# A CASE STUDY OF FOUR MAC AIDS FUND SUPPORTED THUTHUZELA



June 2017















# Acknowledgements

The researcher wishes to express her gratitude to all the key informants (FPD personnel and USAID personnel), site coordinators, VAOs and managers from NGOs who were willing to spare their time and share their experiences and insights with us. We believe that this TCC case study on MAC AIDS Fund supported TCCs will go a long way in contributing to the work that the TCCs are doing.

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The case study evaluation was conducted by Sunet Jordaan, and benefitted from the experience of the 2016 TCC compliance audit and gap analysis conducted by FPD.

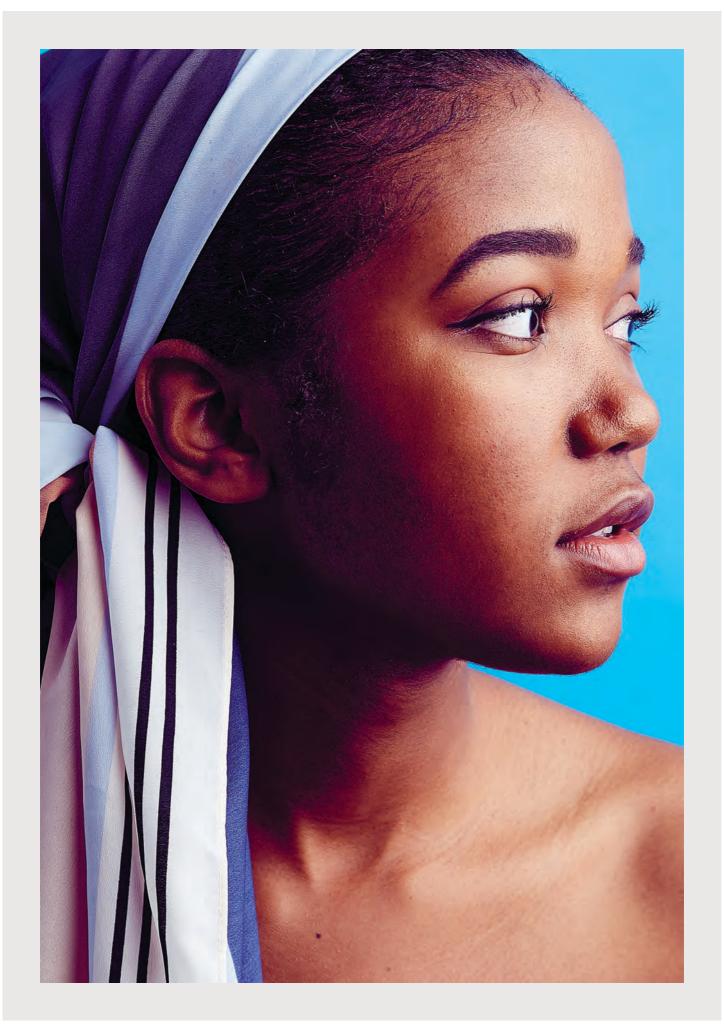
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**AIDS** 

Acquired immunodeficiency syndrome

**ACRWC** 

African Charter on the Rights and Welfare of the Child

**ART** 

Antiretroviral therapy

**ARV** 

Antiretroviral

**CBO** 

Community based organisation

CDC

Centers for Disease Control

**CEDAW** 

Convention for the Elimination of all forms of Discrimination Against Women

**CGE** 

Commission for Gender Equality

CPD

Continuing professional development

cso

Civil society organisation

DBE

**Department of Basic Education** 

**DHET** 

Department of Higher Education and Training

**DoH** 

Department of Health

DoJ

Department of Justice and Constitutional Development

DSD

**Department of Social Development** 

**DVA** 

**Domestic Violence Act** 

**EMS** 

**Emergency medical services** 

EU

**European Union** 

**FBO** 

Faith based organisation

**FCS** 

Family Violence, Child Protection and Sexual Offences Investigation Unit

**FHI 360** 

Family Health International 360

FPD

Foundation for Professional Development

**GBV** 

Gender-based violence

GNP

**Gross National Product** 

HCP

Healthcare practitioner

**HCT** 

HIV counselling and testing

HIV

Human immunodeficiency virus

**HSRC** 

**Human Sciences Research Council** 

IDMT

Interdepartmental management team

**IDP** 

Integrated Development Plan

**IEC** 

Information and education communication

IMC

Inter-ministerial committee

iMMR

Institutional Maternal Mortality Ratio

155

Institute for Security Studies

**ISSSASA** 

Increasing services for survivors of sexual assault in South Africa

**LGBTI** 

Lesbian, gay, bisexual, trans and intersex persons

MRC

Medical Research Council

MSE

Médicins Sans Frontièrs/Doctors without Borders

**NACOSA** 

Networking HIV & AIDS Community in South Africa

NGO

Non-governmental organisation

NPA

**National Prosecuting Authority** 

#### **OCHA**

UN Office of the Coordination of Humanitarian Affairs

#### **PEP**

Post-exposure prophylaxis

#### **PEPFAR**

President's Fund for Emergency AIDS Relief

#### **PEPUDA**

Promotion of Equality and Prevention of Unfair Discrimination Act

#### **PFA**

Psychological first aid

#### PHC

Primary healthcare clinic

#### **POA: VAWC**

Programme of action to address violence against women

#### **PWC**

**PricewaterhouseCoopers** 

#### **RAPCAN**

Resources aimed at the prevention of child abuse and neglect

#### RTI

Research Triangle Institute

#### SADC

Southern African Development Community

#### **SAECK**

Sexual assault evidence crime kit

#### SAHRO

South African Human Rights Commission

#### **SANCA**

South African National Council on Alcoholism and Drug Dependence

#### SAPS

South African Police Service

#### **SASSA**

South Africa Social Security Agency

#### SC

Site coordinator

#### SDG

Sustainable Development Goals

#### SOA

Sexual Offences and Related Matters Amendment Act

#### SOC

Sexual offences court

#### SOCA

Sexual offences and community affairs

#### Stats SA

Statistics South Africa

#### STI

Sexually transmitted infection

#### **SWEAT**

Sex worker education and advocacy task force

#### TR

**Tuberculosis** 

#### TCC

Thuthuzela Care Centre

#### **TIMS**

Thuthuzela Information Management System

#### TOP

Termination of pregnancy

#### VAO

Victim assistance officer

#### VAWC

Violence against women and children

#### UN

**United Nations** 

#### UNICEF

United Nations Children's Fund

#### UNCRO

United Nations Convention on the Rights of the Child

#### UNODO

United Nations Office on Drugs and Crime

#### **UNPF**

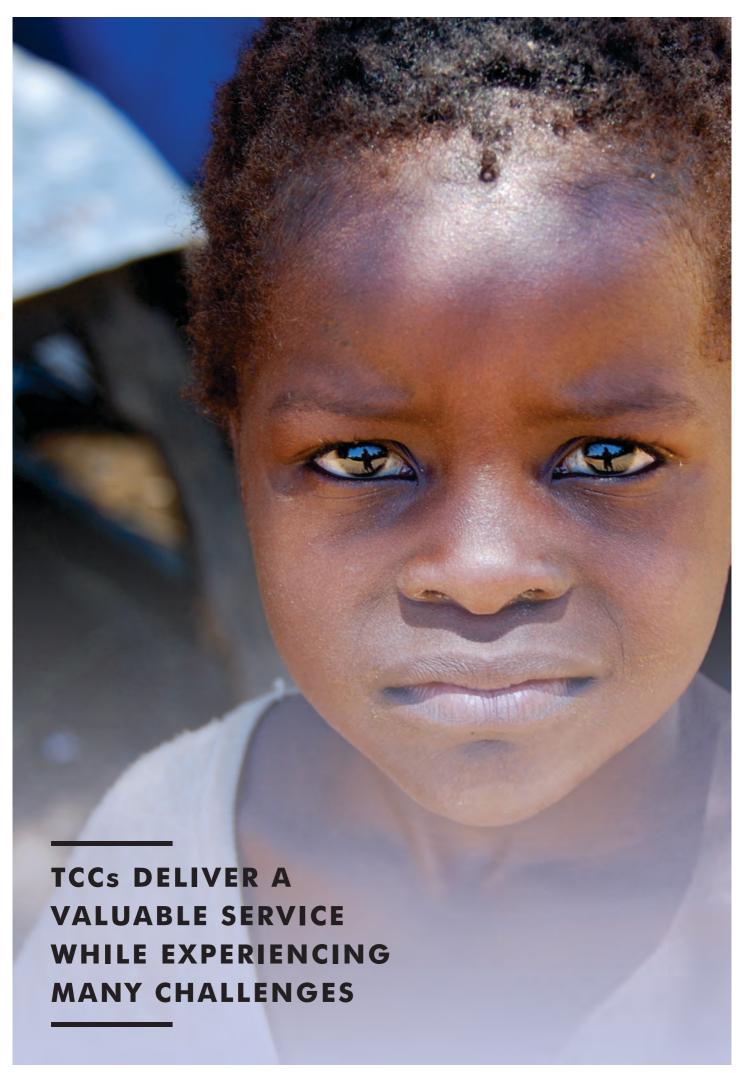
**United Nations Population Fund** 

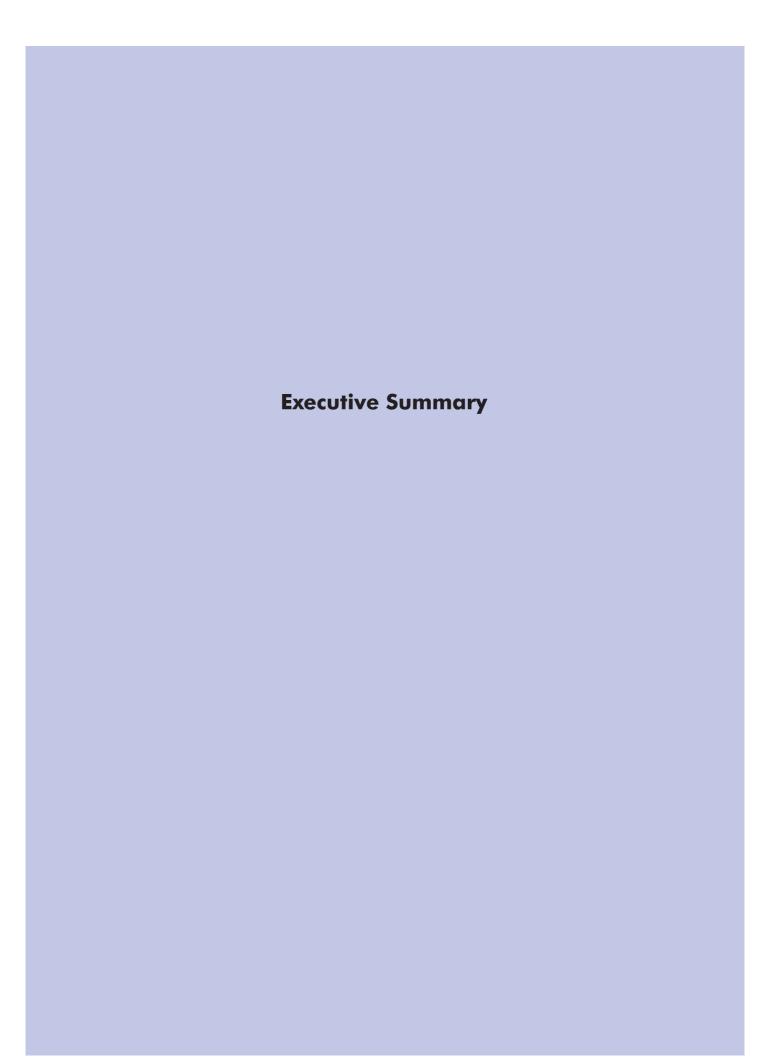
#### IISΔID

United States Agency for International Development

#### WHC

World Health Organization





# **Background**

The Foundation for Professional Development (FPD) was contracted by USAID to establish and manage four MAC AIDS Fund supported TCCs. These TCCs are Grey TCC at Grey Hospital, Madadeni TCC at Madadeni Hospital, Groblersdal TCC at Groblersdal Hospital and Wesfleur TCC at Wesfleur Hospital. To showcase the results of this project, FPD was requested to prepare a case study based on the process of establishing, managing and the successes of these four TCCs. This case study was informed by the compliance audit and gap analysis of 55 Thuthuzela Care Centres (TCCs) in South Africa that was conducted in 2016 by FPD.

The establishment and management of the four MAC AIDS Fund supported TCCs formed part of the larger Increased Services for the Survivors of Sexual Assault in South Africa (ISSSASA) programme, funded by USAID under the Democracy, Rights, and Governance-Learning, Evaluation, and Research (DRG-LER) contract. The objective of this programme was to improve service provision and community awareness for survivors of sexual assault in South Africa. The collaboration was led by FPD, and was co-implemented by The Soul City Institute, Sonke Gender Justice Network and the South African Medical Research Council (MRC). The project consisted of the establishment and management of four new TCCs, training programmes for various service providers in the TCC referral and care networks, as well as multi-media community dialogues to increase awareness of the TCCs. It focused on educating community members on sexual assault and gender-based violence (GBV) issues.



Thuthuzela Care Centres in South Africa



Focussing on educating community members on sexual assault and gender-based violence issues

## **Purpose**

The purpose of this case study is to showcase the results and successes of the four MAC AIDS Fund supported TCCs. The study reviewed the results of the 2016 compliance audit and gap analysis, and focused on all components related to the functioning and sustainability of the TCCs. The case study assessed the services provided, the equipment in facilities, the staffing of the TCCs as well as the relationship between the TCC and any NGOs working within them. The results of the study contribute to better informed decision making about the functioning of the TCCs, foster an environment of excellent service delivery and promote greater accountability for performance of facilities. The study results provide information regarding the working relationships between the TCC personnel and the NGOs who are involved in the functioning of TCCs, and address the sustainability of service delivery within the four TCCs.





# Methodology

The case study was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two, field work and data collection, and phase three, reporting. The researcher used a concurrent triangulation mixed methods design. Quantitative and qualitative data of equal weight were collected and integrated during the interpretation of the findings. Sampling was not necessary, as all four TCCs were part of the study.

There were two populations in this case study, the FPD-employed TCC staff and the NGO staff. The researcher also interviewed key FPD personnel and representatives from the donors.

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

The TCC model was studied and a questionnaire was developed based on the model. For the 2016 TCC Compliance Audit and Gap Analysis an application (ODK App) and survey tool was developed in collaboration with Medical Practice Consulting, which uses TRISCOMS cloud hosting technology, to allow the team to collect data electronically using tablets. The quantitative data collected in 2016 was used for this case study as well.

The quantitative data were exported from the database into Excel<sup>™</sup>, where it was cleaned and coded. It was then imported into the Statistical Package for Social Sciences (SPSS®) version 22.0. Descriptive analyses were conducted and the data analysis output was displayed in graphs, tables and cross-tables. No inferential analyses were conducted.

The audio recordings were analysed through a combination of deductive and inductive thematic coding. Themes were drawn from the semi-structured interview schedules and added to the coding frame.



# **Major findings**

The findings suggest that the four MAC AIDS Fund supported TCCs are generally functioning extremely well, but that services and stakeholder involvement vary across provinces, mainly due to the unique context of each TCC.

One of the greatest strengths of the TCC is the multisectoral approach, bringing all services and stakeholders together (i.e. NPA, DoH, DSD, SAPS and various NGOs). In the four MAC AIDs Fund supported TCCs this multisectoral approach is working well.

All four TCCs are based in park homes, but are designed according to the TCC Blueprint. There is adequate office space as well as private counselling rooms in all TCCs. At some sites, there have been issues around the security of after-hours staff.

Victim friendliness in TCCs is a minor problem. The TCCs are laid out in a victim friendly manner, all staff are sensitised and have received adequate training. All the TCCs have a child friendly room with toys. All the ablution facilities are disabled friendly, and there is a wheelchair ramp at each TCC. There is still a lot of secondary victimisation within the surrounding communities, and some secondary victimisation from the SAPS personnel. All the TCCs provide comfort packs when available, but also need basic groceries to provide food and beverages to victims.

There are a number of factors that influence the quality of services delivered: All four TCCs could provide a 24/7 service. This might change after June 2017, when NGO funding runs out. There are inconsistencies in the delivery of health services within the TCCs after hours. At some TCCs all services are delivered in the TCCs after hours, in others, victims are either referred to the casualty All four TCCs have a site department of hospitals or have to coordinator, and three have a wait for a forensic nurse or doctor to VAO but none have a case come to the TCC from casualty. manager. OPEN Human Accessibility resources All four of the TCCs There are serious concerns about the ability of TCCs to have all the equipment required to deliver their provide long term psychosocial support. services. All the TCCs have external telephone lines as The Department of Social Development Equipment and supplies **Psychosocial** (DSD) is not well as access to the support providing enough social workers and internet. The TCCs have all the medical psychologists for the equipment required TCCs. This will be to deliver their further affected if the services. NGOs are not funded in the future. Health services **Transport** All of four of the TCCs have at least

Transport is a major barrier for almost all components of the TCC model. While SAPS usually bring victims to the TCCs, they cannot wait to transport the victim home or to a place of safety. Many victims do not have transport to come back to the TCCs to receive follow-up PEP or follow-up psychosocial support. This also influences the victims' ability to attend court proceedings. Due to lack of transport NGOs cannot provide follow-up psychosocial support at the victim's home and the NGOs and TCC staff cannot participate adequately in community awareness campaigns.

one Department of Health (DoH) staff member dedicated to the TCC, but this is mainly during the day. The TCCs are, in some cases, dependent on casualty staff after hours and during weekends. At other TCCs, the hospital has allocated a dedicated doctor on a weekly roster to assist the TCCs with after hours services. Emergency medical service (EMS) personnel are not adequately sensitized to work with victims of GBV and do not prioritize victims. Post-exposure prophylaxis (PEP) is provided, but victims generally receive only a starter pack when they present after hours and need to return to the TCC for the remainder of the medication.

There are problems within the funding environment that need to be addressed. A sustainable, consistent and stable funding environment is required to ensure that the necessary services can be delivered at all TCCs. The current funding environment is damaging and does not lead to trust between TCCs and victims.

#### **Recommendations**

The researcher made many recommendations to improve the service delivery and functioning of the TCCs. The recommendations can be summarised as follows:

# IMPROVEMENT OF SERVICE DELIVERY RECOMMENDATIONS



All vacant positions should be filled, specifically those of case managers, and staff should receive regular, face-to-face debriefing.

In TCCs where it is not possible to deliver a 24/7 service protocols need to be developed that involve all stakeholders to ensure access to services after hours.

DoH must ensure that all TCCs have either a forensic nurse or a doctor available at the TCCs. DoH needs to implement protocols for access to these services after hours. It is recommended that PEP be provided earlier in the continuum of care and that a full 28-day course is provided to victims who have difficulty returning to the hospital.

DSD must take greater responsibility in the provision of both short-term and long-term psychosocial support.

The NPA need to ensure that TCCs have access to basic groceries to provide victims with refreshments. Hospitals may be able to provide food for victims, as at the Grey TCC, and this option should be explored in other TCCs.

It is recommended that stakeholders meet and a find a long-term solution to the transport problems that TCCs experience.

The NPA and DoH must meet and find a long-term solution for the TCCs based in park homes.

# GOVERNANCE AND OPERATIONAL RECOMMENDATIONS



The TCC framework needs to be legalised to ensure that all stakeholders take responsibility and be held accountable for their roles and responsibilities within the model.

A new, inclusive set of guidelines needs to be developed for the management of sexual assault in South Africa.

#### **NGO RECOMMENDATIONS**



NGOs need to be recognised for the services they provide.

There should be a long-term solution to ensure adequate funding for the NGOs.

### OTHER RECOMMENDATIONS



It is recommended that all stakeholders investigate how GBV services can be upscaled. This should include upscale of GBV services within existing health facilities. This should include a protocol for referral for services not provided at the existing health facilities. In addition to this the model needs to be linked with the other existing rape crisis centres and Kgomotso Care Centres.

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

The TCCs deliver a valuable service while experiencing many challenges. The team believes that if the recommendations are adhered to, all GBV services in the country will be strengthened.



# 

Chapter One
Introduction and Objectives

## Introduction and Objectives





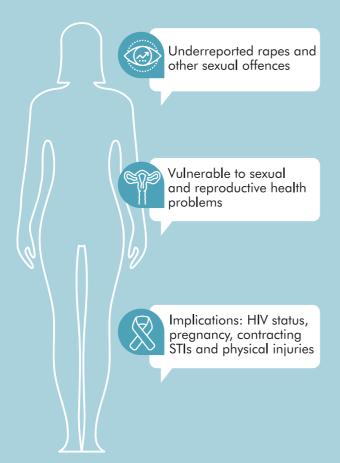
# 1 Contextual background and context for the case study of four MAC AIDS Fund supported Thuthuzela Care Centres

The Foundation for Professional Development (FPD) was contracted by USAID to establish and manage four MAC AIDS Fund supported TCCs. These TCCs are Grey TCC at Grey Hospital, Madadeni TCC at Madadeni Hospital, Groblersdal TCC at Groblersdal Hospital and Wesfleur TCC at Wesfleur Hospital. To showcase the results of this project, FPD was asked to prepare a case study-based report on the process of establishing and managing, and the successes of these four TCCs. This case study was informed by the compliance audit and gap analysis of 55 Thuthuzela Care Centres (TCCs) in South Africa that was conducted in 2016 by FPD.

The establishment and management of the four MAC AIDS Fund supported TCCs formed part of the larger Increased Services for the Survivors of Sexual Assault in South Africa (ISSSASA) programme, funded by USAID under the Democracy, Rights, and Governance- Learning, Evaluation, and Research (DRG-LER) contract. The objective of this programme was to improve service provision and community awareness for survivors of sexual assault in South Africa. The collaboration was led by FPD, and was co-implemented by The Soul City Institute, Sonke Gender Justice Network and the South African Medical Research Council (MRC). The project consisted of the establishment and management of four new TCCs, training programmes for various service providers in the TCC referral and care networks, as well as multi-media community dialogues to increase awareness of the TCCs. It focused on educating community members on sexual assault and GBV issues.

The purpose of this case study is to showcase the results and successes of the four MAC AIDS Fund supported TCCs. The results of the 2016 compliance audit and gap analysis conducted by FPD were reviewed, and all components related to the functioning and sustainability of the TCCs are examined. In the case study, the services provided were assessed, along with the equipment in facilities, the staffing of the TCCs as well as the relationship between the TCC and any NGOs working within them. The results of the study contribute to better informed decision making about the functioning of the TCCs, fostering an environment of excellent service delivery and promoting greater accountability for performance of facilities. The study results provide information regarding the working relationships between the TCC personnel and the NGOs who are involved in the functioning of TCCs and address the sustainability of service delivery within the four TCCs.

# 2 Contextual background for the creation of the TCCs

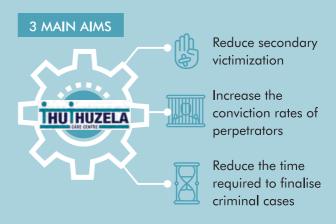


South Africa has some of the highest levels of sexual violence and related offences in the world. Experts in GBV and sexual offences think that many rapes and other sexual offences are still underreported. Women and children who are subjected to rape and other sexual offences are also more vulnerable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



## 3 Government response

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



South Africa has several responses to GBV. As a result of the high levels of GBV in South Africa, the National Prosecuting Authority's (NPA) Sexual Offences and Community Affairs (SOCA) unit developed the TCC model to respond to the GBV crisis in a comprehensive and multi-sectoral way. The first TCC was established in 1999 to provide comprehensive services to victims of GBV. The TCCs have three main aims. Firstly, to reduce secondary victimisation of victims of GBV and sexual assault, to increase the conviction rates of perpetrators and lastly to reduce the length of time required to finalise criminal cases related to GBV and sexual assault (Vetten, 2015). The government departments mentioned above collaborated to establish the TCCs. Initially the overall management and functioning of the TCCs was with the interdepartmental management team (IDMT), consisting of senior officials from the above departments. This has now changed to a sector specific management team.

The word Thuthuzela is derived from the isiXhosa word for 'comfort' and the TCCs function in two arenas.

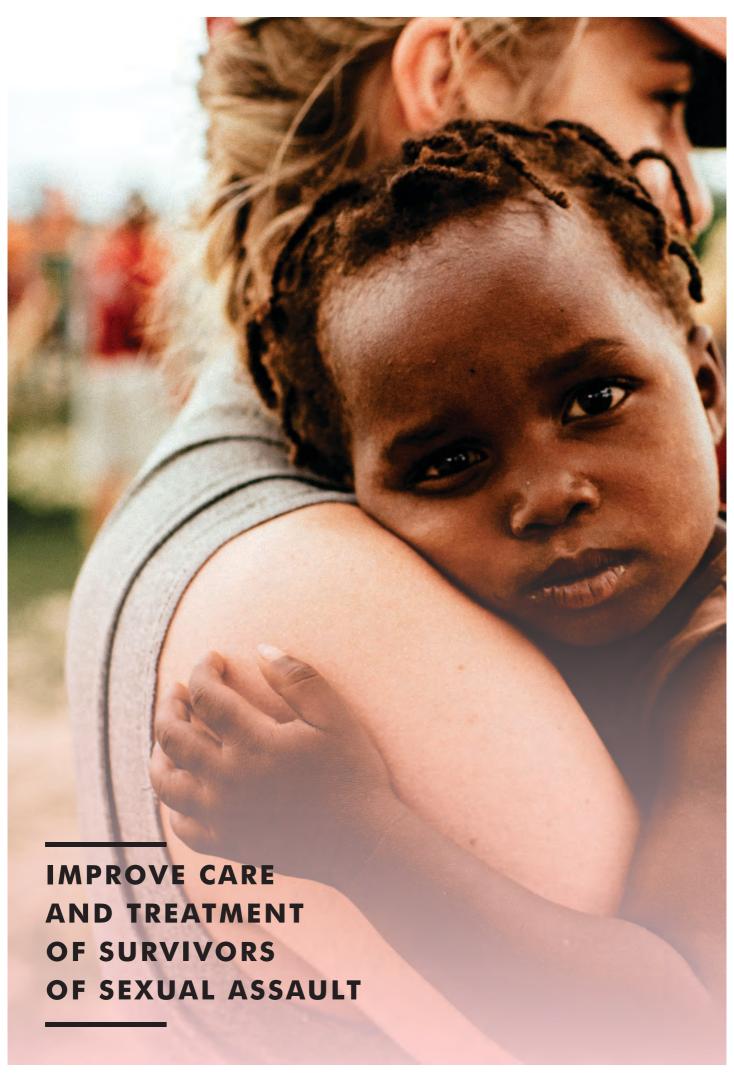
- Immediate services are delivered in a care centre that is located within a public healthcare facility.
- The legal component is ideally dealt with at a sexual offences court.





# 4 Purpose of the case study of four MAC AIDS Fund supported TCCs

The purpose of this case study on the four MAC AIDS Fund supported TCCs is to showcase the establishment and functioning of the four TCCs, as well as to highlight examples of excellence in their work, and finally to highlight possible issues around the sustainability of the four TCCs. The case study focused on all the components related to the functioning of the four TCCs. It assessed the services provided, the equipment available in facilities, the staffing of the TCC personnel as well as the relationship between the TCC and any NGOs working within the TCCs. The results of the study address the sustainability of service delivery within the four TCCs.



# 

Chapter Two **Desk Review and Situational Analysis** 

The desk review and situational analysis provides a broad background on the current GBV environment in South Africa in which the TCCs function. It takes into account reports, reviews and assessments done on all 55 TCCs, as well as other GBV-related services in South Africa.

This desk review and situational analysis will focus on the definition of key terms and a discussion on GBV in South Africa. It will then highlight the international standards for managing sexual assault and describe the South African legislative and policy frameworks as well as policy guidelines, norms and standards. It will discuss the functioning of TCCs, other responses and identify still existing gaps.

## 1 Introduction

# 1.1 Objectives of the desk review and situational analysis

This desk review and situational analysis can be read as a stand-alone document describing the situation regarding GBV in South Africa. It is, however, part of a larger project, namely a case study on four MAC AIDS Fund supported TCCs. This focus guides the areas covered in the desk review, which in turn will aid the interpretation of findings from the case study.

This desk review and the subsequent case study focuses directly on one of the structural drivers that increase young women's risk of HIV infection, namely sexual violence. Sexual and GBV and HIV are linked, as violence places women at risk of contracting HIV. Women could not only be directly infected with HIV because of rape, but women's unwillingness to subordinate themselves to men also increases their HIV risk and risk of experiencing violence (Kilonzo et al., 2013). The desk review and case study looks specifically at the establishment of the four MAC AIDS Fund supported TCCs and the contribution they make towards post-violence care at these facilities.



**SEXUAL VIOLENCE** 

One of the structural drivers that increase young women's risk of HIV infection

## 1.2 Methodology

In line with the nature and scope of desk reviews and situational analyses (McCoy and Bamford, 1998; Presidency, 2009), the methodology for this report involves a review of selected qualitative and quantitative research on several main research categories, each with relevance to the case study.



# 2 Key terms in gender-based violence

### 2.1 Gender-based violence (GBV)

Gender-based violence refers to harm that is committed against a person's will because of their gender. This can have a negative impact on the person's physical or psychological health, development and identity. This is usually linked to inequality in power relations between men and women (Mpani and Nsibande, 2015). GBV is defined as violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life' (Khan, 2011). It also includes any harm against a person's will as a result of gender and power inequalities. It can manifest in various forms including domestic violence, rape, trafficking and forced prostitution as well as forced marriage. It is important to note that GBV is not exclusive to violence against women and girls, but can include men and boys. In South Africa GBV is often normalized, and therefore underreported (Mpani and Nsibande, 2015).

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



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

That GBV is a violation of women's human rights is evident in the human rights-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 GBV as:

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

#### 2.2 Sexual violence

Sexual violence, specifically, is defined as any sexual act, attempt to commit a sexual act, unwanted sexual comments and advances, coercion, threats and physical force to obtain a sexual act (WHO, 2003). This can be conducted by any person, regardless of their relationship with the victim and can happen in any setting (including home and work).

Similar to the discussions on the definition of GBV, some of the literature on sexual violence point out the range of possible victims (not exclusively women):

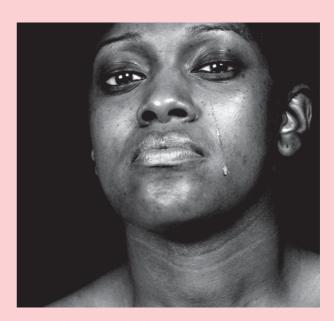
'[Sexual violence] refers to all forms of assault and abuse of women, men, adolescents, and children (girls and boys), including rape, incest, indecent assault and defilement [child sexual abuse]. Sexual violence occurs when a person uses psychological pressure, abuse or authority, threats or physical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

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

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

The above definition points to two additional dimensions to sexual violence. The first of these is the recognition that sexual violence can be perpetrated in any setting. This not only acknowledges home, work, and other environments as possible settings, but also indirectly acknowledges the use of sexual violence and specifically rape in situations of armed conflicts and war (OCHA, 2008). In addition, the definition also acknowledges 'acts to traffic women's sexuality' which refers to human trafficking and sexual slavery (OCHA, 2008). Both the WHO (2003) and the South African Human Rights Commission (SAHRC) (2015) acknowledge the worldwide growth in the trafficking of women and children for sexual exploitation. In 2003 the WHO stated that 1 to 2 million worldwide are being affected annually.

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).





#### 2.3 Sexual assault

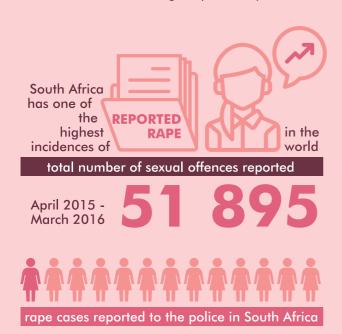
Sexual assault includes all non-consenting sexual activity from fondling to penetration (as well as attempts at penetration) of one person into the anus, mouth or genital organs of another person. This can be with a part of the body, genital organs or any other object (Mpani and Nsibande, 2015).

Rape is defined as forced sexual intercourse or a sexual act perpetrated against a person without consent. Kim et al. (2009) highlight that sexual violence is an important driver of the HIV epidemic in southern Africa. Survivors of sexual assault are at an increased risk of acquiring HIV due to possible lacerations and trauma in the vaginal and/or anal area (Herstad, 2009). 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'.

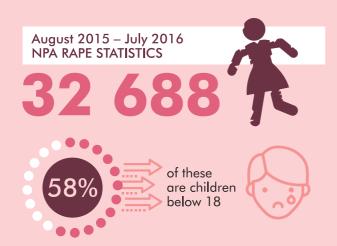
## 2.4 Domestic violence

This is a broad definition of any physical, sexual, emotional, verbal, psychological abuse committed against an intimate partner. This is also called intimate partner violence. This can include forced sexual violence, withholding resources and controlling behaviour (Doctors without Borders, 2016; Mpani and Nsibande, 2015).

The terms 'victim' and 'survivor' of rape or sexual assault are used interchangeably in this report.







#### 3 The GBV situation in South Africa

South Africa has very high levels of GBV and sexual assault (Hwenha, 2014). Women, girls, and other atrisk populations' distinct vulnerability to GBV are rooted in the various inequalities they experience and this includes unequal power relationships based on biological sex, gender identity, and sexual orientation (Khan, 2011). It also reflects the high levels of inequality and patriarchy found in South Africa (Hwenha, 2014).

South Africa has one of the highest incidences of reported rape in the world. The South African Police Services figures show that the total number of sexual offences reported between April 2015 and March 2016 was 51 895 (SAPS, 2016). SAPS do not disaggregate the sexual offences statistics into categories, so this number is made up of sexual assault, rape and domestic sexual abuse. The Institute for Security Studies (ISS) (2015) highlights that only one in 13 rape cases are thought to be reported to the police in South Africa. In addition, nearly 33% of men report that they have raped a woman at some time during their lifetime (Hwenha, 2014). NACOSA (2015) adds that 37.4% of men in South Africa admitted having perpetrated sexual offences. In South Africa, one in four women report sexual or physical intimate partner violence. There has also been an increase in interim protection orders for domestic violence over the past few years, and the warrant of arrest orders on protection orders has also increased (Watson, 2015). The National Prosecuting Authority's (NPA, 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.

According to the Global Review of Violence against Women, 35% of women worldwide have experienced physical and/or sexual intimate partner or non-partner violence (UNWOMEN, 2013). Violence is one of the most critical problems facing women and girls in South Africa. Rape has reached epidemic levels and domestic violence is a daily occurrence for millions of women in the country.

Soul City (2013) identified a number of barriers for reporting sexual violence. These include inadequate services for rape survivors, previous experience where the SAPS were not helpful and blamed victims, stigma and shame, distrust in the criminal justice system, dependence on and/or fear of the perpetrator and lack of information about support services. Soul City (2013) also highlighted concerns regarding confidentiality as a reason for lack of reporting by survivors.



# 3.1 The prevalence of gender-based violence in South Africa

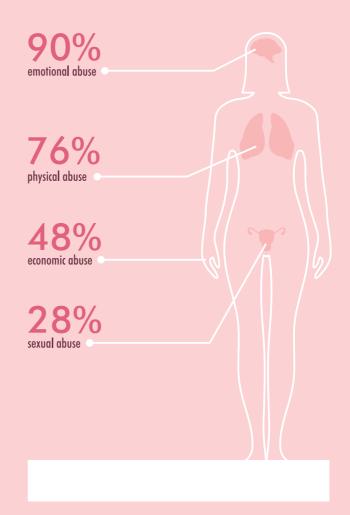
When interpreting statistics and other empirical evidence on the prevalence of GBV authors caution that careful interpretation is necessary. Under reporting is likely for a variety of reasons that include shame, familiarity with the perpetrator, internalization, inappropriate societal norms that blame 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). 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).

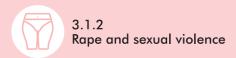
# 3.1.1 Intimate partner and domestic violence

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 10 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 10 years when they were interviewed (Weideman, 2008). Similarly, Rasool et al. (2003), in a national survey of violence against women, also found that much of the abuse suffered by survivors took place over a longer period of time. The Sonke Change Trail (2016) report that 32% of South African men used violence towards their partners, and 28% have raped.

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

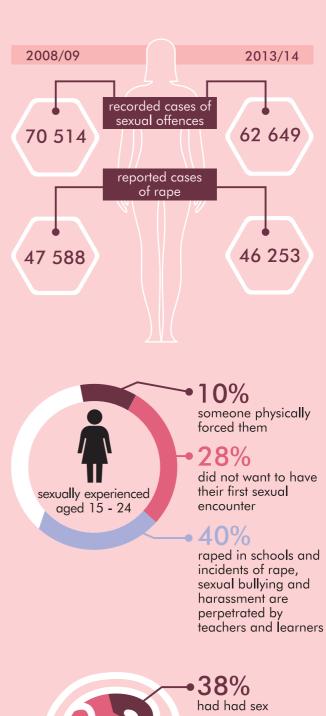


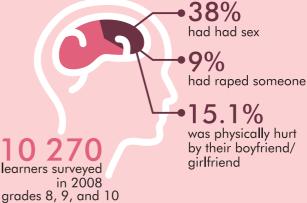




A brief overview of some of the empirical data available illustrates the extremely high rates of rape and sexual violence in South Africa. A 2015 report by the SAHRC states that 'sexual violence has reached "epidemic" proportions' in the country (SARHC, 2015:29). Between 2008/09 and 2013/14 there was 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, 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 at a young age echo the findings of a 2012 study on perpetrators/rapists that found that many commit their first rape while still in their teens (Jewkes, 2012). Jewkes (n.d.) indicates 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.









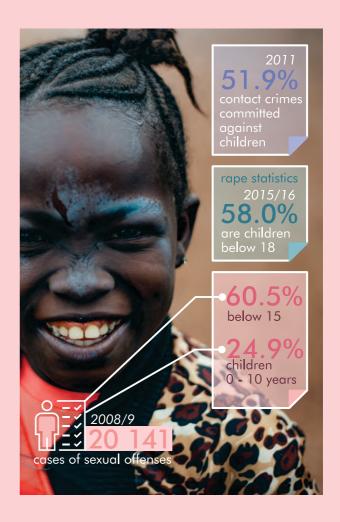
3.1.3 Violence against sex workers

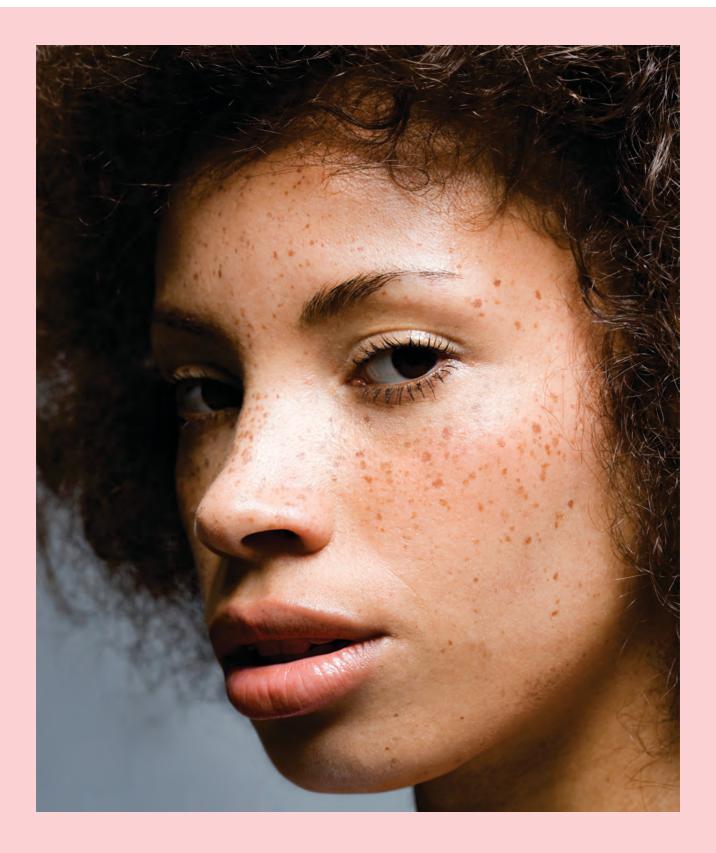
Sexual violence against sex workers is also underreported due to the nature and legality of their work. The data that exist indicate that both clients and police officers are perpetrators (WHO, n.d.; Curran et al., 2013; NACOSA, 2015). During a survey of 1 136 sex workers in South Africa more than half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



3.1.4 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 GBV and the rights of children. It noted in particular the vulnerability of the girl child to violence and argued for concerted efforts to address secondary victimisation (SAHRC, 2015). Among the dominantly social contact crimes committed against children in 2011, 51.9% were sexual offences (ISS, 2011). The National Prosecuting Authority's (FPD, 2016) rape statistics for the TCCs for the year August 2015 - July 2016 are 32 688. Of these 58% are children below the age of 18 years. The Institute for Security Studies (ISS) notes the disturbing finding that in the case of the most prevalent crime against children, namely the 20 141 cases of sexual 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).





# 3.2 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.

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; and 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). An example of such blame and normalisation is a study conducted of professional male and female nurses in rural South Africa by Kim and Motsei (2002). Male nurses used terms like 'discipline', 'justified punishment' of women when 'they don't listen', 'stand up for their rights', or are 'lazy' in performing household chores. Violence was described as the appropriate and 'manly' response to (perceived) female infidelity, while male infidelity was praised. Many of the female nurses had similar views, had been victims of GBV and were, for example, forced to hand over their salaries to male partners each month as 'men are traditionally in charge of money'.





#### Destructive masculine identities:

Several 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 risky behaviour (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 older than 11 believed that forcing someone to have sex is not an act of violence (MRC, 2010).



62% believe 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, 2014a). 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 multifaceted. For example, poverty increases powerlessness and vulnerability to domestic violence, as 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 compromise 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). Although the link between poverty and GBV is well argued in the literature, some authors caution against assuming that GBV is less likely to affect the educated, professionals, the middle class or the wealthy as such an assumption might mean overlooking the full spectrum of people who are affected (RAPCAN and MRC, n.d.)







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



#### Childhood exposure to violence/child abuse:

Several studies nationally and internationally demonstrate that children who have witnessed violence or who 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 also relates to subjecting 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.).





#### 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.









#### 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, and 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 woman to have sex when she was unable to refuse because she was 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).



men admitted to forcing a women to

have sex when she was drunk or drugged 14.2%



women had been raped while drunk or drugged



The Centre for the Study of Violence and Reconciliation (CSVR, 2009) explains the high levels of violence in South Africa:



Violence in South Africa is normalized and often seen as justified way of resolving conflict.



The criminal justice system is perceived as ineffective and corrupt.

High levels of inequality, poverty, unemployment and social exclusion are leading to higher levels of violence in the country.

In addition, DSD (2014) highlights that there are additional contributing factors, including HIV status, sexual identity, the breakdown of family structures, discrimination, unequal power relations and patriarchy. The historical inequalities related to race, gender and socio-economic conditions also add to this (NACOSA, 2015).

Watson (2015) highlights a number of myths related to rape in South Africa. According to her, this influences the poor prosecution and conviction rates for reported rape. These myths include the belief that it is not possible to rape a woman if she resists, some forms of sex are not regarded as rape and that when a woman says 'no' to sexual intercourse, she actually means 'yes'. There are also links to woman 'asking for it' based on the way she dresses, or that she is responsible for rape and sexual assault if she drinks alcohol.

#### 3.3 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, 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). At individual level, the survivor can experience:



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.

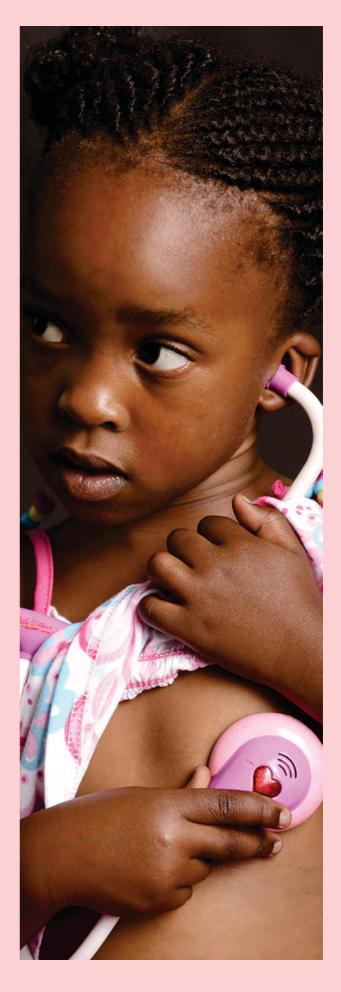


Direct cost of GBV in SOUTH AFRICA is between R28.4 - R42.4 billion

The health costs of direct treatment and follow-up psychosocial support is estimated at R105 billion

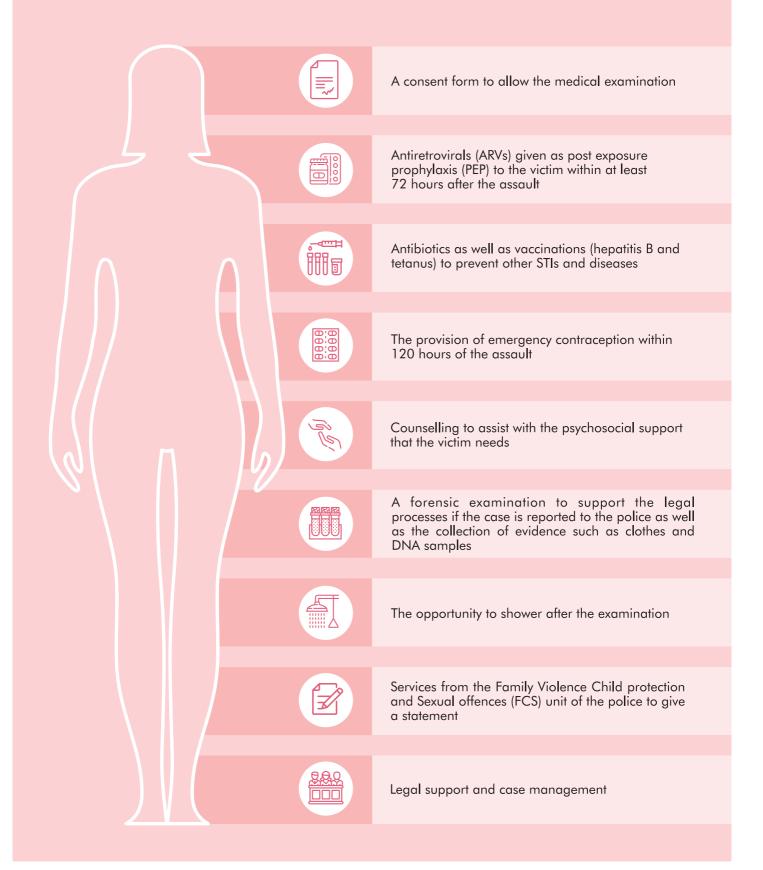
per year





#### 3.4 Post-violence services

In order to deal with the results of GBV, Doctors without Borders (2016) and Shukumisa (2016) identified a package of care that is required for the survivors of sexual assault, which includes:



In spite of various services that are currently available to the victims of sexual assault and rape, Doctors without Borders (2016) report that many women do not make use of the services available at clinics, hospitals, TCCs and other facilities.

It is also reported that many women who access services arrive after the 72 hour timeframe for PEP and the 120 hour timeframe for emergency contraception.



This also inhibits the forensic investigation. There are various reasons provided for the barriers in the uptake of services:



Individual circumstances can influence access to services and care. Many victims are not aware of the treatment and care that is available for them, or where to access services. If the victim was raped by someone that she/he is financially dependent on, it is less likely that she/he will seek care and support.



Availability of care and support services can have an influence on accessing post-rape service and care. Not all health facilities are equipped to provide the package of care needed in the case of rape. The proximity of emergency services, especially in rural areas, to where the victim lives, inhibits the uptake of services.



Societal attitude and stigma associated with rape and sexual assault prevents the uptake of services.

#### 4 International standards for managing sexual assault

This section highlights the minimum standards that WHO, CDC and other international bodies prescribe in the case of sexual assault. There is a large body of knowledge related to international guidelines that can assist the health sector (and other stakeholders) to plan for the provision of comprehensive care and support following a sexual assault. It also assists health systems to improve the quality of treatment and support provided, provide protocols for evidence collection and ensure the correct training for all service providers.

### 4.1 WHO: Guidelines for medico-legal care for victims of sexual violence

The aims of the guidelines are to improve the services delivered to victims of sexual assault. These assist healthcare workers with the knowledge and skills required to manage the services provided to sexual assault victims. The guidelines provide standards for service delivery and guidance on how to establish services for the victims of sexual assault.

This document highlights the care and welfare of the client and makes recommendations regarding the timing of health and forensic services (at the same time and conducted by the same healthcare professional (HCP)). It includes the minimum care that needs to be provided (testing for pregnancy, emergency contraception, STI testing and prophylaxis, treatment of injuries, psychosocial counselling and referral). It highlights the training requirements for HCPs who deliver the services (special training as well as an understanding of local protocols, rules and laws) and the requirements for service delivery within facilities. The document provides the recommendations for administering PEP. It also provides guidelines on specimen collection and delivery to the required laboratory to ensure prosecution (WHO, 2003).

# 4.2 A step-by-step guide to strengthening sexual violence services in public health facilities: Lessons learned from sexual violence services in Africa

Keesbury and Thompson (2010) made several recommendations on the improvement of services provided to survivors of sexual assault and how facilities should be managed. They highlight the following:



Healthcare providers must be appropriately trained to manage a victim of sexual assault

Victims must be treated with respect and sensitivity and particularly be protected against secondary victimisation

Patient confidentiality is essential at all times

The victim (or a caregiver, if the victim is underage) must give informed consent at all stages of examination and treatment

The health and welfare of the victim must be the priority of healthcare providers and should take priority over evidence collection

Reporting to the police should not be a prerequisite for examination, treatment and support

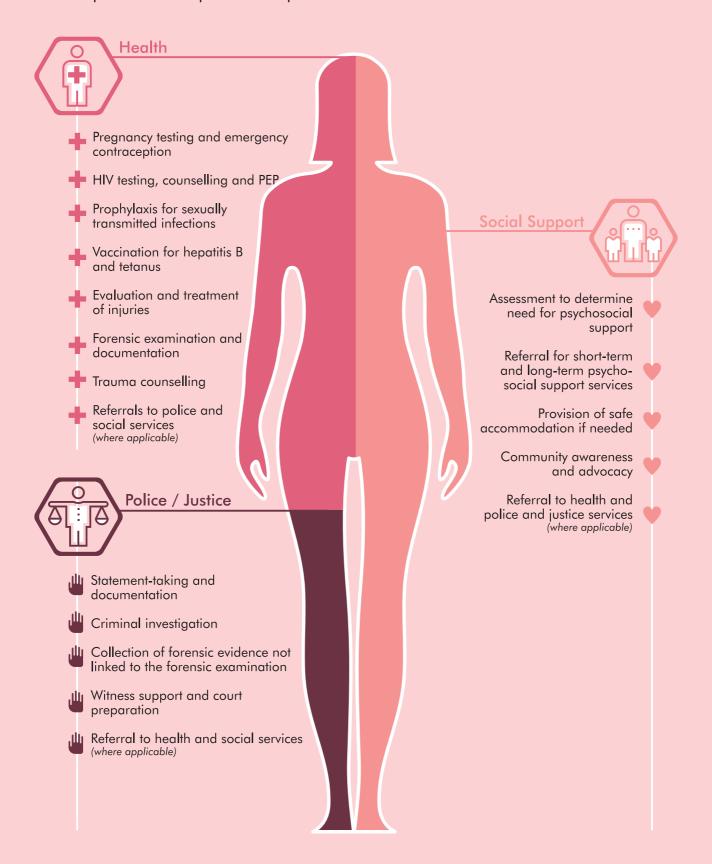
In the case of children, the best interests of the child should always take precedence and healthcare providers and other staff must understand and comply with their legal obligation to report cases of suspected sexual abuse of children

Research involving survivors should be limited as far as possible

Comprehensive care must be provided to the victim, including the medical, legal and psychosocial needs that should be addressed. This can be provided at a 'onestop-centre' or facilitated through a referral network between stakeholders

Special care should be taken to ensure that the needs of children and adolescents are taken into account and that facilities are child friendly Keesbury and Thompson (2010) identified the core components for service delivery, divided by sector/stakeholders.

#### Core components of a comprehensive response to sexual violence





#### 4.3 Regional policies, legislation and conventions

All 17 of the United Nations Sustainable Development Goals (SDGs) have relevance to the issue of GBV given its complexity, the underlying causes and the holistic interventions required to address it. The SDGs that are generally relevant include those that address poverty, food security, health and well-being, education, the environment, water and sanitation, energy, decent work and economic growth, reduced inequality, and peace, justice and strong institutions. Goal five, however, specifically seeks to achieve gender equality and empower women and girls. The goal aims specifically at addressing the global scourge of discrimination and violence against women and girls. It emphasises gender equality as a fundamental human right, and a 'foundation for a peaceful, prosperous and sustainable world' (UN, 2015:1). It further seeks to provide women and girls with education, healthcare, decent work, and representation in political and economic-decision making processes.

In addition to its attempts to meet the SDGs, South Africa has signed and ratified a number of international instruments over the last three decades which set the standard for State obligations with regard to the rights of women and girls. Although not an exhaustive list, these instruments, what obligations, rights or protections they refer to, as well as South Africa's obligations are set out next.

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

#### International Instrument

#### **CEDAW**

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

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

#### **UNCRC**

United Nations Convention on the Rights of the Child, 1989

The Declaration on the Elimination of Violence against Women, 1993

Beijing Declaration and Platform for Action, 1995

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

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

#### Overview of the Instrument and South Africa's Status

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 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)

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)

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)

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 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)

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)

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 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
(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 genderbased 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.

## 5 South Africa's legislative and policy frameworks as a response to GBV in South Africa

The South African government, in conjunction with various international development agencies, civil society organisations and bilateral funding agreements responded to the issues discussed above in various ways. A number of Acts were promulgated and legislative changes were made. Various government departments are tasked to address GBV, either via services, policies or campaigns. This includes the Departments of Social Development, Health, Justice and Constitutional Development, Education and many others. There are also various awareness programmes (such as the Sixteen Days of Activism from 25 November to 10 December each year and Women's month in August) and other projects managed by NGOs.

South Africa has a number of responses addressing GBV. This a comprehensive list of legislative and policy frameworks to address and combat the prevalence of GBV in South Africa. Some will be discussed in more detail.



The Domestic Violence Act (Act No. 116, 1998)



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



Firearms Control Act (Act No. 60, 2000)



The Children's Act (Act No. 38, 2005)



National Policy Guidelines on Victim Empowerment



National Instructions on Domestic Violence



National Policy Framework on the Management of Sexual Offences



National Instructions on Sexual Offences



National Directives and Instruction on Conducting a Forensic Examination on Survivors of Sexual Offences in terms of the Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007)



The Victims Charter (2004)



National Management Guidelines for Sexual Assault (2003)



Court System and Case Flow Management



Family Violence Child Protection and Sexual Offences (FCS) investigation units at the SAPS

It is also important to realise 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 within the South African context.

#### 5.1 The Victims Charter (2004)

The Victims Charter (also called the Service Charter for Victims of Crime in South Africa) ensures that a client's physical health, mental health and criminal justice needs are met, while preventing secondary victimisation. It highlights what should be included to ensure a victim friendly environment, considering which services should be delivered, and which referral structures should be in place.

The Department of Justice (n.d.) highlights that the Victims Charter explains the rights of clients, including dignity, privacy and access to criminal justice. The aim of the Victims Charter is to eliminate secondary victimisation as part of the justice process, to ensure that the victim remains central to the criminal justice process and to ensure resources for the victim within the criminal justice system. The Charter describes the following seven rights of victims:



#### 5.2 The Domestic Violence Act 116 of 1998

This Act provides specific guidelines with regards to victims of domestic violence, and can provide some guidance to the case study of the TCCs.

This Act responds to the high incidence of domestic violence in South Africa and attempts to protect victims by making provision for the issuing of protection orders. The Act aims to give greater protection to victims and has broadened the definition of domestic violence. It also creates the opportunity for the SAPS to assist victims of violence. The Act makes provision for a police officer to arrest any person who may have committed an act of domestic violence (without a warrant of arrest) and to seize any weapons from the premises. Applications for protection orders can also be made on behalf of the victim with their written consent, unless the victim is a minor, has intellectual disabilities or is unconscious. Disobeying a protection order is a crime and the offender can be sentenced to imprisonment of up to 5 years (Mpani and Nsibande, 2015).

## 5.3 The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

This Act describes all the legal aspects of sexual offences and how these should be dealt with by the relevant authorities. It provides definitions for rape, sexual assault, compelled rape and sexual offences against children as well as statutory sexual offences. It also explains the special protection measures for children and persons with disabilities. It defines all sexual crimes under one law.

The Act introduce the rights of victims such as the right to PEP after rape, the introduction of a Sexual Offenders Register and minimum sentencing for various offences.

Important features of this Act:



#### 5.4 Sexual Offences Courts

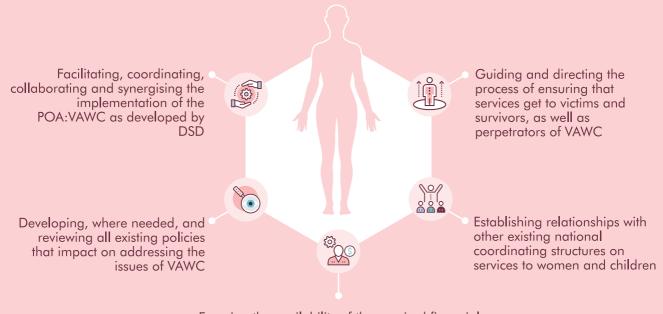
The Department of Justice and Constitutional Development is in the process of re-establishing Sexual Offences Courts in specific areas in the country. The aim of this is to increase conviction rates and reduce the secondary victimisation for survivors of sexual assault (Mpani and Nsibande, 2015). These courts reinforce the existence of a victim-centred court system and will cooperate with the various support services dedicated to victims of sexual assault, such as the TCCs, the Khusuleka One Stop Centres and the FCS Units at SAPS (Radebe, 2013).

#### 6 South Africa's policy guidelines, norms and standards to address GBV

The South African government developed a number of policy guidelines, and norms and standards that inform the functioning of the TCCs. These assist in the case management of clients, taking into account the various government departments, as well as NGOs, who play a role in the process. There are many key documents that provide guidance, and for the purpose of this case study the following documents were reviewed, the TCC Blueprint, Department of Health National Norms and Standards, and the South African Integrated Programme of Action Addressing Violence Against Women (2013 – 2018, DSD). A number of other documents were consulted and will be mentioned where relevant.

In order to manage cases of GBV and sexual assault, the NPA created an inter-departmental management team (IDMT) that includes various government departments such as the NPA, SAPS, Departments of Justice and Constitutional Development, Health, Social Development, Safety and Security, Education, Local Government, Correctional Services and Treasury. This team was chaired by the NPAs SOCA unit.

In 2010 Cabinet established an inter-ministerial committee (IMC) on violence, made up of ministers of Social Development, Justice and Constitutional Development, Women, Health, Home Affairs, Police, Communications and Basic Education (DSD, 2014). The IMC has the following responsibilities:



Ensuring the availability of the required financial and human resources to oversee and implement the integrated POA:VAWC of the DSD

The IDMT was dissolved and its tasks were allocated to the IMC.

#### 6.1 The TCC Blueprint

The TCC model is one of the key responses from the South African government to provide care and support to victims of sexual assault. The aim is to provide a wide range of post-rape care services to survivors without exposing them to secondary victimisation. A total of 55 TCCs have been established across the country.

The TCC Blueprint explains all the steps and processes for the management of a case of sexual assault 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 department 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).





Guide stakeholders who need to be involved in the day-to-day running of TCCs





how quickly court cases should start



facilities & space for functioning



additional services



actions to be taken to prevent secondary



time frames required for proper service delivery



legal processes to ensure case management case be registered on court roll within 48 hours cases ideally concluded within 9 months prepare witnesses for court and management of evidence



confidential counselling rooms private ablution facilities



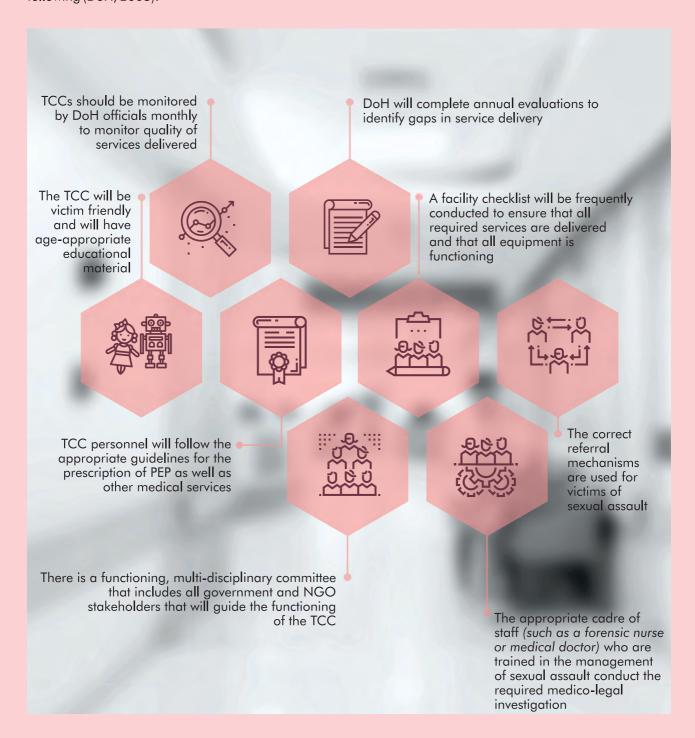
comfort packs and fresh clothes toys for children to play with



treated with dignity privacy confidentiality

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

As TCCs are linked to a hospital, they are subjected to the DoH Norms and Standards that provide guidance on the functioning of primary healthcare (PHC) facilities. These norms and standards include the following (DoH, 2003):



#### 6.3 The South African Integrated Programme of Action Addressing Violence Against Women (2013 – 2018, DSD)

The Department of Social Development (DSD) 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).



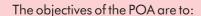




and care

## 6.4 National Management Guidelines for Sexual Assault, 2003

The National Management Guidelines for Sexual Assault (2003) provide a structured, integrated approach to the management of sexual assault. This focuses on the emotional and physical needs of the client (DoH, 2003a). The goal of this guideline is to improve the healthcare of victims of sexual assault and has five main objectives:





Prevent violence against women and children



To establish an institutional framework to ensure collaboration between all stakeholders



Develop a response to violence in a coordinated manner



To establish designated, specialised and accessible healthcare services for the management of patients after sexual assault. These centres should be available 24/7



Ensure long-term care, support and empowerment to survivors of violence



To operate as part of an inter-sectoral service with the community and key stakeholders



Assist with reintegration and rehabilitation of perpetrators of violence



To provide training, guidelines and structures for the management of sexual assault



Strengthen all systems to ensure a coordinated response



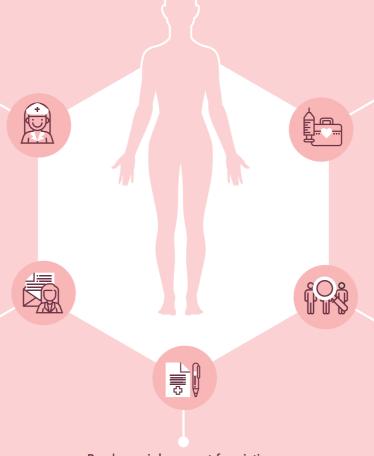
To ensure adequate monitoring and evaluation of the services to ensure quality services The guidelines provide for the provision of PEP, training of healthcare workers, debriefing of healthcare workers, and the health management of survivors. Other aspects include:

## Competency of healthcare workers

H C Ps must be adequately trained to provide various medical and social services to clients. This includes emotional support, emergency medical care, and relevant PEP. They must be trained to document injuries and collect forensic evidence

## Medico-legal evidence

The guidelines provide specifics regarding the collection of forensic evidence with the approved sexual assault kits and the completion of the relevant legal forms (J88)



#### Psychosocial support for victims

The guidelines highlight the emotional support and counselling services that should be provided to clients

## Treatment of victims

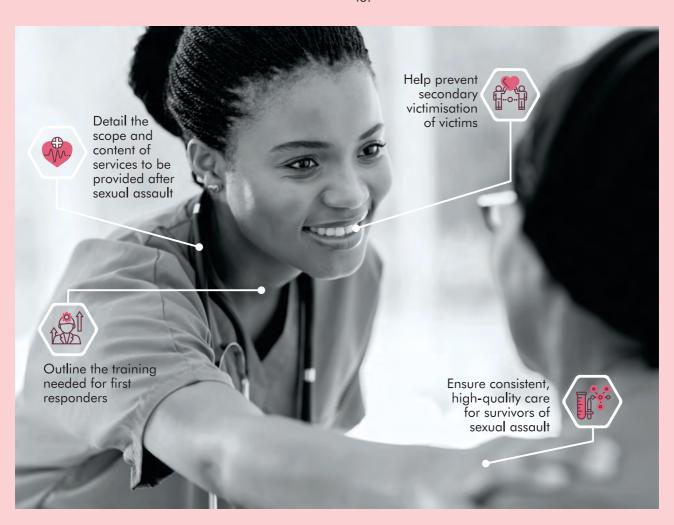
The guidelines explain the various types of PEP that are available and when it should be prescribed

## Investigations of sexual assault cases

The guidelines explain that the collection of evidence should be conducted at the same time as the medical treatment of a client. This also provides guidelines on how evidence should be collected if a facility does not have the approved evidence kits available

# 6.5 Guidelines and standards for the provision of support to rape survivors in the acute stage of trauma (NACOSA, 2015)

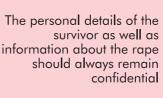
NACOSA (Networking HIV&AIDS Community of Southern Africa), with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria, developed the Guidelines and Standards for the Provision of Support to the Survivor of Sexual Assault, which aim to:



The guidelines recommend that the following guiding principles are followed when providing emergency services to victims of sexual assault:



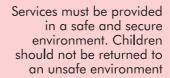
Rape survivors should be treated with dignity and respect. The first responder should avoid secondary victimisation of the rape survivor







Service providers must maintain records of their work in manner that is accountable and transparent







Rape survivors must participate in their treatment and be part of the decision-making process

Service providers and first responders must not discriminate against any victim and must not be judgemental





Services provided must be rights-based and responsive to the needs of the individual survivor

> Services must consider the special needs and interests of children





Services must be accessible to all groups of rape survivors. This includes physical accessibility in terms of transport, but also wheelchair access. Procedures must be adapted to the special needs of different groups of victims. Information must be available in a variety of languages, as well as braille or audiotapes. The attitudes of staff members must not distance specific groups and there should be no financial barrier to access services



The NPA was established in 1998 and is responsible for the start of criminal proceedings on behalf of the state.

Within the NPA is the SOCA (Sexual Offences and Community Affairs) unit which is responsible for the management of the TCCs as well as the case management of the criminal cases as a result of sexual assault.

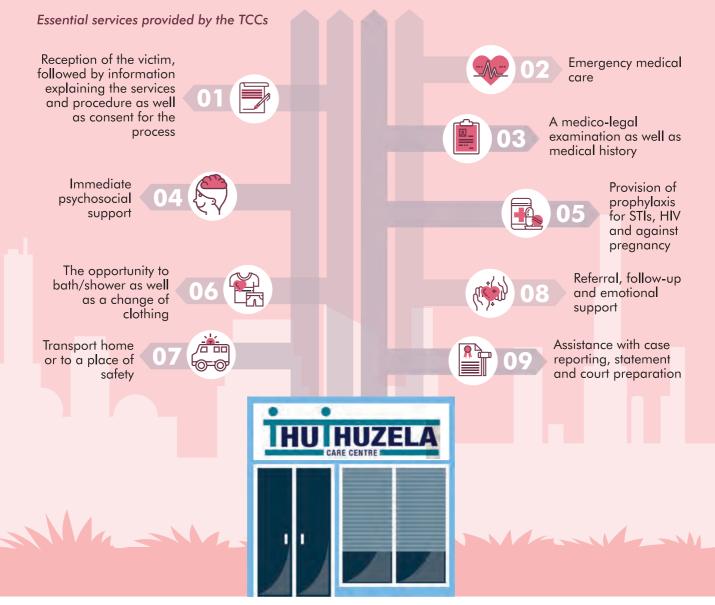
Owing to the high levels of GBV in South Africa, the NPAs SOCA unit developed the TCC model to respond to this crisis in a comprehensive and multisectoral way.

TCCs have been developed to reach three main goals:



TCCs function in two arenas – immediate services are delivered in a care centre that is located within a public healthcare facility, and a legal component that is ideally dealt with at a sexual offences court. The ideal is that the centre should be located within a public health facility, but that is not always the case. In many instances TCCs are based in park homes on the grounds of the healthcare facility.

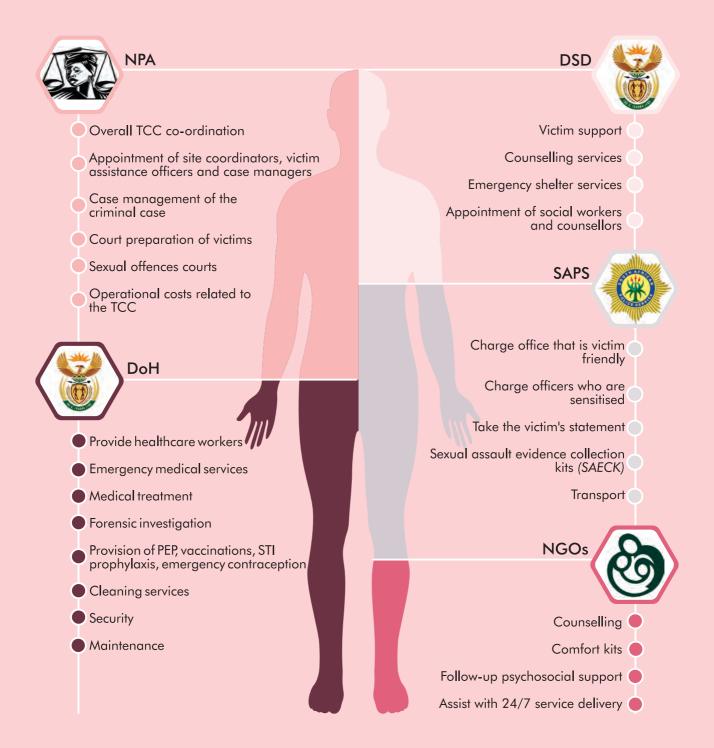
TCCs provide a comprehensive set of services for victims of sexual assault and for this reason they are often called a one-stop service centre. They are also intended to streamline the treatment and care processes for the survivors, which include:



At some TCCs the victim can also give the required police statement. The required staff component for a TCC is prescribed by the TCC Blueprint. This includes a case manager, a victim's assistance officer, a site coordinator, counsellors, trained detectives and personnel (either from the police or emergency medical personnel) to transport victims back home or to a place of safety (Vetten, 2015). The sexual offences court provides the personnel required for the legal component of the TCC model.

In recent years, the use and access to TCCs has increased dramatically. In the 2009/10 financial year, there were 25 TCCs established, and they dealt with 13 756 cases. By 2012/13, there were 51 TCCs in existence, which dealt with 33 112 cases (Vetten, 2015). By mid-2016 there were 55 TCCs functioning in all nine provinces in South Africa.

The different government departments have different roles in the TCC model.



Since the inception of the TCCs there have been many reports, reviews and studies on their functioning and services delivered. The following were consulted for this report:

RTI, 2012. Final compliance audit of 23 Thuthuzela Centres. Pretoria: USAID.

Soul City, 2013. Qualitative formative research on the knowledge, attitudes and behaviours relating to reporting sexual assault and the use of Thuthuzela Care Centres. Soul City Research Unit.

Vetten, L. 2015. "It sucks/ It's a wonderful service": Post-rape care and the micropolitics of institutions. Johannesburg: Shukumisa Campaign and ActionAid South Africa.

Shukumisa, 2016. Improving after-rape care services. Young urban women programme, Johannesburg.

Foundation for Professional Development (FPD). 2016. Thuthuzela Care Centres Compliance Audit and Gap Analysis. FPD, Pretoria.

Robinson, J.; Sabet, D., Feenstra, M., Stahlberg, S. & Rostapshova, O. 2017. Impact evaluation of the 'Increasing services for survivors of sexual assault in South Africa' program – Endline Impact Evaluation report. Social Impact Inc.

The findings were as follows.

#### 7.1 Human capacity

The human capacity of the TCCs is crucial to ensure proper service delivery in line with the TCC Blueprint and the DoH norms and standards. Lack of adequate staffing, inadequate training and work experience will have a critical impact on service delivery within TCCs.

All TCCs must have the following staff:



Each TCC must retain the services of one parttime or full-time *doctor*.

Each TCC must have a *forensic nurse* allocated to it. A forensic nurse is trained to collect forensic evidence, complete the necessary legal forms and is allowed to testify if the case goes to court.

The medical personnel must be provided by DoH



Non-medical personnel, including a site coordinator (SC), victim assistant officer (VAO), case manager

provided by the NPA



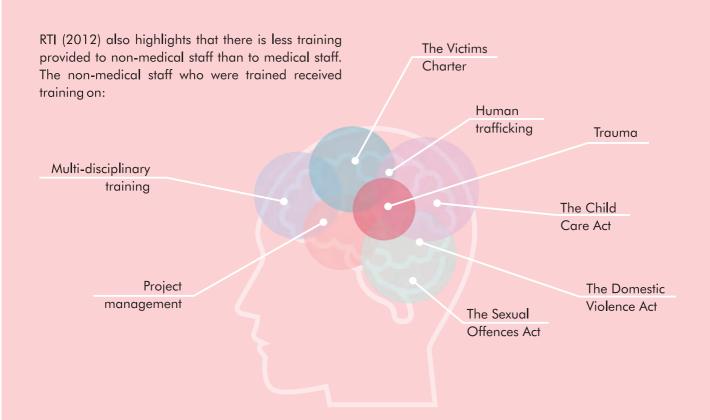
Psycho-social support personnel such as a social worker, HCT counsellor and access to a psychologist and forensic social worker

provided by DSD and NGOs

RTI (2012) found that many TCCs do not have site coordinators and very few have dedicated doctors or forensic nurses. Many TCCs do not have social workers. Gaps in the staffing at TCCs have an impact on their service delivery as other staff members provide services in areas in which they are not adequately qualified. Robinson et al. (2017) reported that even with NGOs supplementing the TCC staff, there is chronic understaffing at many TCCs. The FPD (2016) study found that 95% of TCCs have a site coordinator, and 70% a VAO, while only 46% have a case manager attached. A major problem with the TCCs is the lack of adequate and continuous debriefing in a very stressful and emotionally demanding work environment.

RTI (2012) highlights that most TCCs provide in-service training for their medical staff members. This includes:





All staff who are involved in the treatment and case management of rape survivors need to receive training on post-rape management. This must specifically include training on the initiation of PEP.

#### 7.2 Health services delivered

The TCC Blueprint requires that TCCs are located within hospital premises, but with a separate entrance and a dedicated area. Some TCCs are based in park homes within hospital premises and others have a dedicated space within the hospital (RTI, 2012). In the 2012 study, 78% of all TCCs reviewed were open 24 hours, 7 days a week. Most TCCs in the 2012 study are disability friendly and have ablution facilities and a counselling room specifically for children. Not all counselling rooms for children are equally equipped. Ablution facilities should be disabled-friendly, and en-suite to the examination room.

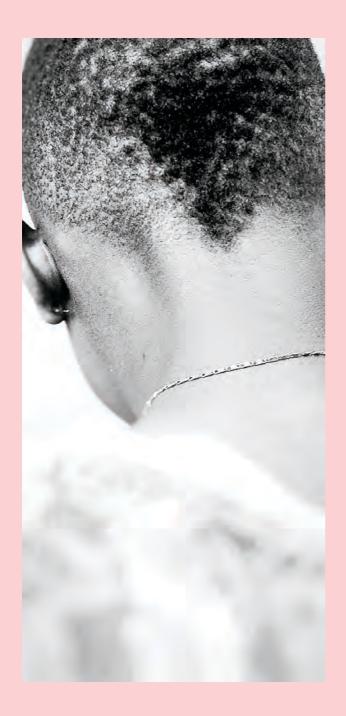
The TCC Blueprint requires that clients are seen by a first responder when arriving at the TCC. It further requires that the client be attended by a doctor or forensic nurse after arrival. The reality is that the doctors are very often busy in the casualty section of the hospital, and this increases the waiting time for victims.

Medical history taking and collection of forensic evidence is part of the medical exam. The HCP must also compete the J88 legal form and send the samples collected for laboratory testing. In some cases the SAECK is stored at the TCC, in other cases at the local police station.

National guidelines also make recommendations for various prophylactic treatments that must be available at facilities. TCCs do not have adequate resources and the staff to provide short- and long-term counselling to clients after sexual assault. Very often, this service is provided by referral organisations. However, there is no adequate system to track if clients make use of the counselling services.

The basic equipment needed for the examination of a client after sexual assault includes a colposcope, speculum and gynaecological light. Seventy-five percent of all TCCs reviewed by RTI (2012) either do not have the equipment, it is out of order, or it is not used.

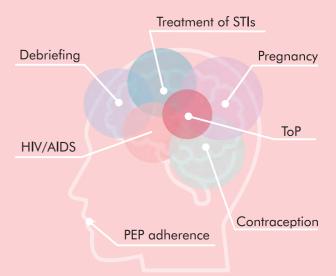
Health services are delivered as prescribed during the day, but many TCCs face challenges with emergency medical treatment, PEP and counselling after-hours and on weekends. In some cases victims have to report to the emergency room, and wait with other patients, or they have to wait for the doctor from the emergency room to come to the TCC.



#### 7.3 Psychosocial support

According to the TCC Blueprint, DSD must make social workers available to provide psychosocial support to TCC clients. The Blueprint also highlights that DSD can partner with NGOs to assist with this service delivery, and to assist with follow-up care.

TCCs deliver various counselling services to clients. This includes:



The RTI (2012) study highlighted that psychosocial support services are hindered by a lack of counselling space, which is compromising confidentiality, too few personnel to deliver the service and personnel who are not trained to deliver the service. Vetten (2015) mentions that in most instances NGOs deliver the counselling services and psychosocial support. Between different TCCs there are different roles allocated to the counsellors, and this makes standardisation of services difficult. One of the main challenges in psychosocial support is follow-up care. Vetten (2015) elaborates that this is a significant challenge and that there is no consistency in the provision of follow-up care between the TCCs. There are also too few psychologists available to assist with follow-up support.

#### 7.4 Stakeholder cooperation

Soul City (2013) explains that the cooperation between different stakeholders (NPA, SAPS, DoH, DSD and various NGOs) increase the level of service delivery to survivors of sexual assault. It also brings together stakeholders who previously worked in silos to ensure a comprehensive service. Special care should be taken to ensure that stakeholders do not see this as an 'outside project', as this might influence long-term sustainability. The government stakeholders are regulated by the Intersectoral Committee on the Management of Sexual Offences. At facility level, stakeholder management is done at the monthly implementation meetings. These meetings are held with a representative of the TCC, police, prosecutor's office, NGO partners, DoH and DSD.

Vetten (2015) describes the stakeholder relationships as a 'contested space where power struggles [are] played out between NPA and DoH, DSD and DoH, NGOs and the NPA, NGOs and DoH and NGOs and DSD'. RTI (2012) also highlights that the relationships between the stakeholders are varied across the different TCCs. Vetten (2015) explains the impact of these micro-politics in detail and mentions that in some cases hospital personnel removed equipment from TCCs, the hospital managers might not allocate enough space for the TCC to be fully functional and in other cases healthcare personnel will disregard the confidentiality of counselling sessions.

#### 7.5 Location and visibility of TCCs

TCCs are located at hospitals, either within the hospital, a building next to the hospital or a park home on hospital grounds. Not all TCCs have signage and this makes them difficult to locate (Soul City, 2013). An impact evaluation conducted by Robinson et al. (2017) indicated that all but one TCC now have signage. Ninety percent of security guards are aware of the location of the TCC (FPD, 2016).



#### 7.6 Operating hours

The TCCs have different operating hours. Some are open 8 hours a day during the week. Others can operate 24 hours a day as well as during weekends. NPA staff (and FPD staff for the four MAC AIDS Fund supported TCCs) only work 8 hours a day during the week and TCCs who operate 24 hours a day have other stakeholders (mostly NGOs) assisting them (Soul City, 2013). Most TCCs reported that there is a higher demand for TCC services after hours and during weekends (Soul City, 2013). FPD (2016) found that seventy percent of all TCCs provide a 24/7 service. However, most health services are not available within the TCC after hours. Victims are either referred to the casualty department of hospitals or have to wait for a forensic nurse or doctor to come to the TCC from casualty.



#### 7.7 Transport

Transport is a major barrier for almost all components of the TCC model. SAPS may bring victims to the TCCs, but they cannot wait to take the victim either home or to a place of safety. Many victims do not have transport to come back to the TCC to receive follow-up PEP or follow-up psychosocial support. This also influences the victims' ability to attend court proceedings. Due to lack of transport NGOs cannot provide follow-up psychosocial support at the victim's home and the NGOs and TCC staff cannot participate in community awareness campaigns (FPD, 2016).

#### 7.8 Services delivered by NGOs

The services delivered by NGOs varies among the different TCCs. The most common services include:



The counsellors provided by the NGOs have different functions. Some act as first responders (specifically at night and over weekends), some act as HIV counsellors, post-rape counsellors and victims' advocates (Vetten, 2015). She also highlights that there is evidence of task shifting from DoH personnel, who are using the NGO staff to conduct some of their tasks. This includes pre- and post-HCT counselling.

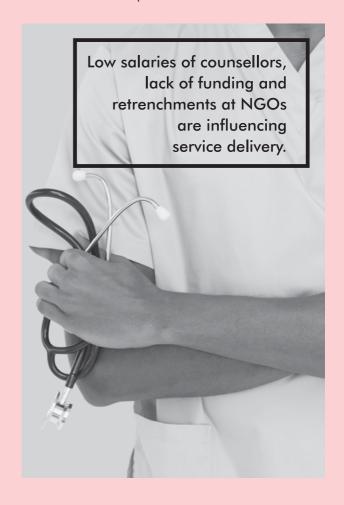
# 21 NGOs deliver services in 70% of TCCs

There are 21 NGOs who deliver services in 70% of the TCCs. The NGOs assist with providing services and the smooth running of the TCC. There are many reported benefits to having an NGO involved, including providing continuous support to clients, rallying communities for campaigning activities, bringing awareness and support for the TCCs, keeping the TCCs open 24 hours a day and on weekends, and providing supplies and resources. The 24-hour service of the NGOs seemed to be the greatest value that they provided to the TCCs. This is important as it was reported that most cases of sexual assault occur at night or over weekends and holidays. There are some challenges with regards to the relationships between the NGO staff, TCC staff and DoH staff. The TCC staff often reported that the NGOs are overstepping their boundaries. The DoH staff often shift reporting and other administrative tasks to the NGO staff. The NGOs feel undervalued. However, without NGOs very few TCCs would be able to deliver a 24/7 service, (FPD, 2016).

#### 7.9 Funding

The funding provided to NGOs is a contested space that influences the ability of NGOs to deliver a 24/7 service, provide counselling directly after the sexual assault and provide follow-up psychosocial support. Vetten (2015) highlights that the low salaries of counsellors, lack of funding and retrenchments at NGOs are influencing service delivery. As a result of funding challenges, some NGOs had to stop their services at TCCs or reduce the number of counsellors they can provide per site. Many NGOs are dependent on NACOSA funding (from the Global Fund) to sustain their services at TCCs.

There is also conflict between DSD and DoH about who should be responsible for funding counselling services in the TCCs. DoH argues that it is a psychosocial support service and therefore within the DSD domain, while DSD argues that the work is done at health facilities, and therefore the responsibility of DoH, (Vetten, 2015). Shukumisa (2016) also reports that in some provinces DSD provides funding for NGO counselling services, and in others not. The amount allocated by DSD per counsellor per month also differs between provinces.



#### 7.10 Community awareness of the TCCs

Despite being in existence for 17 years, community awareness of TCCs is still not adequate.

Both Soul City (2013) and Robinson et al. (2017) reports that many South Africans are still unaware of the existence of TCCs and the services they deliver.

# 8 Other government responses in South Africa

# 8.1 DSD: Khusuleka One-Stop-Centres

The word 'Khusuleka' is derived from isiZulu, meaning 'to be protected'. DSD developed the Khusuleka One-Stop-Centres to provide support to women and children who are victims of crime and violence. The functioning of the centres is dependent on intersectoral collaboration between key government departments. It is described as a '24-hour place of refuge' for victims of crime and violence and provides:



Shelter services for victims of crime and natural disaster



Trauma counselling and psychosocial support



Referral to healthcare facilities



A close working relationship between SAPS and the court system

(Western Cape Government, 2015)

The Khusuleka model is supported by the European Union (EU) and the United Nations Office on Drugs and Crime (UNODC), (Gender Links, 2014).



Khusuleka: to be protected

### 8.2 DoH: Kgomotso Care Centres

The North West Department of Health (2015) allocated funding for the establishment and staffing of Kgomotso Care Centres to assist victims of violence in the province. In July 2015, North West DoH, in collaboration with Médicins Sans Frontièrs/Doctors without Borders (MSF) opened a Kgomotso Care Centre in Rustenburg to provide emergency medical care and psychosocial support to victims of sexual violence. The package of care includes:



Medical first aid to treat injuries



A comprehensive medical assessment and forensic examination



Provision of PEP for HIV and STIs



Vaccinations to prevent hepatitis B and tetanus



**Emergency contraception** 



Counselling and linkage to care

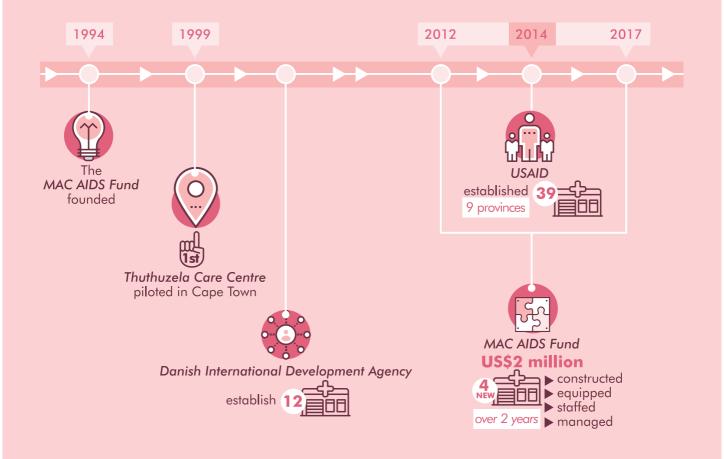
(Mail and Guardian, 2016)

# 9 Donor response to gender-based violence in South Africa

The first Thuthuzela Care Centre was piloted in Cape Town in 1999. The Danish International Development Agency (with UNICEF as the implementing partner) supported the establishment of 12 TCCs as a response to GBV. In addition, USAID (with RTI as an implementing partner) supported the South African government to establish additional TCCs to ensure that by 2014 there were 51 TCCs established across all nine provinces (Vetten, 2015). The USAID department of Southern Africa Democracy, Rights and Governance works with various South African government departments to ensure that women's right and access to justice are promoted. This also includes the support of civil society organisations (USAID, 2016).

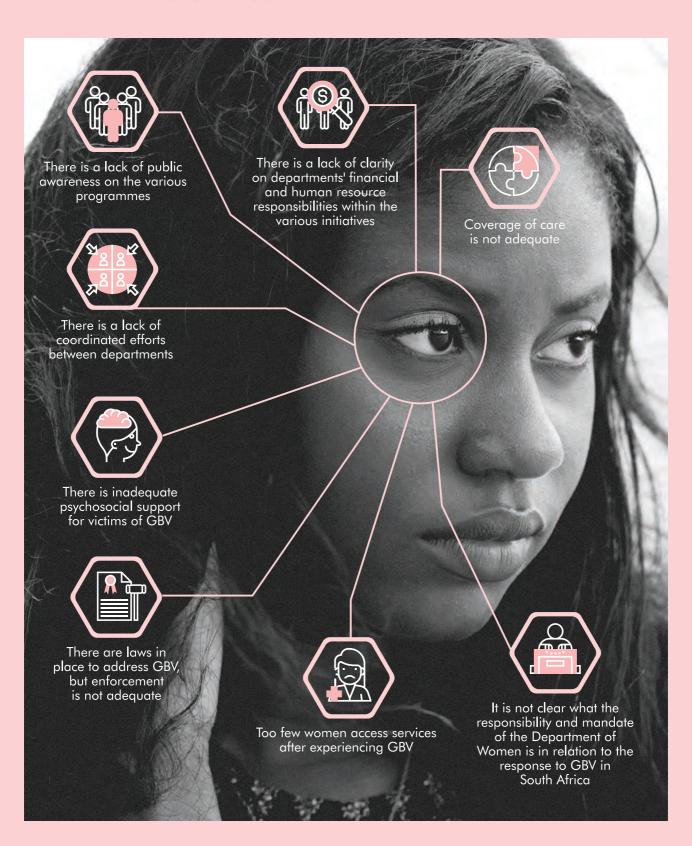
The MAC AIDS Fund, the corporate social investment arm of MAC Cosmetics, was founded in 1994 and support organisations across the world to combat HIV/AIDS. The fund appoints celebrities to act as ambassadors for MAC to assist with fundraising and promotion of the brand. As part of its reach, the MAC AIDS Fund committed US\$2 million to expand the Thuthuzela Care Centre network in South Africa in conjunction with USAID. Four new TCCs were constructed, equipped, staffed and managed for two years with this funding.

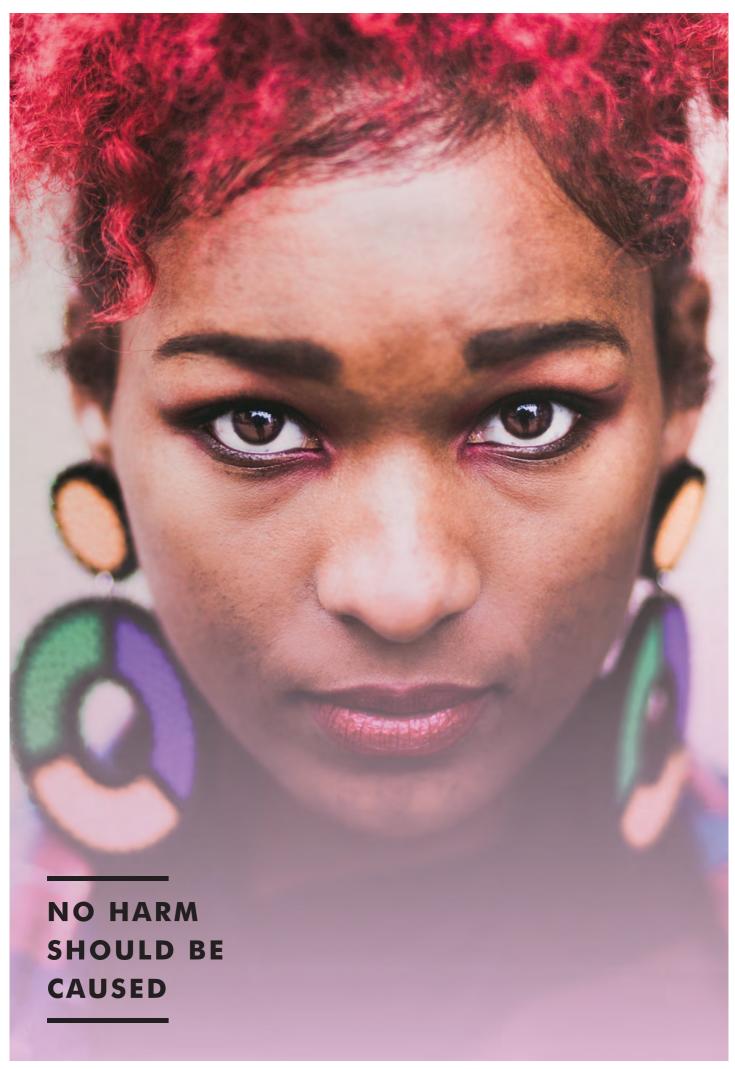
The implementation of this project formed part of the larger Increased Services for Survivors of Sexual Assault in South Africa (ISSSASA) programme that focused on the improvement of holistic services to survivors of sexual assault by improving services provision and raising community awareness of the services available to survivors of sexual assault in South Africa. This programme was implemented between 2012 and 2017 by the FPD in conjunction with the Soul City Institute, Sonke Gender Justice Network and the South African Medical Research Council (Robinson et al., 2017).



# 10 Conclusion and still existing gaps

In assessing the South African government response to GBV and sexual assault in South Africa, there are good legislative, policy and implementation programmes in place to address, manage and curb GBV in South Africa. The literature, however, highlights a few gaps that still need to be considered:



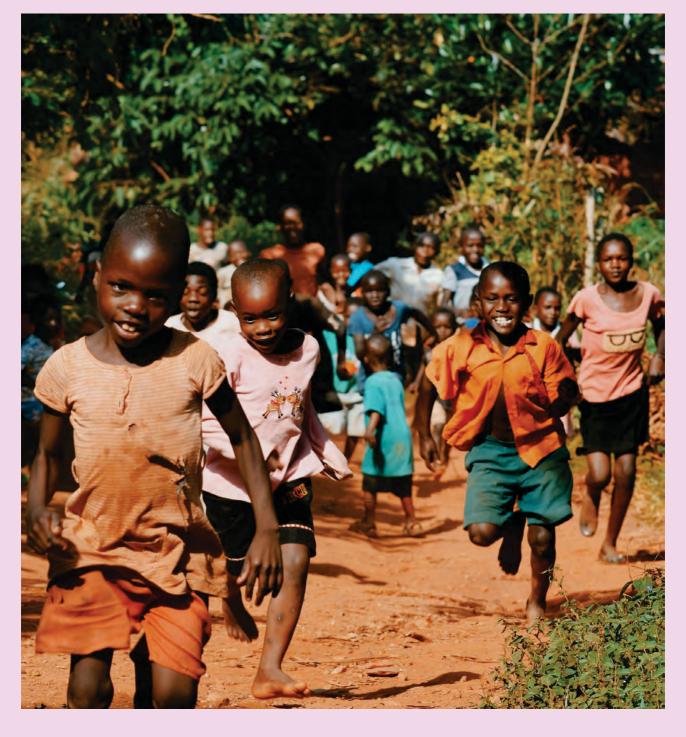


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Chapter Three **Methodology** 

This case study showcases the establishment and functioning of, and highlights aspects of sustainability of the four MAC AIDS Fund supported TCCs. It was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two was field work and data collection, and phase three, reporting. The case study draws heavily on the data collected during the 2016 Compliance Audit and Gap Analysis conducted by FPD.

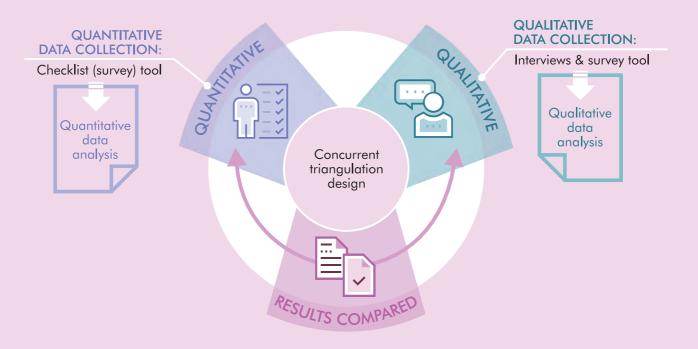




# 1 Approach

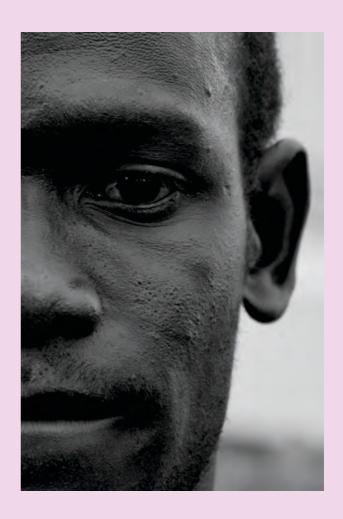
The scope of this case study required collection of quantitative and qualitative data. The researcher took a pragmatic approach to the case study because evaluation, specifically the components related to the functioning of the TCCs, took precedence over the actual method of the evaluation (Creswell, 2009). According to Creswell (2009), problems that are addressed through health and social science research are complex, which makes either quantitative or qualitative methods insufficient when used separately. Therefore, mixed methods were used. Mixed methods contain both quantitative and qualitative elements (De Vos et al., 2005) and their overall strength can be greater than that of quantitative or qualitative research alone (Creswell and Plano Clark, 2007, as cited in Creswell, 2009). The quantitative data for this case study were collected during the 2016 Compliance Audit and Gap Analysis on the TCC (FPD, 2016). The qualitative data were collected specifically for this case study.

# Approach to the case study



# 2 Sample

Data were collected from all four MAC AIDS Fund supported TCCs, therefore random sampling was not used. There were two populations in this case study, the FPD staff employed at the TCCs and the NGO staff. One FPD staff member per facility was interviewed (three site coordinators and one VAO). The researcher also interviewed a representative of each of the NGOs working within the facilities. The NGO informants were conveniently sampled based on who was available at the time of data collection. Other key informants included FPD managers and representatives from USAID.



# 3 Situational analysis and desk review

The researcher conducted a situational analysis using a desk review. The researcher used international and local reports, articles and standards to develop the situational analysis. This also informed the data collection tool that was developed as well as the interview schedules. It considered the South African legislative and policy frameworks. National, international policy guidelines, norms and standards on the delivery of GBV support services were consulted. The desk review and situational analysis provide a broad background on the current environment in South Africa in which the TCCs function, taking into account all reports, reviews and assessments done on TCCs, as well as other GBV-related services in South Africa. The team also consulted NGO, administrative and government secondary data for this.

# 4 Data collection methods, tools and procedure

A database containing contact information for the TCCs was used by the researcher to contact each facility. This database is based on the 2016 Compliance Audit and Gap analysis. Site visits were scheduled with each TCC and the NGO based within the TCC.

# 4.1 Data collection methods

Data collection is summarised in the figure below and elaborated on below. It is important to note that no data was collected from survivors, victims or clients of the TCCs.

# Diagram of data collection



Situation analysis in the form of a desk and literature review



Facility level Compliance audit and gap analysis data (2016)

# Key informant interviews for broader context

Interviews with FPD managers and USAID representatives

Facility level Interviews with FPD staff based in the TCCs and NGOs working in the TCCs



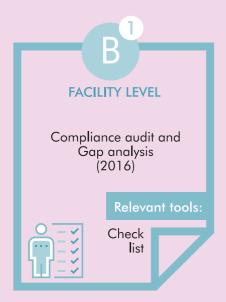




# 4.2 Data collection tools

The data collection tools (figure below) for the case study included an electronic check list and interview schedules.

### Diagram of data collection tools







# 4.3 Quantitative data acquisition

FPD used the quantitative data collected during TCC compliance audit and gap analysis of 2016. During that study, the TCC model was studied and a questionnaire was developed based on the model. An application (ODK App) and survey tool was developed in collaboration with MPC, to allow the team to collect data electronically using tablets.

One (or more) respondent(s) from each TCC helped each data collector to complete the checklist. The data collectors were also required to use their own discretion and to validate the information given by the respondents.

# 4.4 Qualitative data acquisition

Semi-structured interview schedules were developed after careful examination of the TCC model and relevant literature. As previously mentioned under the sampling section, four groups of participants were interviewed and therefore four different interview schedules were developed – for the FPD staff within the TCC, NGOs working within the TCC, FPD managers and representatives from USAID respectively. Each interview lasted approximately 40 to 60 minutes.

# 5 Data analysis procedure

### 5.1 Quantitative data analysis

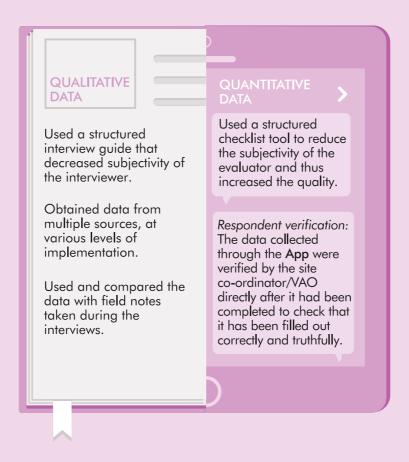
During 2016, the quantitative data were exported from the database into Excel™, where it was cleaned and coded. It was then imported into the Statistical Package for Social Sciences (SPSS®) version 22.0. Descriptive analyses were conducted and the data analysis output was displayed in graphs, tables and cross-tables. No inferential analyses were conducted.

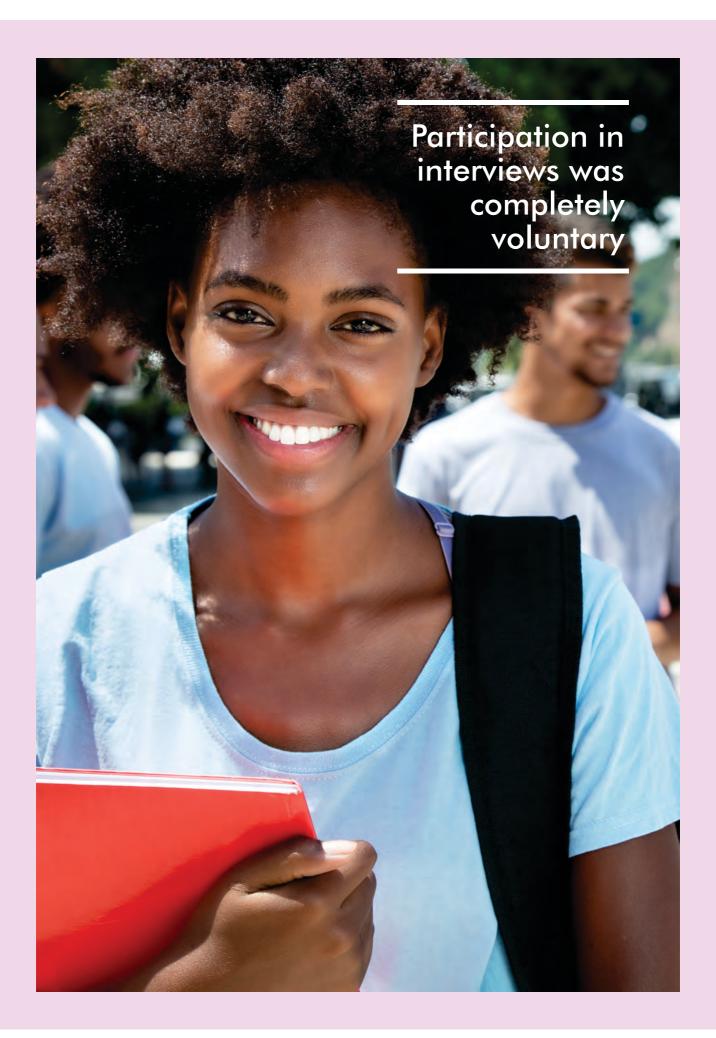
# 5.2 Qualitative data analysis

The qualitative data was analysed through a combination of deductive and inductive thematic coding. Themes were drawn from the semi-structured interview schedules and added to the coding frame. The interview notes were initially read as a whole and notes were made at the end. Codes were developed and grouped as categories under each theme. This method was deemed appropriate since multiple participants were interviewed using a semi-structured data-gathering tool. Structural coding is content-specific and is applied to segments of text in order to categorise the data according to specific research questions (Saldaña, 2009).

# 6 Data verification and quality assurance

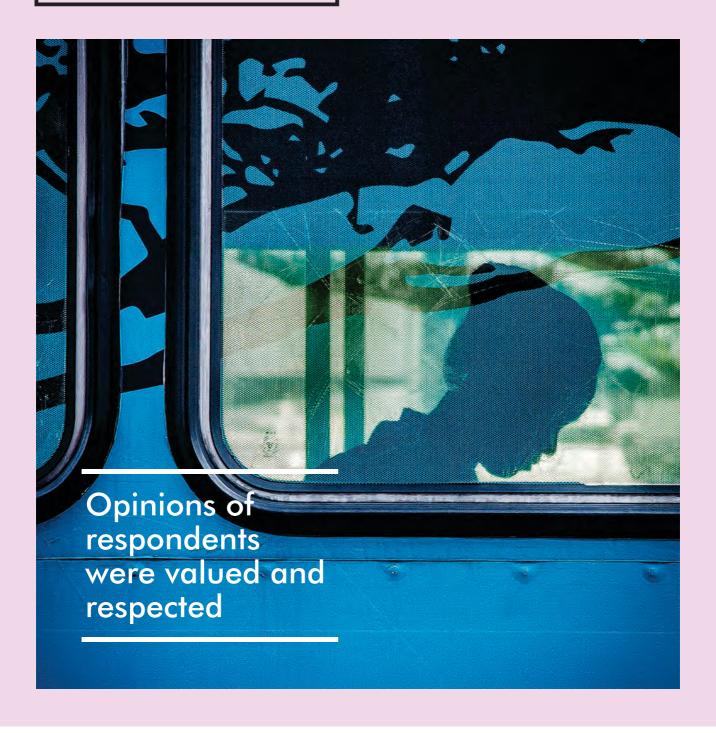
# Data verification





# 7 Ethics

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



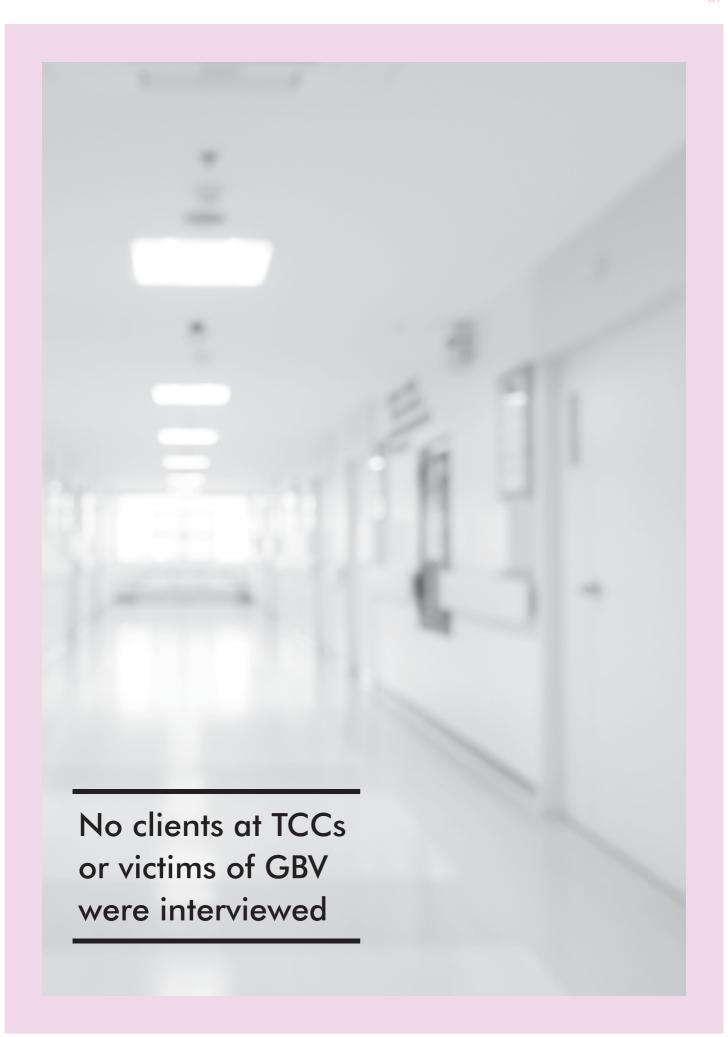
# **8 Limitations**

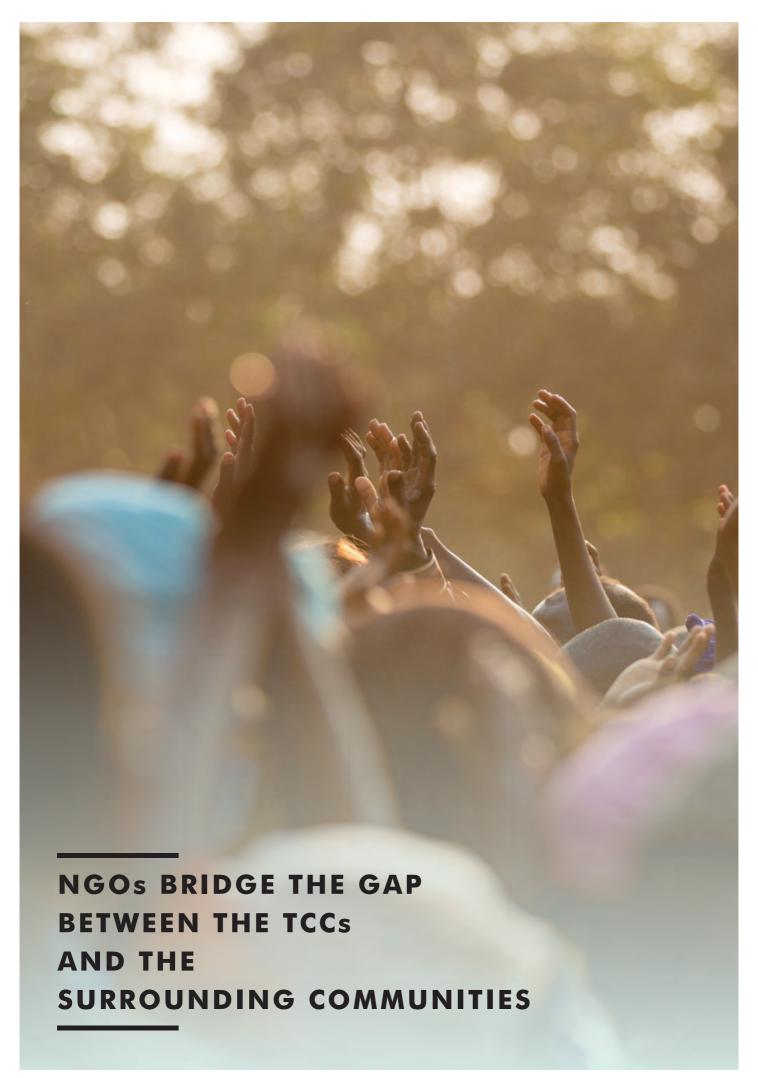
The following constraints were experienced in the data collection phase:

- The key informants were representative of the four TCCs and the NGOs working within the TCCs. The sample was determined by the availability of personnel on the day of the scheduled interview. The key FPD managers and USAID representatives interviewed were selected using convenience sampling. FPD identified the most appropriate key informants, and they were selected for interviews.
- No clients at TCCs or victims of GBV were interviewed. This is a limitation as perceptions of the clients on how victim friendly and appropriate the services of the TCCs are, were not captured.
- Only FPD staff and NGO staff were interviewed within the TCCs. The focus was not on other government departments who also deliver services within the TCCs, such as the DoH, SAPS, DSD and others. TCC-related aspects such as court proceedings and the judicial system were not part of this case study.

The focus of the case study was on TCC functionality and success and not the resulting court processes.

The findings are based on self-reporting by the FPD personnel in the TCCs, FPD managers, NGOs and USAID representatives. The findings were not triangulated with client files or interviews with clients.





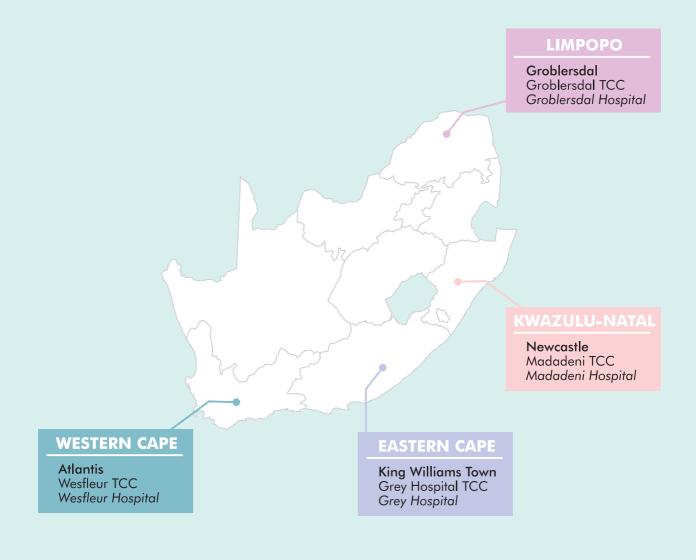


Chapter Four Findings: Case study on four MAC AIDS Fund supported TCCs

This case study is divided into five sections. Section 1 is a summary of the general findings of all four TCCs. This is based on the key informant interviews. Sections 2 to 5 are TCC specific and provide a general overview of each TCC.

# 1 National TCC findings

MAC AIDS Fund supported TCCs location



# 1.1 The ISSSASA project

The Foundation for Professional Development (FPD) was contracted by USAID to establish and manage four MAC AIDS Fund supported TCCs. These TCCs are Grey TCC at Grey Hospital, Madadeni TCC at Madadeni Hospital, Groblersdal TCC at Groblersdal Hospital and Wesfleur TCC at Wesfleur Hospital. In order to showcase the results of this project, FPD was requested to prepare a case study-based report on the process and successes of these four TCCs. This case study was informed by the compliance audit and gap analysis of 55 Thuthuzela Care Centres (TCCs) in South Africa that was conducted in 2016.

The establishment and management of the four MAC AIDS Fund supported TCCs formed part of the larger Increased Services for the Survivors of Sexual Assault in South Africa (ISSSASA) programme, funded by USAID under the Democracy, Rights, and Governance – Learning, Evaluation, and Research (DRG-LER) contract. The objective of this programme was to improve service provision and community awareness for survivors of sexual assault in South Africa. The collaboration was led by FPD, and was assisted by The Soul City Institute, Sonke Gender Justice Network and the South African Medical Research Council. A key informant from USAID highlighted that the value of this type of funding is that there is South African ownership from both government and civil society. It provides a holistic model of support to victims.

The project consisted of the establishment and management of four new TCCs, training programmes for various service providers in the TCC referral and care networks, as well as multi-media community dialogues to increase awareness of the TCCs. It focused on educating community members on sexual assault and GBV issues. The value of this programme lies in the fact that FPD not only established four new TCCs, but also linked existing TCCs to ongoing GBV initiatives, strengthened intersectoral collaboration and brought together various role-players in the GBV community.

Under the ISSSASA programme, Soul City Institute conducted community dialogues by focusing on the services of TCCs in the context of GBV and child abuse. The outputs included community action plans that incorporated engagement by participants with the broader community on the issues of GBV and child abuse, as well as a strategy to connect GBV survivors to TCC services. The targeted stakeholders at these community dialogues are community based organisations, women's groups, faith based organisations, community leaders, local authorities, youth groups and TCC staff. The Soul City Institute developed information packages on GBV that are available for download. The toolkit is a collection of resources for survivors of sexual assault or GBV and a catalogue of materials useful for programme managers, advocates, clerks of the court, health workers, civil society, South African Police Services and social workers. They conducted a national campaign on social media, raising awareness on GBV and the TCCs.

The Sonke Gender Justice Network's interventions on local radio with the theme of GBV and information highlighting the purpose of TCCs have been successful. Sonke trained community radio stations' staff on GBV, provided technical assistance during radio shows and provided printed and electronic material. The Safe Ride Campaign was launched with taxi drivers, aiming to create a safe environment for women in taxis.

The South African Medical Research Council conducted a national research study of the prosecution and adjudication of sexual assault. The goal of the study was to generate evidence-based recommendations for strengthening the prosecution and adjudication of sexual assault cases.

# 1.2 Establishment of the four MAC AIDS Fund supported TCCs

FPD established four new Thuthuzela Care Centres in four provinces in South Africa in consultation with the NPA, according to the recommendations of the 2009 Audit of Multi-Disciplinary Services in South Africa Dealing with Sexual Offences. This was accomplished by constructing, furnishing and equipping the facilities according to the TCC Blueprint. FPD also appointed, in conjunction with the NPA, a site coordinator and VAO at each of the TCCs. A key informant mentioned that it is unlikely that the South African government would have been able to establish these four TCCs without the assistance of the MAC AIDS Fund.

In addition to this, FPD appointed and disbursed grants to NGO service providers at all four TCC to enable a 24-hour, 7-days a week comprehensive service at the TCCs.

# Construction of the TCCs





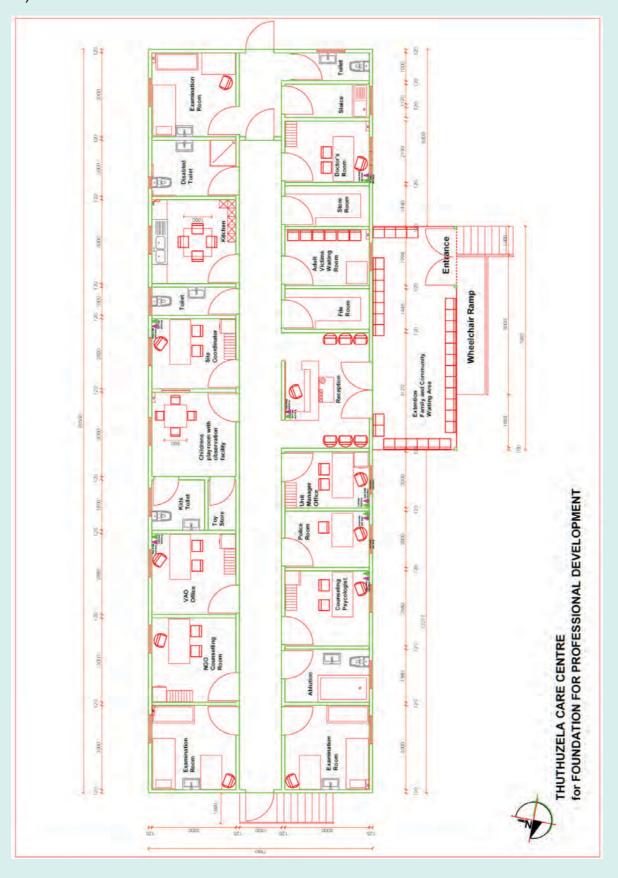




# 1.3 Facilities and sites

All TCCs were constructed according to the TCC Blueprint. The figure below shows the lay-out of the TCCs.

# TCC Lay-out



# Structure and equipment

The TCCs were established in park homes outside the hospitals, and equipped with all the medical equipment needed for the functioning of a TCC. This includes a gynea couch, crash carts, a colposcope, speculums and sufficient lighting for examinations. The TCCs were also equipped with laptops and printers, office furniture, security cameras and security systems. FPD ensured that the TCCs have all the supplies and services needed to ensure normal operations, including cleaning materials, stationary, ink cartridges, 3G dongles and telephone lines. FPD also took responsibility for all repairs and maintenance at the TCCs.

The TCCs were constructed and equipped to ensure that all services can be delivered according to the TCC Blueprint. All four TCCs can provide the following services:



### All four TCCs have the required facilities:



# Safety

All four TCCs have been equipped with security cameras as well as security doors and burglar bars.

# Signage

FPD ensured that all four TCCs have a sign outside the TCC, as well as signs from the hospital gate to the TCCs.

# TCC Signage









# 1.4 Victim friendliness

Victim friendliness is very important in the TCC environment. The staff at the four TCCs are ensuring that the TCCs are victim friendly and they try to reduce secondary victimisation as far as possible.

### Secondary victimisation

Most informants mentioned that victims may experience secondary victimization as a result of the lack of victim friendliness from other stakeholders. Some auxiliary staff lack sensitivity when treating and receiving clients. Lack of privacy when assisting victims may also be another factor in secondary victimisation. All four TCCs have a separate entrance for victims and perpetrators, reducing secondary victimisation.

The interviews revealed that, regardless of the TCCs' best efforts, clients still experienced secondary victimisation due to the actions of other stakeholders. Participants believe that a lot of secondary victimisation comes from the police, despite their training.

They believe that the police have become desensitised towards clients and their situations.

# Child friendliness

All four TCCs are child friendly with a dedicated room for children. The rooms have a TV, toys and furniture.

# Refreshments and comfort packs

According to key informants, the TCCs need comfort packs and refreshments for victims. The respondents felt that offering food and comfort packs is one way to reach out to clients and make them feel comfortable and relaxed. They also mentioned that NGOs may sometimes provide them with supplies for victims.



# 1.5 Factors influencing service delivery

# **Human resources**

All four TCCs were staffed with a site coordinator and a VAO. The VAO at Groblersdal resigned before the TCCs was handed over to the NPA. The staff had the opportunity to attend workshops and conferences as part of capacity building during their employment at FPD. The NPA have not yet appointed case managers at any of the four TCCs.

Some of the participants thought that it would be of benefit to the TCCs if the TCC staff were able to conduct HIV counselling and testing and other basic medical procedures. They reasoned that it would relieve some of the pressure put on TCC staff because of the shortage of healthcare staff.

# Accessibility

Accessibility to the TCCs is an important factor in ensuring that the services are used by victims.

The availability of staff members after hours (i.e. on-call staff, NGOs, security guard) influences the medical and psycho-social support that can be delivered after hours.

# 24/7 service

Until the end of May 2017, all four TCCs indicated that they can deliver a 24-hour service that can cater to clients who present at the TCC after working hours and on weekends. This was possible due to the sub-grants provided to four NGOs to deliver this service. When their funding ended, the 24-hour service was no longer possible. Not being able to open after hours means that services available to clients are compromised.

# Security's awareness of TCCs

Most victims are referred and transported to the TCCs after presenting to the SAPS. However, as some victims present directly at the TCCs it is important that hospital security is aware of the existence and location of the TCCs. All the security guards who were stationed at the hospitals knew where the TCCs were during the research. This is a significant improvement from previous studies and also helps with referring victims to the correct services after hours where necessary.

### Health services

All TCCs mentioned the availability of allocated health staff such as doctors and forensic nurses stationed at the facility, or available to the facility.

An important component of the TCC service is ensuring that PEP is supplied within 72 hours of the sexual assault. Adherence to PEP is a major concern. PEP is usually only provided for a week as part of a starter pack, and the client needs to return to the hospital to collect the rest. Many clients do not have funds for transport to return for PEP and additional medical services.

# Psychosocial support

All four TCCs mentioned that the TCC have access to essential staff such as social workers to assist with short- and long-term psychosocial support as well as court preparation. Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours.

Long-term psychosocial support is a big concern. One key informant reported that there are long waiting times for victims to access follow-up care. In some cases, victims wait up to 2 months see a DSD appointed psychologist or social worker. These services are not available over weekends. There are instances where the NGOs linked to the TCC, as well as DSD social workers and psychologists can assist with follow-up care. In these cases, there are often other problems, for example the NGOs may not have access to the contact details and address of victims.

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

# **Transport**

SAPS usually brings the victim to the TCCs, but cannot always wait for the completion of the medical exam, forensic exam, blood tests and counselling. This means that the victim requires transport from the TCC to home or a place of safety. Key informants highlighted that responsibility for subsequent transport is not clear in the TCC Blueprint.

There are also problems with follow-up, as discussed earlier. Without transport many victims do not come back to the hospital for PEP or to the TCC for follow-up care. It is also not possible for the TCC staff and NGO staff to provide transport to offer follow-up care at a victim's home.

Lack of transport may also affect the ability of TCC and NGO staff to participate in community campaigns to increase awareness of the TCC model. Site coordinators may also not be able to attend meetings and stakeholder events because of lack of transport.

### 1.6 Additional activities

FPD managed the TCCs to ensure that they are fully operational until handover to the NPA. To assist with the smooth operation of the TCCs, FPD conducted a number of additional activities not directly related to the operations of the TCCs.

### Pilot case management system

FPD piloted the Gender-Based Violence Case Management System at the four TCCs. The system was intended to provide an electronic platform to record, store and analyse data gathered from victims of GBV. The application allowed for a multi-sectoral use system, coupled with a user-specific authority, to interface with the data being captured, viewed or analysed. The aim of the system was to provide a platform so that all data can be shared among the TCC stakeholders and to assist with a more effective case management system. A key informant explained that this system allowed them to communicate better with victims, alerting them to follow-up examination dates. This also improved supervision and monitoring within the TCC.

### Community awareness

All four TCCs reported that they, together with the NGOs associated with them, are involved in various community awareness and advocacy campaigns, in spite of transport challenges. To enable this, FPD provided all TCCs (not just the four MAC AIDS Fund sponsored TCCs) with branded gazebos and banners.

### 1.7 NGOs

FPD managed sub-grants for four NGOs that supported the 24-hours a day, 7-days a week access to the TCCs. The overall project objectives of the subgrants to NGOs was:



24/7 reception, administrative and immediate trauma debriefing services for victims with special focus on after hours, weekend and public holiday support.



Trauma counselling services at TCC for children & adults.



Psycho-social counselling to ensure that survivors have continuous care after they returned to the communities where they live.



Court preparation and court support services to child rape survivors.

FPD awarded sub-grants to LifeLine Pietermaritzburg in Madadeni, ChildLine Limpopo in Groblersdal, MOSAIC in Atlantis, and Masimanyane Women's Support Centre in King Williamstown.

# NGOs providing services in the TCCs



It is important to understand the full contribution of NGOs within the TCC model. The informants were asked to explain the value of their organisation at the TCCs. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCCs. The participants also discussed how their absence would affect the TCCs. NGOs assist with providing services and the smooth running of the TCC.



One of the most important services is trauma containment.

Other services offered at the TCCs were HIV counselling and testing (HCT), psychosocial support, education, the provision of supplies and referral services. HCT and education were related topics that were discussed with the NGOs. HIV counsellors not only tested the clients for HIV, but also educated them about HIV-related issues and how to use their medication.

The NGOs offer a variety of 'psychosocial support to the victims' as described by them in various terms such as 'therapy', 'long-term counselling', 'emotional containment' and 'trauma containment'.

Some of the NGOs also refer victims for other social services. NGOs also bridge the gap between the TCCs and the surrounding communities. Most participants viewed this role as useful for clients from the surrounding communities.

# Changes in service delivery at the TCCs if NGOs are not funded

It is important to understand how changes in the funding environment will affect service delivery within the TCCs. The four NGOs based within the TCCs will not be able to deliver services after hours within the TCCs once the sub-grants expire. One NGO mentioned they will downscale the services they deliver, as they receive funding for other TCCs. The other NGOs will completely stop all services delivered to the TCCs.

The following services will be influenced if NGOs are not adequately funded:



There will be a lack of counselling services to victims, both short and long term.



Without adequate counselling services, fewer cases will go to court.



It is unlikely that any TCC will be able to deliver after-hours services if the NGOs are not available to do so.

There is a need for a sustainable, consistent and stable funding environment to ensure that the necessary services can be delivered at all TCCs. The current uncertain funding environment is damaging and does not lead to trust between TCCs and victims.

# Support and mentoring of NGOs through technical assistance

NGOs delivering the 24/7 service in the TCCs are dependent on donor funding to conduct their activities. In order to ensure sustainability when funding comes to an end, FPD, in collaboration with the Relevance Network, developed a sustainability programme to ensure that NGOs can access funds and deliver services when the current donor funding comes to an end.

### 1.8 Other stakeholders

Stakeholder cooperation and cohesion at almost all levels of government, was mentioned by numerous key informants. There is however a need to strengthen relationships at provincial level. The relationship between stakeholders working with these four TCCs have been described as exceptionally good, after a difficult start. A key informant highlighted that all the relevant stakeholders were involved in the establishment of the four TCCs and this clearly influenced the relationships positively. A key informant mentioned that the value of this model lies with the fact that government and civil society is working on this together.

'This model doesn't lead to donor dependency, and that is what you want to see' – Donor key informant 'We had really good local partners, where everybody is an expert in their area' – Donor key informant

The development of a communication strategy from the start assisted with the successful implementation of the programme.

'The fact that the implementing partners developed a communication strategy really helped. Often, with multiple partners, they just stumble along'

- Donor key informant

The challenges mentioned with the individual stakeholders are discussed below.

# **FPD**

All key informants highlighted that the relationship between FPD and TCCs as well as NGOs, assisted in contributing to the success of the establishment of the four new TCCs.

'FPD has done a great job'

– NGO Key informant

'This is the first time that I work for an organisation that really look after the needs of the centre'

- TCC key informant

A key informant mentioned that FPD's prior experience in working with PEPFAR and USAID assisted with the implementation of the programme. In addition, FPD conducted a lot more activities than originally planned and found innovative ways of implementing the programme. The partnership with

MAC AIDS Fund allowed for innovation and flexibility. FPD's history in working with DoH also ensured smooth implementation of the TCCs within the hospitals.

It was highlighted that FPD implemented the whole ISSSASA project innovatively, and added a number of additional activities to the programme, such as various evaluations, the case management system and the Social Lab intervention.

'FPD added additional interventions to complement what the programme was doing'

Donor key informant

'The amount of learning that came from this project was incredible'

– Donor key informant

### **NPA**

Some key informants highlighted that the NPA has not been very involved with the management of the four TCCs and specifically mentioned lack of support from the NPA national office. The NPA was very slow absorbing the TCC staff.

### DoH

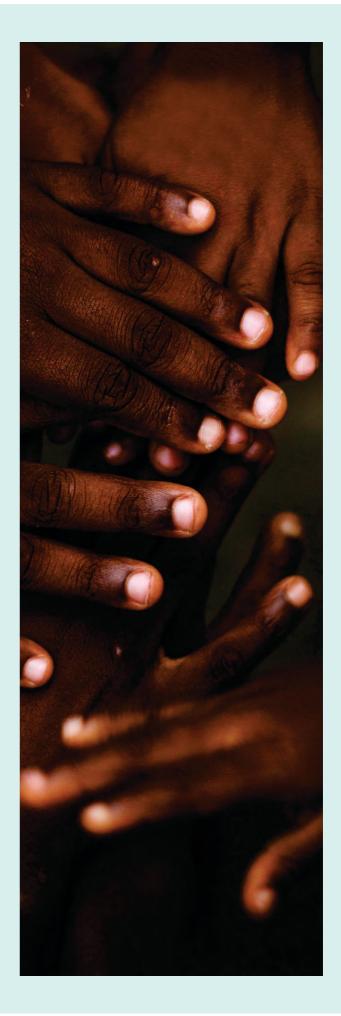
There are generally good relationships between the TCCs and DoH at all levels. At facility level, the relationship between the TCC and the hospital is often dependent on hospital management's attitude and practice regarding the TCCs. All key informants highlighted excellent working relationships with hospital management and other DoH staff members.

# DSD

It is reported that there is generally a good relationship between the TCCs and DSD. However, key responders think that DSD does not provide enough social workers within the TCCs. Within the TCC model DSD should fund psychosocial services, either by delivering it with their own staff, or funding NGOs to deliver the services. This is not happening to the extent that it is needed.

# **SAPS**

Most key informants reported excellent relationships with, and good support from, SAPS. Their specialised FCS units are functioning well and are contributing to the functioning of the TCC model.



# 1.9 Sustainability

The NPA was involved in the staff recruitment process from the start. This assisted with the absorption of staff members and the handover of the TCCs to the NPA. This also contributed to the sustainability of the programme, as the staff are already trained and sensitized to the work that the TCCs are doing.

There is definitive value in implementing programmes over a 4 year period or longer, as this allows for government departments, such as the NPA, to budget for staff as well as operational costs.

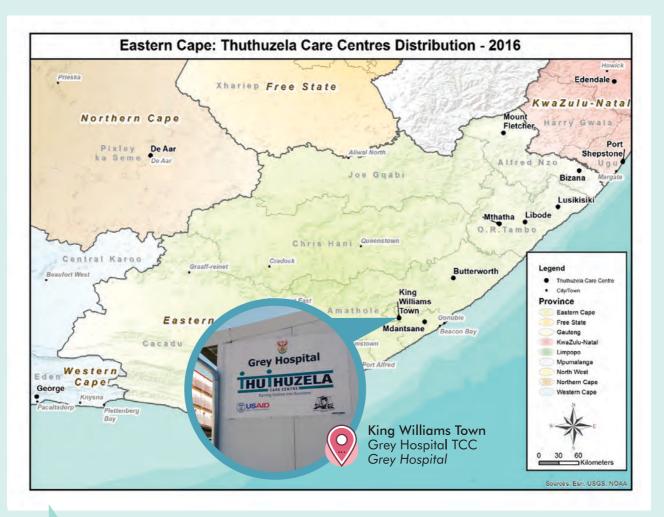
It is a concern that all four new TCCs are based in park homes, as the park homes have a limited lifespan. This might influence sustainability on the long-term.

The four TCCs was handed over to the NPA on 31 May 2017. The NPA has absorbed the staff members and FPD handed over all equipment and supplies to the NPA. All the TCCs have all the equipment and supplies they need to continue their work for some time. All facilities and equipment are well maintained.

The additional sustainability assistance that was provided to the NGOs will assist with the future sustainability of the NGOs as well, contributing to the services delivered by the TCCs.



# 2 Grey TCC in the Eastern Cape

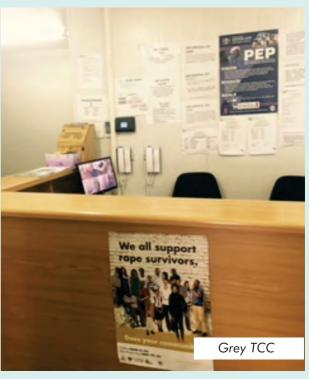




FPD interviewed the VAO and a representative from Masimanyane Women's Support Centre at Grey TCC in the Eastern Cape.

# 2.1 Facility and site

The Grey TCC is based in a park home outside the Grey Hospital in King Williamstown. The entrances are secured and the TCC have four CCTV cameras. The TCC delivers all the services required by the TCC Blueprint, except court preparation. The TCC has all the required equipment as per the Blueprint, and the facility is disabled-friendly. In addition, the TCC has a room available where doctors can sleep over when they are on call, or if they had to come to the TCC during the night.



### 2.2 Victim friendliness

Victim friendliness is very important in the TCC environment. The staff at the TCC are ensuring that the TCC is victim friendly and they try to reduce secondary victimisation as far as possible.



### Secondary victimisation

The TCC have a separate entrance for perpetrators as well as a separate examination room. All the forensic nurses are female, ensuring that female victims can have a female health worker present during examination. A key informant highlighted that the TCC ensure that there is limited secondary victimisation, but that victims get blamed and humiliated outside the TCC, specifically at home.



# Child friendliness

The TCC is child friendly with a dedicated room for children. The room has a TV, toys and furniture.



# Refreshments and comfort packs

According to key informants, the TCC has comfort packs and can provide victims with clean clothes. The NGO linked to the TCC assist with the collection of clothes.

# 2.3 Factors influencing service delivery



### Human resources

The TCC was staffed with a site coordinator and a VAO. Staff received the opportunity to attend conferences, workshops and training. This ensured that they could keep up with their required CPD points.



### Accessibility

Accessibility to the TCCs is an important factor in ensuring that the services are used by victims. The availability of staff members after hours (i.e. on-call staff, NGOs, security guard) influences the medical and psychosocial support that can be delivered after hours.

### 24/7 service

Until the end of May 2017, Grey TCC indicated that they can deliver a 24-hour service that can cater to clients who present at the TCC after working hours and over weekends. This was possible due to the subgrant provided to an NGO, Masimanyane, to deliver this service. When their funding ended, the 24-hour service was no longer possible. Not being able to open after hours means that services available to clients are compromised.

### Security's awareness of TCC

Most victims are referred and transported to the TCC after presenting to the SAPS. However, as some victims present directly at the TCC it is important that hospital security are aware of the existence and location of the TCC. The security guards who were stationed at the hospital knew where the TCC is based on the hospital grounds.

### C.

#### Health services

The hospital provided two forensic nurses within the TCC. They are based at the TCC. At night and over weekends there is a doctor and a nurse on call specifically for the TCC. The hospital's health services are available 24/7. A key informant highlighted that some of the medical personnel are not adequately trained in forensic investigations with children. Many of the doctors are completing their community service, and therefore leave the hospital after a year. New doctors need to be trained each year.

'We now have doctors specifically allocated to the Thuthuzela, and the doctor comes in 3 minutes'

- NGO key informant

All medicine and PEP is stored within the TCC. In the evenings and over weekends, victims receive a starter pack of PEP, but during weekdays they receive the full 28-day pack. The TCC has access to PEP for children.



#### Psychosocial support

The TCC mentioned that they have access to essential staff such as two social workers provided by the hospital and DSD to assist with short- and long-term psychosocial support. Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours.

#### 2.4 Additional activities



#### Community awareness

Grey TCC participates in community awareness and advocacy campaigns with other stakeholders, specifically Masimanyane and the hospital. Topics include discussion on intimate partner violence and access to protection orders.



#### Referrals

The TCC has a good relationship with other social service providers in the area and refers victims to other organisations, social workers and psychologists when needed. This is both for additional psychosocial support as well as other social services. The TCC also refers victims to shelters when needed. The TCC refers victims to Bisho Hospital where there is a professional nurse who specialised in play therapy to assist children with court preparation.

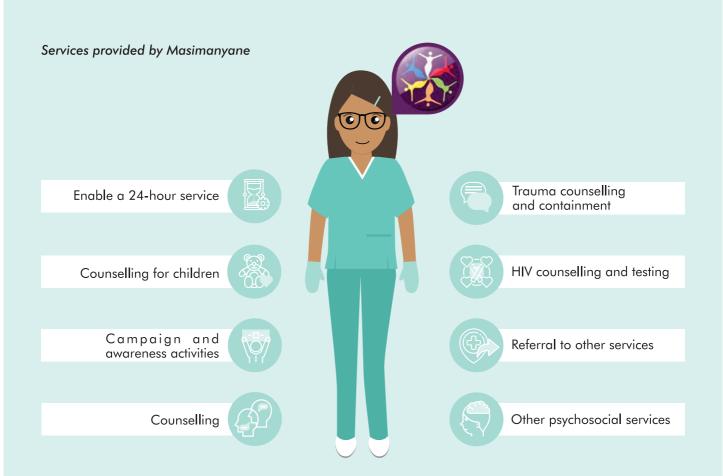
#### 2.5 NGO: Masimanyane Women's Support Centre

Masimanyane Women's Support Centre was awarded the sub-grant to provide services to the Grey TCC. It is important to understand the full contribution of NGOs within the TCC model. The participants were asked to explain the value of their organisation at the TCCs. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCCs.

#### NGO providing services in Grey TCC







Masimanyane employed four lay counsellors at the Grey TCC and they are all adequately trained. They provide continuous containment to victims.

A key informant highlighted that it would add value if the counsellors can conduct HCT as well. The NGO also bridges the gap between the TCC and the surrounding communities.

Masimanyane was involved in awareness campaigns in the surrounding communities.

"They bring value in the sense that during the night, there is no one in the centre except them. So they open the centre and also they do the trauma containment to the survivors'

— TCC key informant



#### Changes in service delivery if NGOs are not funded

If Masimanyane is not funded in the future this will be devastating to victims. A key informant highlighted that the 24/7 service will be disrupted and victims will have to present at the casualty section of the hospital. This might delay service delivery and there is a real possibility that PEP will not be delivered on time.

'I was so worried when I heard that the contract is coming to an end, because the people are going to suffer'.

– NGO key informant

#### 2.6 Other stakeholders

Stakeholder cooperation and cohesion, at almost all levels of government, was mentioned by numerous key informants. The relationship between stakeholders working with this TCC have been described as exceptionally well.

The challenges mentioned with the individual stakeholders are discussed below.



#### **NPA**

Some key informants highlighted that the NPA has not been very involved with the management of the this TCC and specifically mentioned lack of support from the NPA national office.



#### DoH

There is an excellent relationship between the TCCs and DoH. The TCC have access to the hospital's boardroom and canteen for meetings. The hospital also assists with the cleaning service, as well as cleaning supplies for the TCC. The hospital provide food for victims from the hospital kitchen. In addition, the hospital matron frequently visits the TCC.



#### DSD

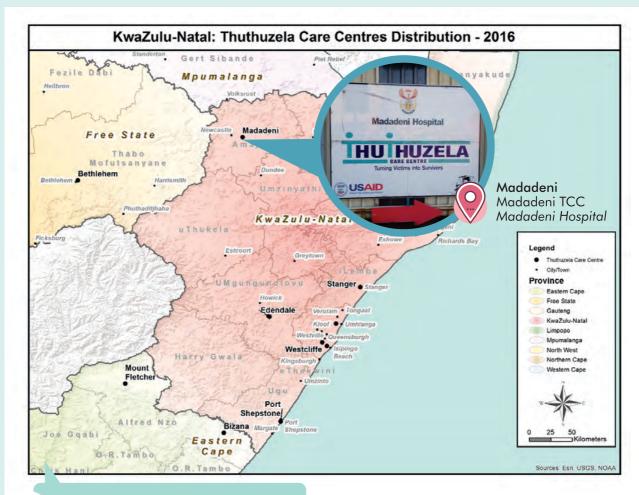
It is reported that there is generally a good relationship between the TCCs and DSD. DSD made social workers available for psychosocial support.



#### **SAPS**

The key informants reported excellent relationships with, and good support from, SAPS. Their specialised FCS units are functioning well and are contributing to the functioning of the TCC model. The FCS personnel follow up on cases and report back to the TCC. A total of 13 police stations are involved with the work that the TCCs are doing. Some police stations do not have SAECK kits, and these need to be sourced from other stations when needed.

#### 3 Madadeni TCC in KwaZulu-Natal

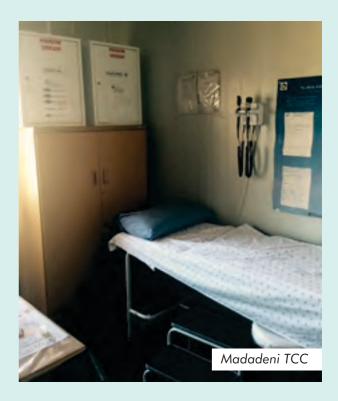




FPD interviewed the site coordinator and a representative from Lifeline Pietermaritzburg at Madadeni TCC in KwaZulu-Natal.

#### 3.1 Facility and site

The Madadeni TCC is based in a park home outside the Madadeni Hospital in Madadeni, near Newcastle. The entrances are secured and the TCC has CCTV cameras as well as a panic button and intercom system. The hospital security guards do regular security checks at the TCC during the day and at night. The TCC deliver all the services required by the TCC Blueprint, except statement taking and case reporting. The TCC has all the equipment required by the Blueprint, and the facility is disabled friendly. The TCC also provide additional referrals to social services to victims, and can provide an overnight facility for the victim if required. An outside play area for children is needed.



#### 3.2 Victim friendliness

Victim friendliness is very important in the TCC environment. The staff at the TCC are ensuring that the TCC is victim friendly and they try to reduce secondary victimisation as far as possible. The Madadeni TCC prides itself in a homely environment that was created at the TCC. Most of the doctors are female, ensuring that female victims have the option have a female healthcare professional assisting them.



#### Secondary victimisation

The TCC has a separate entrance for perpetrators as well as a separate examination room. The TCC highlighted that male victims experience a lot of secondary victimisation, especially from SAPS.



#### Child friendliness

The TCC is child friendly with a dedicated room for children. The room has a TV, toys and furniture. Since the establishment of the TCC they have improved the care and support that they can offer to child victims. More than 50% of the victims who present at the TCC are children.



#### Refreshments and comfort packs

According to key informants, the TCC have comfort packs and can provide victims with clean clothes. Age-appropriate underwear is needed.

#### 3.3 Factors influencing service delivery



#### Human resources

The TCC was staffed with a site coordinator and a VAO. They received training from FPD. The TCC developed a monthly debriefing structure for the TCC staff with a local counsellor. The TCC managed to arrange funding from private individuals to sustain this service until December 2017.



#### Accessibility

Accessibility to the TCCs is an important factor in ensuring that the services are used by victims. The availability of staff members after hours (i.e. on-call staff, NGOs, security guard) influences the medical and psychosocial support that can be delivered after hours.

#### 24/7 service

Until the end of May 2017, Madadeni TCC indicated that they can deliver a 24-hour service that can cater to clients who present at the TCC after working hours and on weekends. This was possible due to the subgrant provided to an NGO, Lifeline, to deliver this service. When their funding ended, the 24-hour service was no longer possible. Not being able to open after hours means that services available to clients are compromised.

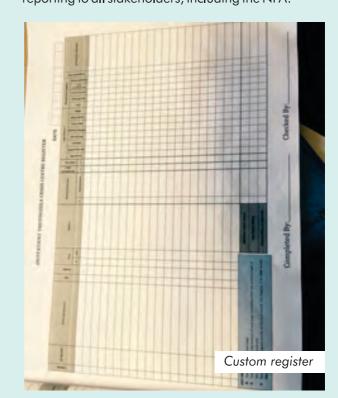
#### Security's awareness of TCC

Most victims are referred and transported to the TCC after presenting to the SAPS. However, as some victims present directly at the TCC it is important that hospital security is aware of the existence and location of the TCC. The security guards who were stationed at the hospital knew where the TCC is based on the hospital grounds.



#### Custom register

One of the major challenges that TCCs experience is reporting to various stakeholders. The NPA, DoH, DSD and the funders of the NGOs all require data from the TCCs. Most TCCs make use of the clinical stationary provided by DoH, but this does not provide adequate data for the needs of the other stakeholders. The professional nurse based at Madadeni developed a custom register for the TCC to ensure that all required data elements are captured for the various stakeholders. This assists with better reporting to all stakeholders, including the NPA.





#### Referrals

The TCC assist with referrals to various other government departments and organisations. They refer to DoH for psychological care, to DSD for social aspects and two places-of-safety when a victim cannot go home. In cases of substance abuse, they refer victims to SANCA. They also receive referrals from various other organisations.



#### Health services

The DoH allocated two professional nurses and two forensic nurses to the TCC. One professional nurse is based at the TCC full time, the rest are part-time. The hospital's health services are available 24/7.



#### **Psychosocial support**

The TCC mentioned that they have access to essential staff such as social workers to assist with short- and long-term psychosocial support. One social worker is supplied by the DoH. Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours. There are only two DoH psychologists available for the whole health district.

#### 3.4 Additional activities



#### Community awareness

The TCC is involved with various community awareness and advocacy campaigns. They have advocated the work and services of the TCC on various community radio stations. They are also part of the Victim Empowerment Forum in Madadeni and take part in events in the area. The TCC ensure that they get involved in specific events based on the DoH Health Calendar, and try to ensure involvement at DSD events as well.

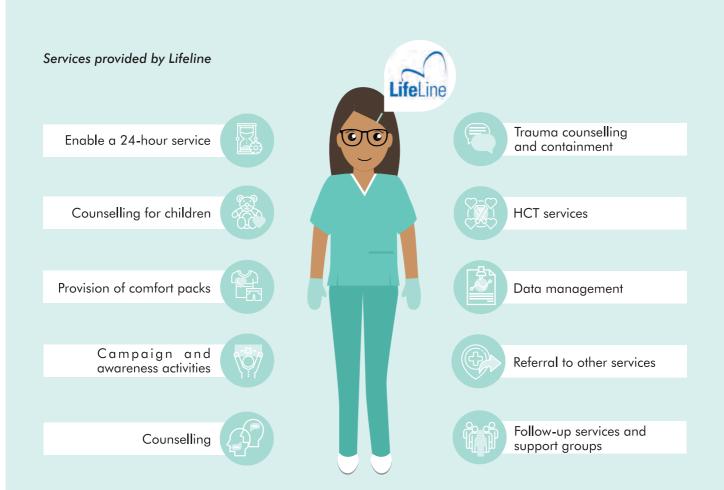
#### 3.5 NGO: Lifeline Pietermaritzburg

Lifeline Pietermaritzburg was awarded the sub-grant to provide services in the Madadeni TCC. It is important to understand the full contribution of NGOs within the TCC model. The participants were asked to explain the value of their organisation at the TCCs. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCCs.

#### NGO providing services in the Madadeni TCC







Lifeline personnel act as first responders and provide a 24/7 service within the TCC. The NGO also bridges the gap between the TCC and the surrounding communities. Lifeline was involved in a number of awareness campaigns in the surrounding communities. This includes workshops and talks at community events and at schools. The focus of these are awareness of GBV as well as the need to access PEP within 72 hours after sexual assault. The services of Lifeline are supplied by five social auxiliary workers and one lay counsellor. Lifeline created support groups for victims to assist with follow-up psychosocial support.

Two key informants mentioned that there is a need to recognise the work that the NGO is contributing to the TCC.

'The value that we bring needs to be recognised'

- NGO key informant



#### Changes in service delivery if NGOs are not funded

Lifeline provide more than just a counselling service. They form long-term relationships with victims to assist them to become survivors. If Lifeline do not have funding in the future it will negatively influence the psychosocial status of victims. Lifeline might be able to deliver some of their day services in the TCC after June 2017, but without funding they will not be able to provide the 24/7 service that the TCC requires. Lifeline might be able to continue day-duty for a maximum of 6 months after the funding comes to an end.

The uncertainty in the funding environment influences the ability of the Lifeline to retain valuable, competent staff members.

#### 3.6 Other stakeholders

Stakeholder cooperation and cohesion at almost all levels of government, was mentioned by numerous key informants. The relationships between stakeholders working with this TCC have been described as exceptionally good.

'We're such a small community that we have to work well together. I can't say that I won't need you tomorrow'...'We're so dependent on each other, everybody must be on board'

— TCC Key informant

The challenges mentioned with the individual stakeholders are discussed below.



#### **NPA**

A key informant highlighted the support the TCC receive from the regional manager from the NPA, but feedback from the NPA head office is slow.



#### DoH

There is a very good working relationship between the TCC and DoH.



#### **DSD**

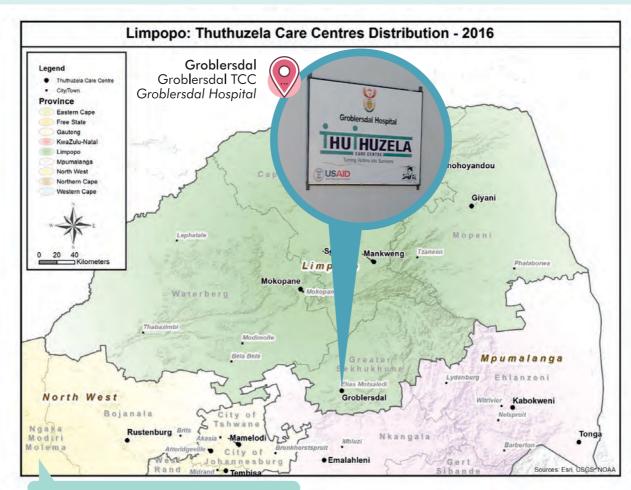
It is reported that there is generally a good relationship between the TCC and DSD. A key informant mentioned that they have a good response rate in cases where a child victim needs to be removed from the household.



#### SAPS

Most key informants reported excellent relationships with, and good support from, SAPS. Their specialised FCS units are functioning well and are contributing to the functioning of the TCC model. At Madadeni the FCS units prefer to take statements at the police stations, and not at the TCC as per the Blueprint. The site coordinator at Madadeni follow-up with the FCS unit regularly.

#### 4 Groblersdal TCC in Limpopo





FPD interviewed the site coordinator and a representative from Childline Limpopo at Groblersdal TCC in Limpopo.

#### 4.1 Facility and site

The Groblersdal TCC is based in a park home outside the Groblersdal Hospital in Groblersdal. The entrances are secured and the TCC has an intercom system. The hospital provided a security guard who periodically checks on the TCC during their patrol of the hospital grounds. The TCC deliver all the services as required by the TCC Blueprint, except updating on case outcomes, as the TCC doesn't have a case manager appointed. The TCC has all the required equipment as per the Blueprint, and the facility is disabled-friendly.



#### 4.2 Victim friendliness

Victim friendliness is very important in the TCC environment. The staff at the TCC are ensuring that the TCC is victim friendly and they try to reduce secondary victimisation as far as possible.



#### Secondary victimisation

The TCC has a separate entrance for perpetrators as well as a separate examination room. A key informant highlighted that secondary victimisation sometimes happens at the police station when the victim is blamed and judged.



#### Child friendliness

The TCC is child friendly with a dedicated room for children. The room has a TV, toys and furniture.



#### Refreshments and comfort packs

According to key informants, the TCC has comfort packs, and can provide victims with clean clothes as well as with refreshments.

#### 4.3 Factors influencing service delivery



#### Human resources

The TCC was staffed with a site coordinator. The VAO recently resigned.



#### Accessibility

Accessibility to the TCC is an important factor in ensuring that the services are used by victims. The availability of staff members after hours (i.e. on-call staff, NGOs, security guard) influences the medical and psychosocial support that can be delivered after hours.

#### 24/7 service

Until the end of May 2017, Groblersdal TCC indicated that they could deliver a 24-hour service that can cater to clients who present at the TCC after working hours and on weekends. This was possible due to the sub-grant provided to an NGO, Childline, to deliver this service. When their funding ended, the 24-hour service was no longer possible. Not being able to open after hours meant that services available to clients were compromised.

Doctors are reluctant to come to the TCC at night, and sometimes request that victims are taken to the hospital's casualty department.

#### Security's awareness of TCC

Most victims are referred and transported to the TCC after presenting to the SAPS. However, as some victims present directly at the TCC it is important that hospital security is aware of the existence and location of the TCC. The security guards who were stationed at the hospital knew where the TCC is based on the hospital grounds.



#### Health services

Key informants at the TCC mentioned the availability of allocated health staff such as doctors and forensic nurses stationed at the facility, is a challenge. The TCC have a professional nurse allocated to the facility during day time, but need to call a doctor and forensic nurse from the hospital when a victim arrives at the TCC. at night time The hospital services are available 24/7.

A key informant highlighted that some of the medical personnel are not adequately trained in forensic investigations. Many of the doctors are completing their community service, and therefore leave the hospital after a year. New doctors need training every year.



#### Psychosocial support

The TCC mentioned that they have access to essential staff such as social workers and counsellors to assist with short- and long-term psychosocial support. Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours. DSD provided a social worker and there are two clinical psychologists based at the hospital who assist the TCC when needed. Childline also provide a social worker during the day.



#### Transport

SAPS usually brings the victim to the TCC, but cannot always wait for the completion of the medical exam, forensic exam, blood tests and counselling. This means that the victim requires transport from the TCC to home or a place of safety. A key informant highlighted that FCS do not have enough vehicles and sometimes transport victims in police vans, leading to secondary victimisation.

#### 4.4 Additional activities



#### Community awareness

The TCC reported that they, together with the NGO associated with them, are involved in various community awareness and advocacy campaigns. They have conducted visits to the tribal authorities, had radio interviews on the local radio stations, and had awareness campaigns during the '16 Days of activism against GBV'. The TCC often gets involved with campaigns in conjunction with other stakeholders, such as SASSA, DSD and other NGOs. Childline and the TCC visited various clinics in the surrounding communities to do presentations on GBV. The TCC also targeted churches and schools to raise community awareness.



#### Referrals

The TCC refers victims on ART to the hospital's Wellness Clinic to ensure adherence. The TCC also has linkages with two emergency shelters. If the shelters are full the TCC can accommodate victims overnight. Groblersdal TCC works well with SASSA to assist victims accessing grants.

#### 4.5 NGO: Childline Limpopo

Childline Limpopo was awarded the sub-grant to provide services in the Groblersdal TCC. It is important to understand the full contribution of NGO within the TCC model. The participants were asked to explain the value of their organisation at the TCC. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCC.

#### NGO providing services in the Groblersdal TCC





# Enable a 24-hour service Counselling for children Campaign and awareness activities Counselling Counselling Other psychosocial services

The NGO also bridges the gap between the TCC and the surrounding communities. Childline was involved in several awareness campaigns in the surrounding communities. This includes workshops and talks at community events and at clinics. The focus of these is awareness of GBV. The NGO also assisted the hospital to develop support groups for HIV+ patients.

The NGO staff act as first responders to attend to victims and ensure trauma containment. They provide a social worker during the day and lay counsellors at night. They have five staff members within the TCC, two social workers and three lay counsellors. A key informant mentioned that it remains a challenge to retain social workers within the NGO, as their salaries are significantly lower than in the public sector, and there's less additional benefits. This influence service delivery.

A key informant highlighted that lay counsellors need to be trained in HCT testing, as this will add value to their work and the functioning of the TCC.

It will also assist in reducing secondary victimisation as fewer healthcare workers are involved in the case management.

The NGO experienced some internal challenges during implementation, but this was corrected.



#### Changes in service delivery if NGOs are not funded

It will not be possible to ensure a 24/7 service if Childline is no longer involved with the TCC. According to a key informant, approximately 70% of their cases present at night and over weekends. Childline will be able to provide services to the TCC for a month after the funding ends. Childline delivered services until the end June 2017, but will not be able to deliver services without funding.

"I think if we were losing Childline we are going to have a very serious problem especially during the night ... there is no-one at night who will be trained to make sure that they are receiving proper services but since they are here we are quite sure that our victims during the night are receiving proper services".

— TCC Key Informant

#### 4.6 Other stakeholders

Stakeholder cooperation and cohesion at almost all levels of government, was mentioned by numerous key informants. The relationship between stakeholders working with this TCC have been described as exceptionally good.

A key informant highlighted that the relationships with all stakeholders are very good, but also that all stakeholders should work together.

'We act as a family'

– TCC Key informant

'When a victim presents here, she needs to access the basket of services, if doesn't help if a service is not delivered and she needs to come back'

- NGO key informant

The challenges mentioned with the individual stakeholders are discussed below.



#### NPA

Some key informants highlighted that the NPA has not been very involved with the management of the TCC and specifically mentioned lack of support from the NPA national office.



#### DoH

The relationship with DoH is very good. A key informant mentioned that this might due to the inclusive process that was followed when the TCC was established.

'If you show them that this TCC is not for the NPA, not for Health, not for DSD, it's for us all, it gives them authority to act'

— TCC Key informant



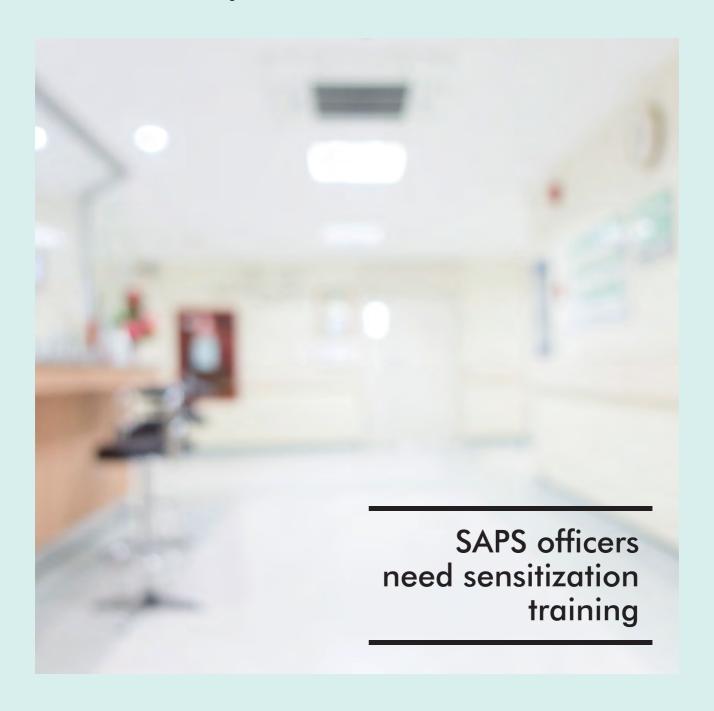
#### **DSD**

There is a very good relationship between the TCC and DSD. They respond quickly when children need to be removed from the household. A major challenge is transport and this inhibits home visits.

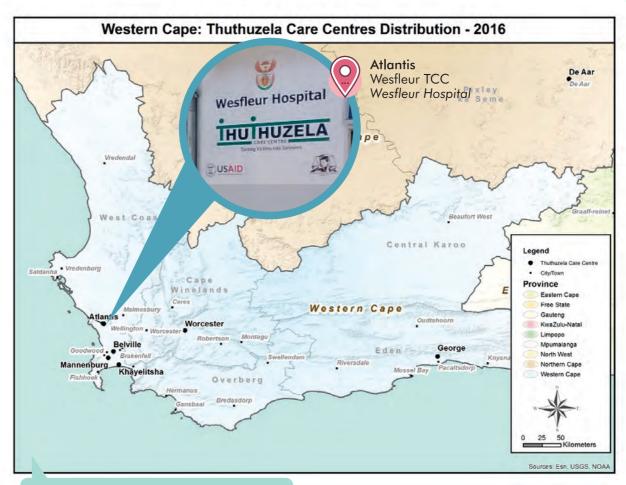


#### **SAPS**

Most key informants reported excellent relationships with, and good support from, SAPS. Their specialized FCS units are functioning well and are contributing to the functioning of the TCC model. Statements are taken at the TCC if the victim presents directly at the TCC, and at the police station if the victim presents at the police station first. A key informant highlighted that the SAPS officers need sensitization training.



#### 5 Wesfleur TCC in the Western Cape

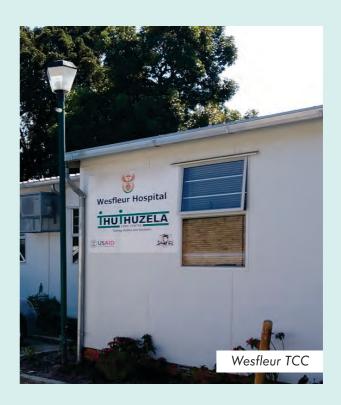




FPD interviewed the site coordinator and two representatives from Mosaic at the Wesfleur TCC in the Western Cape.

#### 5.1 Facility and site

The Wesfleur TCC is based in a park home outside the Wesfleur Hospital in Atlantis. The entrances are secured and the TCC has three security cameras. Wesfleur TCC depends on hospital security at night. A key informant expressed concern about the safety of staff members at night. The TCC delivers all the services as required by the TCC Blueprint, except updating on case outcomes, as the TCC does not have a case manager appointed. In addition, the TCC also provides bereavement counselling for children and referrals to shelters as well as referrals for substance abuse. The TCC has all the equipment required by the Blueprint, and the facility is disabled-friendly.







#### 5.2 Victim friendliness

Victim friendliness is very important in the TCC environment. The staff at the TCC ensure that the TCC is victim friendly and they try to reduce secondary victimisation as far as possible. It was highlighted that this TCC is constructed in a victim friendly manner.

All services at the TCC are available 24/7, including statement taking, health services and counselling. This ensures victim friendliness as the victims do not have to return to the TCC for certain services later.

A key informant described the victim friendliness and importance of TCCs.

'Definitely, that's the first thing the people feel when they walk in here. It's less intimidating, they almost feel if they are home. There is somebody at reception that greets them, they come in and everywhere they just feel at ease. When you go to the hospital, everyone is looking at you and wondering what happened to you. When someone has been raped and it's a fresh case you can pick up something happened. You can see in the way the person is traumatised or perhaps the clothes are torn, here it's private and the person feel more at ease to express herself. I think it helps the process a lot. Often the people feel intimidated by the Police. I can explain to them that the Police have a role to play and what is that role. If they're not happy with that, they can ask me and I will find things out for them. How is the procedure at court, often the feel intimidated when they must go to court. Or they must go for a consultation and they don't understand the process, then I can explain it to them. They come here and feel more at ease because we understand and we're at their level. Everyone here has the means to help a victim. I think because we are from this area, we understand the people and the service that they require.'

- TCC Key informant

External staff, such as cleaners and the security guards are sensitized to the services delivered at the TCC and the need for a victim friendly environment.



#### Secondary victimisation

The TCC has a separate entrance for perpetrators as well as a separate examination room. Some victims experience secondary victimisation from other stakeholders as well as family members. The TCC and DoH ensure that female victims have the option to request that a female healthcare worker attend to them, as far as possible.



#### Child friendliness

The TCC is child friendly with a dedicated room for children. The room has a TV, toys and furniture. A key informant highlighted that people need training in counselling children.

"We often see children, especially if the perpetrator is also a child, we do not want to victimise the child, that child do not have criminal capacity. At the end of the day we work with victims, we do not work on the other side of the spectrum. Sometimes we feel we want to help the people on the other side as well. But at the end of the day we just do a referral to social services to take action. If that is enough, that's the question. For us, when we work with children it's a specialized field and we need more training in that field."

- TCC Key informant



#### Refreshments and comfort packs

According to key informants, the TCC have comfort packs, and can provide victims with clean clothes as well as with refreshments.

#### 5.3 Factors influencing service delivery



#### Human resources

The TCC has a site coordinator and a VAO.



#### Accessibility

Accessibility to the TCCs is an important factor in ensuring that the services are used by victims. The availability of staff members after hours (i.e. on-call staff, NGOs, security guard) influences the medical and psychosocial support that can be delivered after hours.

#### 24/7 service

Until the end of May 2017, Wesfleur TCC indicated that they could deliver a 24-hour service that can cater to clients who present at the TCC after working hours and on weekends. This was possible due to the sub-grant provided to an NGO, Mosaic, to deliver this service. When their funding ended, the 24-hour service was no longer possible. The NGO indicated that they might be able to provide a reduced service for another 2 months. Not being able to open after hours means that services available to clients are compromised.

#### Security's awareness of TCC

Most victims are referred and transported to the TCC after presenting to the SAPS. However, as some victims present directly at the TCC it is important that hospital security is aware of the existence and location of the TCC. The security guards who were stationed at the hospital knew where the TCC is based on the hospital grounds.

#### 5.4 Additional activities



#### Community awareness

The TCC reported that they, together with the NGO associated with them, are involved in various community awareness and advocacy campaigns. This includes appearances on community radio, school awareness activities, activities at the hospital as well as puppet shows at Early Learning Centres. The Wesfleur TCC ensure that they are involved in the community at least once a month. Conducting the awareness campaigns is a challenge, as the TCC do not have a separate budget for this.

'We've managed to make sure that the community regained confidence in the justice system. We have walk-ins coming into the centre, not referred by a service provider. This tells us the word is out in the community about the work we're doing'

- TCC Key informant



#### Health services

This TCC has access to a doctor and professional nurse to deliver forensic and clinical management services. The hospital services are available 24/7 and the hospital provides all the medication required for the functioning of the TCC.



#### Psychosocial support

The TCC mentioned that they have access to essential staff such as social workers and counsellors to assist with short- and long-term psychosocial support. The hospital has a full-time psychologist and the TCC refer victims to DSD as well. Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours. A key informant highlighted that the staff at the TCC become emotionally involved in the process of delivering their services and they are committed to see every case through.

'We want to see them turning into survivors, because that's why we're here'. – TCC Key informant



#### **Transport**

A key informant highlighted the need for transport to assist with follow-up services and continued psychosocial support.



#### **Protocol**

The Wesfleur TCC has an existing protocol that guides all stakeholders on the minimum requirements and activities when assisting victims of GBV. This protocol was updated before the TCC was handed-over to the NPA. This includes guidelines on:





#### Referrals

The TCC assists with referrals to various other government departments and organisations. This is working well, but the TCC mentioned that they do not receive adequate feedback on the progress of referred clients. The TCC also refers victims to other NGOs for long-term support, including Molo Songololo, Child Welfare and various shelters. Victims are referred to SANCA in cases of substance abuse.

#### 5.5 NGO: Mosaic

Mosaic was awarded the sub-grant to provide services in the Wesfleur TCC. It is important to understand the full contribution of NGOs within the TCC model. The participants were asked to explain the value of their organisation at the TCC. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCC.

#### NGO providing services in the Wesfleur TCC





#### Services provided by Mosaic

Enable a 24-hour service

Counselling for children

Provision of comfort packs

Campaign and

awareness activities

Counselling



There is an excellent working relationship between the TCC and Mosaic. Mosaic assists with immediate trauma containment, but also provides long-term psychosocial support to victims. The Mosaic staff based at the Wesfleur TCC have a wealth of work experience, and can assist with various counselling services including HCT, trauma counselling, couple counselling and bereavement counselling. They also assist with court preparation and assistance during court processes. The Mosaic staff consist of one coordinator and four counsellors.

The NGO also bridges the gap between the TCC and the surrounding communities. Mosaic was involved in several awareness campaigns in the surrounding communities.

"The value they add is very valuable. Often we have to go into the field for our awareness campaigns. Then there must be counsellor here so the centre is operational. It doesn't help us if we have to go into the field or attend meetings and there is nobody here. Secondly, they are my support. If we get a lot of cases they are my support system. I can ask them to cover things or do things for me. We work like a network together. I cannot imagine how a centre can be without Mosaic or an organisation like them."

— TCC Key informant



'We're a little family, we are sisters'

– TCC Key informant

'Mosaic help the victims to regain their dignity. They serve as a net, not only to victim, but also to their family members'

— TCC Key informant



#### Changes in service delivery if NGOs are not funded

Mosaic secured additional funding to deliver services in two other TCCs in the Western Cape. With this, they might be able to deliver some services at the TCC for a short period of time. Most of the night services will be discontinued. A key informant highlighted that most victims present at the TCC at night and over weekends.

#### 5.6 Other stakeholders

Stakeholder cooperation and cohesion, at almost all levels of government, was mentioned by numerous key informants. The relationship between stakeholders working with this TCC have been described as exceptionally good. The monthly implementation meetings are well attended.

The challenges mentioned with the individual stakeholders are discussed below.



#### **NPA**

A key informant highlighted that they have an excellent working relationship with the regional NPA manager and that they are supported well. Although Wesfleur TCC do not have a case manager, they commended a dedicated prosecutor at the Sexual Offences court. This person provides adequate feedback on case management.



#### DoH

There are generally good relationships between the TCC and DoH at all levels. At facility level, the relationship between the TCC and the hospital is often dependent on hospital management's attitude and practice regarding the TCC. All key informants highlighted excellent working relationships with hospital management and other DoH staff members. A key informant mentioned that they are very committed to the TCC's functioning.



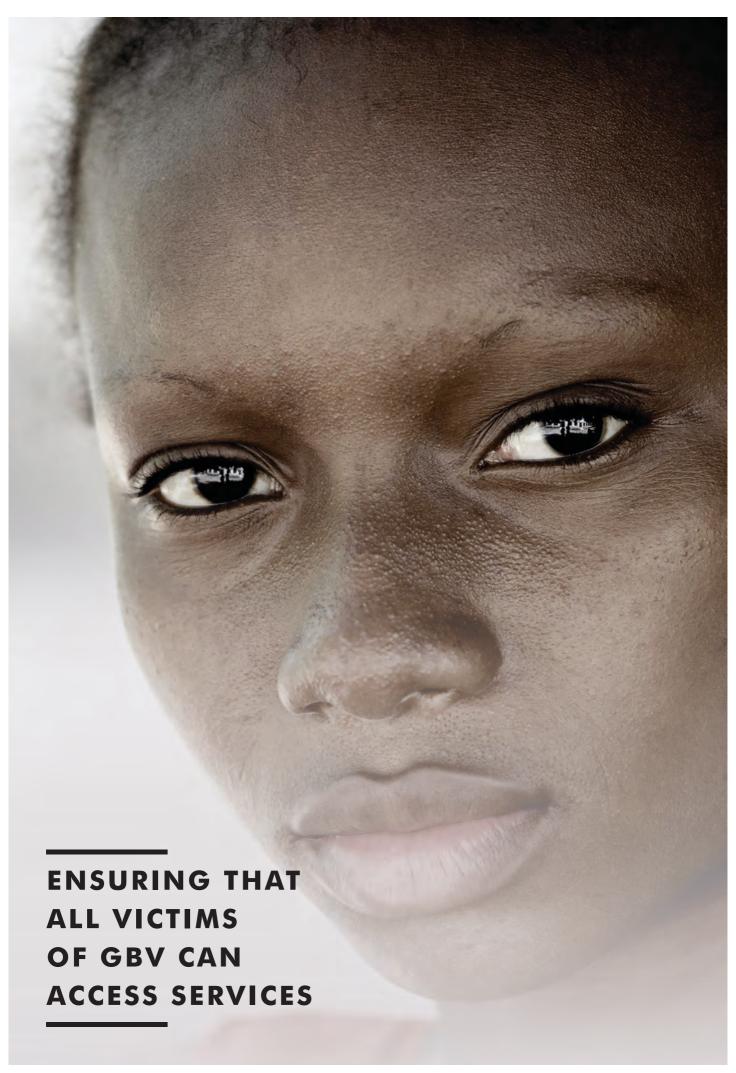
#### DSD

It is reported that there is generally a good relationship between the TCC and DSD. However, although they respond promptly to requests, there is limited feedback from them on victims' progress.



#### **SAPS**

Most key informants reported excellent relationships with, and good support from SAPS. Their specialised FCS units are functioning well and are contributing to the functioning of the TCC model. The TCC explained that the FCS units are on board and they have a very good working relationship with them.



## 

Chapter Five **Recommendations** 

To improve the service delivery and functioning of the TCCs as well as future implementation of new TCCs, the team who conducted the case study have a number of recommendations.

#### 1 Governance and operational recommendations

If the TCC model is implemented with donor funding with an implementing partner, a partner with extensive experience in working with donor funding should again be used, and good relationships with the relevant government departments maintained as this enabled the implementation of this programme.

The MAC AIDS Fund component of the project was implemented over a 4 year period. This allowed for all stakeholders to plan and budget to ensure sustainability of the project. It is recommended that this is also considered for future programmes.

All TCCs should have a protocol that guides all stakeholders (the NPA, NGOs, SAPS, DSD and DoH) in the management of victims of sexual assault. Existing protocols need to be updated. The updated version should take into account the possibility that NGOs might not be able to deliver services if the current funding environment changes.

To ensure that all stakeholders cooperate, the TCC model needs to be legalised. It is understood that this is a tedious and complex process, but will ensure that the model is institutionalised. While this process is in progress, it is recommended that there are Memorandums of Understanding at national level and service level agreements at provincial and site level in place to ensure that all stakeholders take responsibility for their role. As part of this, it should be clear which department should finance which component at all levels of operations. This formalisation of the cooperative framework will ensure that there is intersectoral cooperation, responsibility and accountability from all relevant stakeholders. There should be regular meetings (bi-annual) between stakeholders at national and provincial level, in the same way that the implementation meetings at site level are structured. This will also assist with better communication structures between the relevant stakeholders.

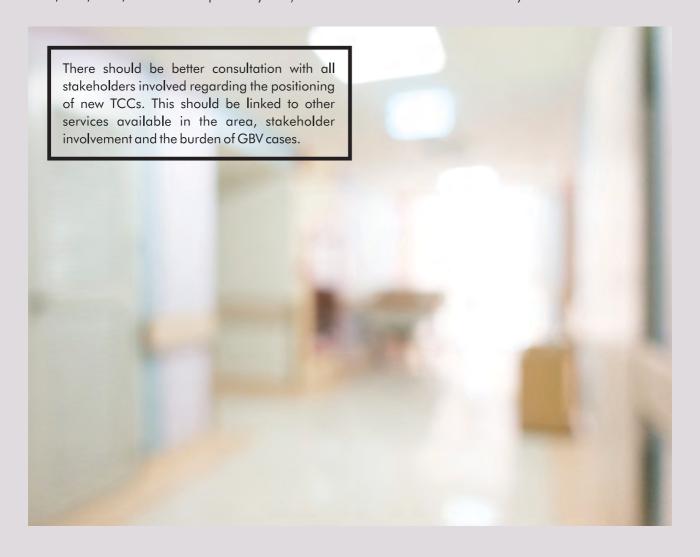
At site level, it is important to ensure that all stakeholders attend the monthly implementation meetings to address strategic issues. This is generally functioning well, but all stakeholders are not always involved.

A new guideline should be developed that takes all the relevant current documentation into account. This should include the TCC Blueprint, NACOSA guidelines, DoH guidelines (cross-referencing HIV guidelines, HCT guidelines, PEP guidelines), and DSD guidelines. All these documents should be integrated into one sexual violence guideline document.

All TCCs and hospitals must have facility level guidelines for service delivery, which should include:



This should be site-specific and take into consideration the staff situation at each facility. This should be updated regularly and when the staff situation changes at a TCC. These guidelines should guide all stakeholders (NPA, DoH, DSD, SAPS, NGO and the judicial system) and will assist with better service delivery.



#### 2 Recommendations to improve service delivery

Based on the findings the team can make the following recommendations to improve the functioning and service delivery of the TCCs.



#### 2.1 Human resources



Most TCCs do not have the full staffing complement as prescribed by the TCC Blueprint. The NPA is in the process of filling most of the vacant case manager posts. It is imperative that TCCs with a higher case load be fully staffed, preferably with the ability to function over 24 hours. None of the MAC AIDS Fund supported TCCs currently have a case manager appointed.

All staff members involved in GBV at the TCCs should receive regular, face-to-face debriefing to provide them with coping mechanisms in the environment in which they work. There should be a better structure in place to provide emotional and psychosocial support to all staff members involved in the TCCs. This can form part of the Employee Wellness programme. Alternatively, the NPA and other stakeholders must determine who is responsible for providing the debriefing.





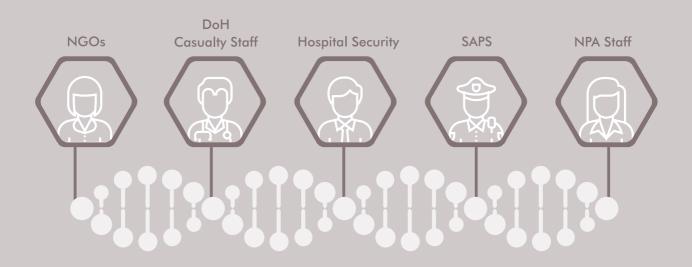
Basic training on HIV counselling and testing for the NPA and NGO staff will improve the flow of services within the TCCs. The training programmes should be broadened and developed and implemented by a recognised training institution that can provide CPD points, specifically for the DoH personnel. It is also necessary to review the content of the NPA Interdepartmental Training. There should be more training on how to deal with child survivors.



Ideally, all TCCs should be fully operational 7 days a week, 24 hours a day.

The MAC AIDS FUND supported TCCs could function 24/7 while the NGOs working within the TCCs were still funded.

This is not likely to continue in the future without additional funding provided to the NGOs. To compensate for this, it is recommended that all TCC sites develop a coordinated system involving the NGOs, casualty staff, hospital security, SAPS and NPA staff so that victims of GBV are treated quickly and confidentially. Victims who present after hours must not be subjected to secondary victimization. This system should include all the TCC requirements (private waiting room, comfort packs, clean clothes, and ablution facilities) that the victim would have access to during the day.





#### 2.3 Health services

To ensure that adequate health services are delivered it is recommended that DoH ensure that all TCCs have a forensic nurse or a doctor allocated to them. The ideal is that there should be either a doctor or forensic nurse available to assist the TCC 24/7. TCCs should not rely casualty rooms to provide essential medical services to victims. There should be a dedicated roster to ensure that there is always an after-hours forensic nurse or doctor available for the TCC. The coordinated system mentioned previously will also assist with this.



EMS personnel in casualty, as well as other DoH staff, should receive GBV sensitization training to ensure that the health services supplied for victims do not expose them to secondary victimization.



Most sites provide a PEP starter pack to victims. It is recommended that victims who are unable to return for follow-up care be supplied with the full 28-day course PEP package. This case study did not consider the national guidelines for PEP and all PEP prescriptions should adhere to national guidelines. It is also advised that victims of sexual assault receive PEP earlier in the continuum of care, as this will reduce the number of cases that receive PEP after the 72 hours period.



It is recommended that all TCCs have a tracking tool that can track all the health-related services provided to the victim, including follow-up support, that is linked to case management. The referral linkages should be formalized to ensure that all necessary government departments are involved, to ensure departmental ownership and accountability. Such a tracking tool was piloted with the four MAC AIDS Fund supported TCCs, but will not be continued from June 2017.





#### 2.4 Psychosocial support





#### 2.5 Equipment and supplies

FPD provided all four TCCs with external telephone lines and internet access. It is recommended that NPA and DoH ensure that all staff (including NGO staff) at the TCCs have continued access to external telephone lines as well as internet access. This will ensure that TCC staff can do their work appropriately and that NGO staff can contact victims for follow-up services and psychosocial support.

It is also recommended that the NPA and other stakeholders ensure that food and groceries are provided to the TCCs. There must be a decision on who is responsible for this full time, to ensure that victims receive food and drink. Many victims spend hours at the TCC and the hospital. Provision of food will also assist to alleviate nausea related to PEP. A possible solution is that the hospital make food available to sexual assault patients after the examination and before medication is supplied, as Grey Hospital is doing.





#### 2.6 Transport

One problem that has been seen almost universally among the TCCs is the lack of transport. This problem greatly effects the working of the TCCs and creates several barriers for effective treatment. It is recommended that the stakeholders decide on who is responsible for providing transport from the police station to the TCC, but also who is responsible for transport after the visit to that TCC. This must be budgeted for by the dedicated department.

In addition to this, transport should be available for the NGOs to deliver long-term psychosocial support and for all staff to be involved in community awareness programmes.



#### 2.7 TCC sites

It is recommended that the NPA, donors and DoH ensure that the TCCs that are in park homes become part of the hospital refurbishment programmes.

Many of the TCC sites have adequate outside space to consider erecting an outside play area for children.

The four MAC AIDS Fund supported TCCs have better security systems in place than the other 51 TCCs across the country. However, security at the TCC at night and over weekends needs to be improved, when there are only one or two NGO staff members on duty.



#### 3 Stakeholder relationships

It is recommended that the accountability and communication between the stakeholders in the TCC model be improved.



3.1 DoH

The TCC model is an intersectoral collaboration, but the DoH have the responsibility to ensure compliance with all relevant health guidelines. It is recommended that the DoH take responsibility for this and ensure that all stakeholders comply with the relevant guidelines. There should also be better screening for GBV at all DoH facilities with the appropriate referral at these facilities.

There should be closer engagement within DoH to ensure that all levels of government, from national, provincial, district and facility level understand their role within the TCC model. There must be a clear understanding of the roles and responsibilities at the various levels to ensure better service delivery at the TCCs.



3.2 DSD

It is highly recommended that DSD ensure the permanent appointments of counsellors. If this is not possible, it is recommended that DSD, NPA, donors and NGOs all engage to ensure a sustainable, permanent system to ensure that psychosocial services can be provided consistently across all provinces. It is recommended that DSD, the NPA, NACOSA and the NGOs meet to ensure that funding for NGOs are available across all provinces and for each TCC. There should be proper guidelines in place to ensure this is happening.

DSD need urgently to improve their support to child victims, as this is major concern in the current model. In addition, there is an urgent need for a feedback system from DSD to the TCCs regarding case management, specifically in the case of child victims. TCCs and NGO invest a lot of time, effort and care into containment, care and treatment of victims, and require feedback with regards to turning victims into survivors.



3.3 SAPS

It is recommended that there is routine sensitization training for all staff members within SAPS, and not only within the FCS.

Stakeholders should meet and formalise the transport arrangements from police stations to the TCCs, and home/place of safety. There should also be a protocol around the length of time a victim must wait for transport. This is very big gap within the current model.

All TCCs with a police officer stationed within the TCC must have a SAPS-supplied computer within the TCC, so that a case number can be allocated at the TCC. This prevents the victim having to return to the police station to get a case number and will increase the efficiency of the judicial system.



## 4 NGOs as service providers



## **5 Other recommendations**



All stakeholders should investigate how GBV services can be upscaled. This should include upscaling of GBV services within existing health facilities, including protocols for referral to services not provided at the existing health facilities. This will assist in ensuring that all victims of GBV can access services. In addition to this, the NPA should meet with other rape crisis centres to ensure that all services for GBV form part of the GBV package of care in South Africa.



In addition, stakeholders need to conduct a community mapping exercise to assess what services are delivered in all areas around TCCs. This will allow better use of resources, referral and community involvement.



A more flexible model of consistent, reliable services should be investigated. Rural areas have special needs that should be considered. The NPA and DoH need to investigate how DoH mobile clinics can assist with service delivery in remote areas.



Community awareness campaigns have great value, and this should be adequately budgeted for. At this stage NGOs, as well as TCC staff members in their personal capacity, are carrying the burden for conducting community awareness campaigns.



There is value in conducting evaluations of a programme while implementing. It is however recommended that evaluations are planned from the start of the programme to ensure better planning implementation of evaluations, specifically at impact level.



## 

Chapter Six Conclusions



This case study on the four MAC AIDS Fund supported TCCs was conducted between April and June 2017 using a mixed methods approach of key informant interviews and the results of the 2016 application-based survey using tablets. Interviews took place in May 2017. Some information, specifically those on the functionality of the NGOs within the TCCs, might have changed, as the funding for the NGOs stopped.

The findings suggest that the four MAC AIDS Fund supported TCCs are generally functioning extremely well, but that services and stakeholder involvement vary across provinces, mainly due to the unique context of each TCC.

One of the greatest strengths of the TCC is the multisectoral approach, bringing all services and stakeholders together (i.e. NPA, DoH, DSD, SAPS and various NGOs). In the four MAC AIDs Fund supported TCC this multisectoral approach is working extremely well.

All four of the TCCs are based in park homes, but are designed according to the TCC Blueprint. There is adequate office space as well as private counselling rooms in all TCCs. At some sites there have been issues around the security of after-hours staff.

Victim friendliness in TCCs is a minor problem. The TCCs are laid out in a victim friendly manner, all staff are sensitised and have received adequate training. All the TCCs have a child friendly room with toys.

All the ablution facilities are disabled friendly, and there is a wheelchair ramp at each TCC.

There is still a lot of secondary victimisation within the surrounding communities, and some secondary victimisation from SAPS personnel. All the TCCs provide comfort packs when available, but basic groceries to provide food and beverages to victims are still needed.

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



All four TCCs have a site coordinator, and three have a VAO, but none have a case manager.



All of four the TCCs have at least one DoH staff member dedicated to the TCC, but this is mainly during the day. The TCCs are in some cases dependent on casualty staff after hours and during weekends. At other TCCs, the hospital allocated a dedicated doctor on the roster to assist the TCCs with afterhours services. EMS personnel are not adequately sensitised to work with victims of GBV and do not prioritise victims. PEP is provided, but victims generally receive only a starter pack when they present after hours and need to return to the TCC for the remainder of the medication.



All four the TCCs have all equipment required to deliver their services. All the TCCs have external telephone lines as well as access to the internet.



All four TCCs were able to provide a 24/7 service. This might change after June 2017, when the NGOs no longer have funding. There are inconsistencies in the delivery of health services within the TCC after hours. At some TCCs all services are delivered in the TCCs after hours. In others, victims are either referred to the casualty department of hospitals or have to wait for a forensic nurse or doctor to come to the TCC from casualty.



There are serious concerns about the ability of TCCs to provide long term psychosocial support. DSD is not providing enough social workers and psychologists for the TCCs. This will be further affected if the NGOs are not funded in the future.



Transport is a major barrier for almost all components of the TCC model. While SAPS usually bring victims to the TCCs, they cannot wait to transport the victim home or to a place of safety. Many victims do not have transport to come back to the TCCs to receive follow-up PEP or follow-up psychosocial support. This also influences the victims' ability to attend court proceedings. Due to lack of transport NGOs cannot provide follow-up psychosocial support at the victim's home and the NGOs and TCC staff cannot participate in community awareness campaigns.

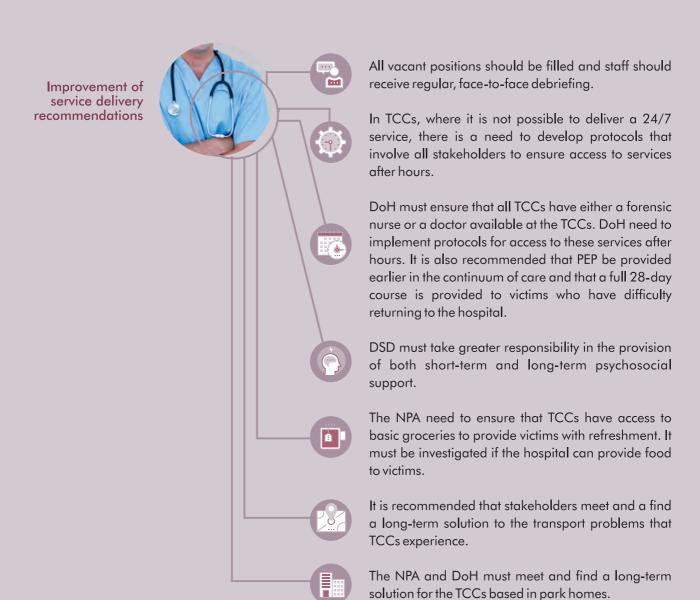


The researcher made several recommendations to improve the service delivery and functioning of the TCCs. The recommendations can be summarised as follows:



The role of TCCs needs to be included in legislation to ensure that all stakeholders take responsibility and be held accountable for their roles and responsibilities within the model.

It is recommended that new, inclusive guidelines are developed for the management of sexual assault in South Africa.





NGOs need to be recognised for the services they provide and should receive better training on the TCC model.

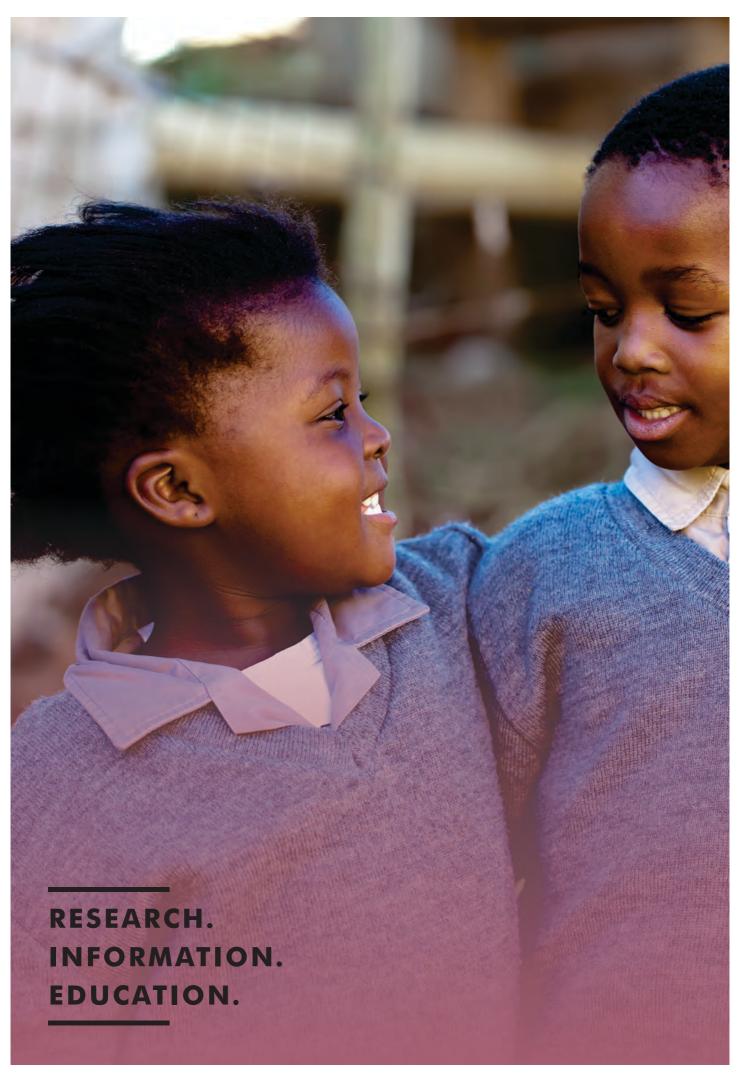
Stakeholders must find a lasting solution for the funding challenges that the NGOs experience.

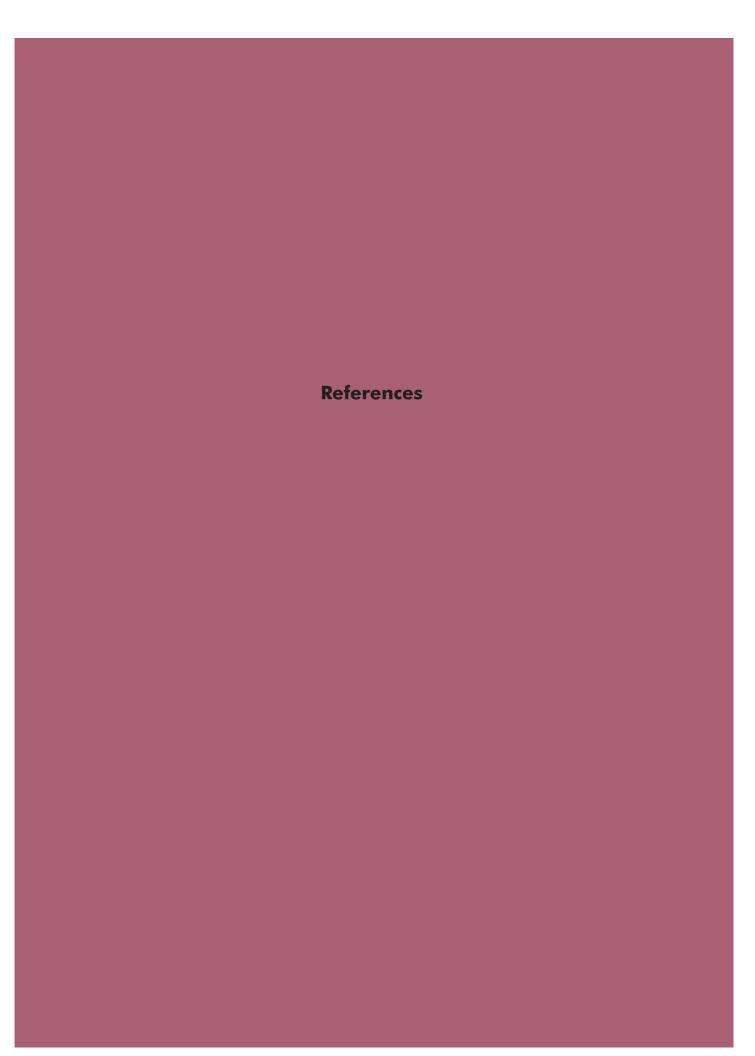


It is recommended that all stakeholders investigate how GBV services can be upscaled. This should include upscale of GBV services within existing health facilities. This should include a protocol for referral for services not provided at the existing health facilities. In addition to this the model needs to be linked with the other existing rape crisis centres and Kgomotso Care Centres.

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







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