tell of horror treatment at hospitals**. *http://www.iol.co.za/news/crime-courts/rape-victim-tells-of-horror-treatment-at-hospitals-2079580*
55. Office of the Coordination of Humanitarian Affairs (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
56. Office of the Premier, Chief Directorate of HIV and AIDS. (8 October 2014**). eThekwini Sexual Crimes (April 2014 to March 2014) and Sexual Assault Cases (April 2013 to March 2014, and April to June 2014)**. KwaZulu-Natal.
57. Parliamentary Research Unit. (April 2013a). **Statistics and figures relating to Violence Against Women in South Africa**, Submission to Parliament.
58. Parliamentary Research Unit (April 2013 b), **Legislation relation to violence against women in South Africa and the challenges relating it its implementation and success**.
59. Peacock D & 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, Vol. 3, No. 3, pp. 173 – 188
60. 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.
61. Presidency, sponsored by UNICEF (2009). **Situation analysis of children in South Africa**. The Presidency, Republic of South Africa.
62. Price Waterhouse Coopers (PwC) (2013). **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/*
63. Rape Crisis Cape Town Trust. (April 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. *http://www.issafrica.org/research/books/violence-against-women.-a-national-survey-s-raskool-k-vermaak-r-pharoah-a-louw-a-stavrou*
65. Ritchie, J., Spencer, L., and O'Connor, W. (2003) Carrying out qualitative analysis, in Ritchie, J, and Lewis, J. (eds.) **Qualitative research practice: A guide for social science students and researchers**. London: SAGE.
66. RTI, 2012. **Final compliance audit of 23 Thuthuzela Centres**. Pretoria: USAID
67. Shenton, A. (2004). **Strategies for ensuring trustworthiness in qualitative research projects**. Education for Information, 22: 63-75.
68. Silverman, D. (2006) **Interpreting qualitative data: Methods for analysing talk, text and interaction. 3rd edition**. London: SAGE.
69. Snape, D. and Spencer, L. (2003). The foundations of qualitative research, in Ritchie, J. and Lewis, J. (eds.) **Qualitative research practice: A guide for social science students and researchers**. London: SAGE.
70. 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*
71. South Africa.net. n.d. **Durban Harbour, KwaZulu-Natal**. *http://www.southafrica.net/za/en/articles/entry/article-durban-harbour-kwazulu-natal*
72. South African Human Rights Commission. (not-dated). **Report on Children's Rights to an Adequate Standard of Living**. Johannesburg.
73. South African Human Rights Commission. (2010). **Section 184(3) Report 2006-2009**. Johannesburg.
74. South African Human Rights Commission. (2014). **Report on the Right to Access Sufficient Water and Decent Sanitation**. Johannesburg.
75. South African Human Rights Commission. (2015). **Equality Report**. Johannesburg.
76. South African Police Service (SAPS) 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*
77. Statistics South Africa (2011). **Census 2011. Municipal Fact Sheet**. Statistics South Africa.
78. Statistics South Africa (2012). **Social profile of vulnerable groups in South Africa 2002 to 2012**, Report number 03-19-00, 2011
79. Statistics South Africa (2013). **Gender Statistics in South Africa, 2011**. Stats SA, Pretoria.
80. SWEAT (2004). **Work wise: Sex worker handbook on human rights, health and violence**. Cape Town, South Africa, SWEAT.
81. SWEAT (2012). **Beginning to Build the Picture: South African national survey of Sex workers' knowledge, experiences and behaviour (2012)**.
82. Tearfund. (2013). **Breaking the silence. The role of the church in addressing sexual violence in South Africa**. Tearfund.
83. UMkhanyakude n.d. **Hlabisa Local Municipality**. *http://ukdm.gov.za/index.php/en/local-municipalities/hlabisa-local-municipality*
84. UMkhanyakude (2015). **UMkhanyakude District Municipality, Integrated Development Plan, 3rd generation**, 2014/2015.
85. UNICEF. n.d. **Thuthuzela Care Centres**. *http://www.unicef.org/southafrica/hiv_aids_998.html*
86. United Nations. 2015. **Sustainable Development Goals**. *http://www.un.org/sustainabledevelopment/gender-equility/*
87. Vetten, L. (2014). **Rape and other forms of sexual violence in South Africa**. Institute for Security Studies. Policy Brief 72.
88. Vogelman, L. and Eagle. G. (1991). **Overcoming Endemic Violence Against Women**. Social Justice. Vol. 18. No. 1 to 2. P. 209 to 229.
89. 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
90. Weideman, M. (November 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.
91. Weideman, M. (December 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*
92. Weideman, M. (December 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.
93. Wekerle, C. and Wolfe DA. (1999). **Dating violence in mid-adolescence: theory, significance and emerging prevention initiatives**, Clinical Psychology Review, Vol. 19, pp. 435-456.
94. Western Cape Government: Department of Social Development. (June 2014). **An evaluation of the Victim Empowerment Programme**. Conducted by the Gender Health and Research Unit at the University of the Western Cape.
95. 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*
96. World Health Organisation (WHO). (2002a). **Injuries and Violence Prevention Department, Guide to United Nations Resources and Activities in the Prevention of Interpersonal Violence**. Geneva, Switzerland. ISBN 9241590270
97. World Health Organisation (WHO). (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
98. World Health Organisation (WHO). (2003). **Guidelines for medico-legal care for victims of sexual violence**. Geneva.
99. World Health Organisation (WHO). (2005) **WHO multi-country study on women's health and domestic violence against women: prevalence, health outcomes and women's responses**. In. Geneva, Switzerland: WHO; 2005.
100. World Health Organisation (2014). **Global status report on violence prevention**. World Health Organisation: Geneva.