Rapid assessment and gap analysis: Post-violence care services at public health facilities in the City of Johannesburg (Region A)

A **DREAMS** INITIATIVE

Conducted by
Foundation for Professional Development

March 2017

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Acknowledgements

The team wishes to express their gratitude to all the key informants, facility managers, and managers from NGOs who were willing to spare their time and share their experiences and insights with us. We believe that this rapid assessment and gap analysis will go a long way towards enhancing the post-violence care services that are provided by health facilities in City of Johannesburg, regions A, D, E and G.

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Disclaimer

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ACRWC	African Charter on the Rights and Welfare of the Child
ART	Antiretroviral therapy
ARV	Antiretroviral
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
CHC	Community Health Centre
CoJ	City of Johannesburg
CPD	Continuing professional development
CSO	Civil Society Organisation
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DoH	Department of Health
DoJ	Department of Justice and Constitutional Development
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, Safe
DSD	Department of Social Development
DVA	Domestic Violence Act
EMS	Emergency medical services
EU	European Union
FBO	Faith-based organisation
FCS	Family Violence, Child Protection and Sexual Offences Investigation Unit
FHI360	Family Health International 360
FPD	Foundation for Professional Development
GBV	Gender-based violence
GNP	Gross National Product
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
ISS	Institute for Security Studies
ISSSASA	Increasing services for survivors of sexual assault in South Africa
KZN	KwaZulu-Natal
LGBTI	Lesbian, gay, bisexual, trans and intersex persons
LA	Local authority

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

EXECUTIVE SUMMARY

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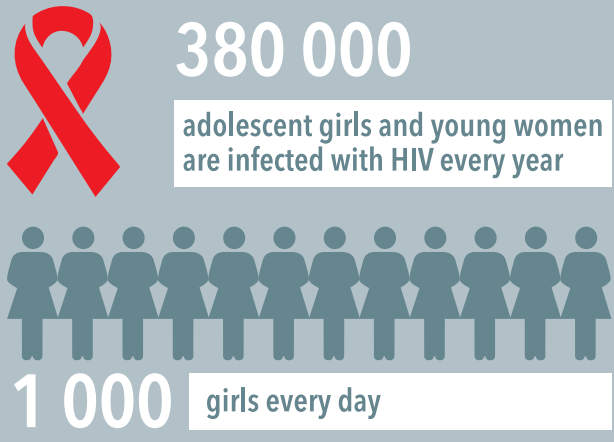
Background

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



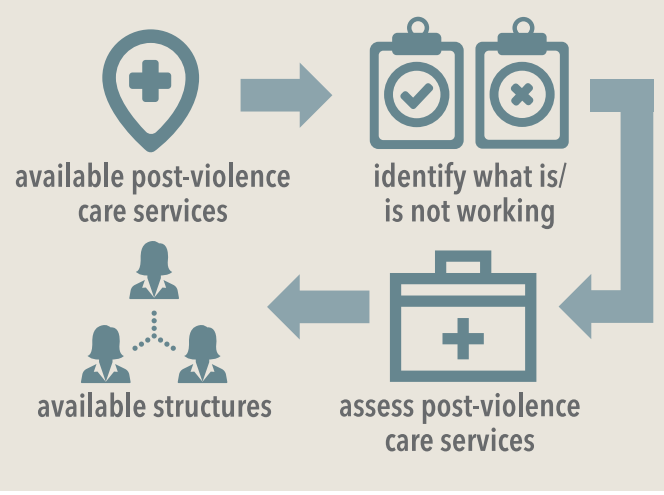
The Foundation for Professional Development (FPD) was contracted by USAID to be the technical assistance partner to:

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

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

Purpose

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



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

[1] *DREAMS innovation challenge* brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
[2] Ibid.
[3] Strategic Plan: DREAMS.

Methodology

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

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

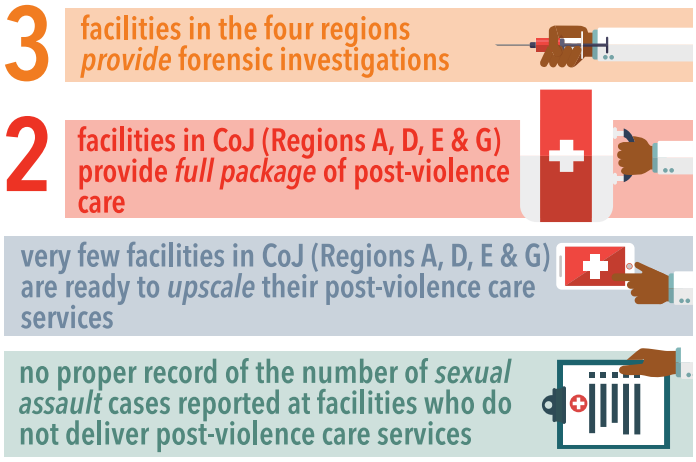
The team conducted a situational analysis using a literature review, using international and local reports, articles and standards to develop this. This also informed the data collection tools that were developed, as well as the interview schedules. They considered the South African legislative and policy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

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

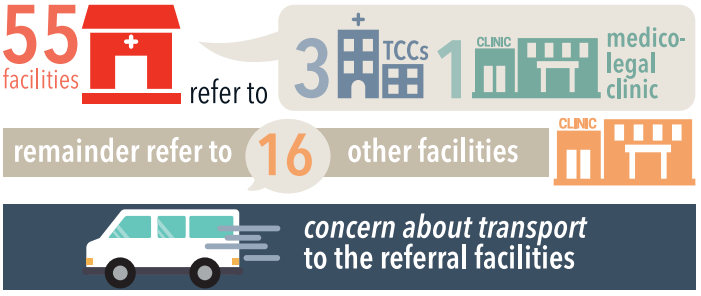
The quantitative data were exported from the cloud database into MS Excel™, where it was cleaned, coded and descriptively analysed. No inferential analyses were conducted. The audio recordings were transcribed verbatim and analysed through a combination of deductive and inductive thematic coding. Themes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

Major findings

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

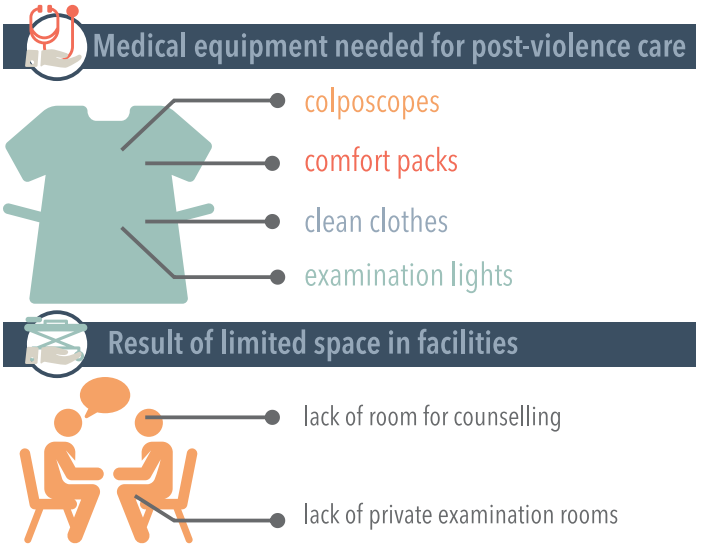


There are only three facilities in the four regions that provide forensic investigations, and only two facilities in CoJ (Regions A, D, E and G) provide the full package of post-violence care as defined by the TCC Blueprint. There are differences in post-violence care available between regions, with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



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

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



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

Human resources

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

Training

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

Victim friendliness

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

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

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

Recommendations

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

Post-violence care service delivery recommendations

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

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

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

Referral pathways recommendations

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

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

Facility and site recommendations

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

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

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

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

Improvement of service delivery recommendations

Refresher training, training on the management of sexual assault and how to conduct a forensic investigation is needed for all stakeholders involved in post-violence care (DoH staff, DSD, SAPS as well as NGOs and CBOs working in the regions).

Training should be provided to all staff working in health facilities, including facility managers and nurses.

NGO recommendations

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

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

Communication channels between NGOs and facilities need to be improved.

Other recommendations

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

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

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


BIG
SISTER

CHAPTER 1: INTRODUCTION AND OBJECTIVES

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1. Contextual background to the rapid assessment and gap analysis

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

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

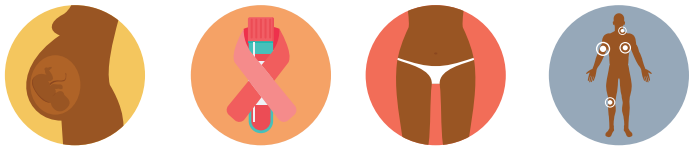
The Thuthuzela Care Centre (TCC) Blueprint was key to determining the package of post-violence care services that should be available at public health facilities[7] as well as the core competencies of staff. TCCs provide a comprehensive set of services for victims of sexual assault and for this reason they are often called one-stop service centres. The TCC Blueprint was read together with the 2015 Guidelines and Standards on supporting survivors of sexual violence published by the Networking HIV/AIDS Community of South Africa (NACOSA),[8] the 2010 PEPFAR Toolkit on Sexual and Gender-based Violence,[9] as well as any other minimum standards of care that the might already be used in provincial health facilities. TCCs are not the only support centres for survivors of sexual violence and the NACOSA guidelines provides more general norms and standards on the provision of post-violence support that could also apply to health facilities.

This assessment of the post-violence care services also took cognizance of service providers who work in, or with, these health centres in the provision of care, such as non-governmental organisations (NGOs). Their role in the provision or care and how this complements the services that the healthcare facilities provide form part of this assessment.

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

2. Contextual background

South Africa has some of the highest levels of sexual violence and related offences in the world. Experts in GBV and sexual offences think that many rapes and other sexual offences are still under-reported. 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.



[4] *DREAMS innovation challenge* brochure. PEPFAR, Bill & Melinda Gates Foundation, GirlEffect.
[5] Ibid.
[6] Strategic Plan: DREAMS.
[7] This includes basic care at primary healthcare facilities, as well as care at community health centres and hospitals; and the referral system between health facilities.
[8] *Guidelines & Standards for the Provision of Support to Rape Survivors in the Acute State of Trauma*. 2015. Published by NACOSA with support from the Global Fund to Fight AIDS, Tuberculosis & Malaria.
[9] Keesbury, J., and Thompson, J. 2010. A step-by-step guide to strengthen sexual violence services in public health facilities: Lessons and tools from sexual violence services in Africa. Lusaka: Population Council.

3. Donor and government response

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

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

4. Purpose of the rapid assessment and gap analysis

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

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

5. Objectives of the rapid assessment and gap analysis

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

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

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

6. Intended users of the rapid assessment and gap analysis

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

[10] Ibid.
[11] Ibid.

Key stakeholders and use of the rapid assessment and gap analysis

CITY OF JOHANNESBURG METROPOLITAN MUNICIPALITY

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

DREAMS implementing partners (Anova and Right to Care)

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

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

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

DEPARTMENT OF SOCIAL DEVELOPMENT

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

SOUTH AFRICAN POLICE SERVICE (SAPS)

- Improved oversight and increased conviction rates

DEPARTMENT OF BASIC EDUCATION

- Improved support to children who are victims of sexual assault

FUNDER: USAID

- Decisions on future funding of GBV initiatives in South Africa

NGOs WORKING WITH HEALTH FACILITIES

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

NGOs WORKING WITHIN HEALTH FACILITIES

- Improved engagement between NGOs and the health facilities

CHAPTER 2: DESK REVIEW AND SITUATIONAL ANALYSIS

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

1. Defining gender-based violence and sexual violence

1.1. Gender based violence and human rights

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

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

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

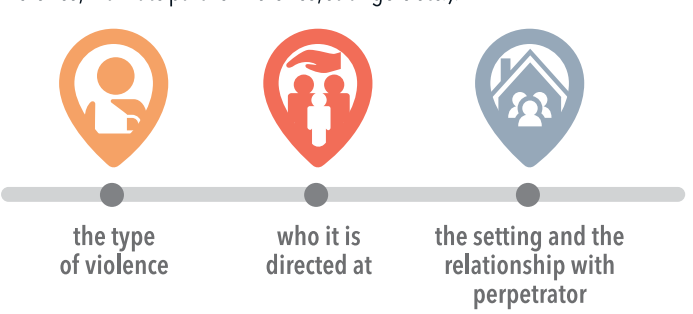
> *"the violation of women's human rights and a form of discrimination that prevents women from participating fully in society and fulfilling their potential as human beings." (WHO, 2002a:28).*

1.2. Gender-based violence as a broad spectrum

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

> *"Gender-based violence is violence involving men and women, in which the female is usually the victim and which is derived from the unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual and psychological harm, including intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community. It includes that violence which is perpetuated or condoned by the State." (WHO, 2002a:15).*

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



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

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

1.3. Defining sexual violence

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

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

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

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

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

1.4. Risk factors and drivers of gender-based violence

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

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

Inappropriate societal norms and standards

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

Destructive masculine identities

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

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

Gender inequality

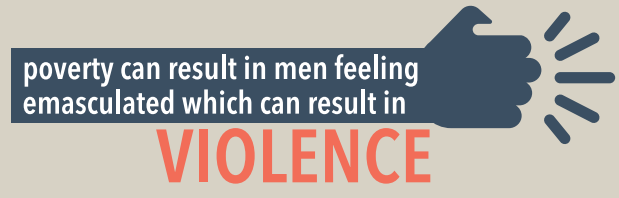
Many authors and institutions, including the WHO, have presented evidence in support of the argument that there is a relationship between the extent of gender inequality and the extent of GBV (WHO, 2002a; WHO, 2002b). Gender inequality is evident in the spheres of political and civil-society decision-making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

Ineffective legislative and policy contexts and ineffective interventions

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

Poverty

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



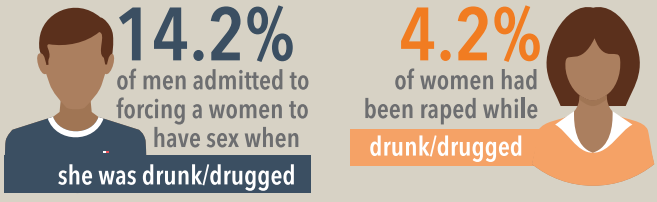
Individual-level factors that relate to the existence of gender-based violence include:

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

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

Use of drugs and alcohol

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



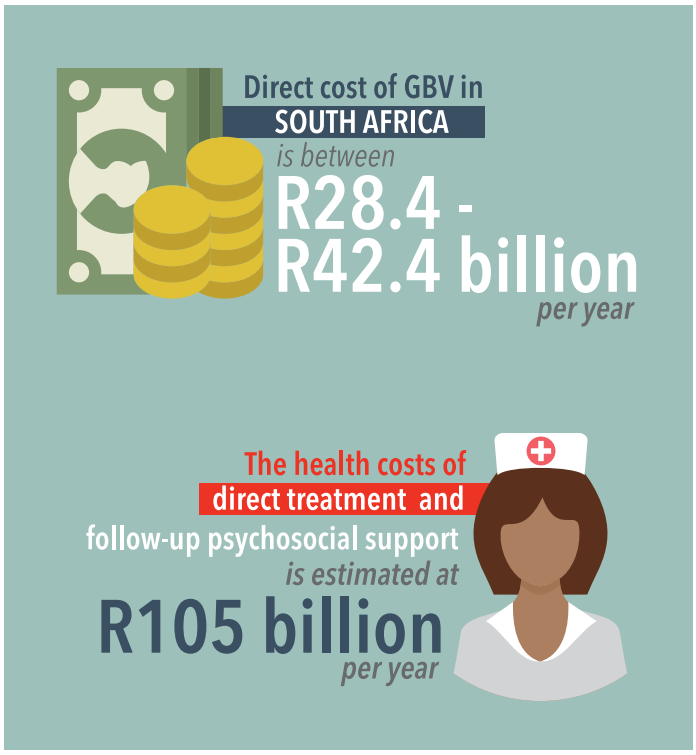
Access to firearms

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

1.5. Impact of gender-based violence

Individuals who have experienced sexual violence may as a consequence suffer from a range of psychological and behavioural problems and physical injuries, many of which can be long-lasting. These individuals are furthermore at an increased risk of a number of reproductive health-related complications. These have been widely documented in the literature and include anxiety, depression, post-traumatic stress disorder, secondary victimisation, suicidal behaviour, risk of substance abuse, death, risks from unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV/AIDS, infertility, etc. (Kruger et al., 2002; WHO, 2002a; WHO, 2002b; WHO, 2003; NACOSA, 2015). In addition, "rape and domestic violence [could] account for 5 - 16% of healthy years of life lost to women of reproductive age" (Murray and Lopez cited in WHO 2003: 18).

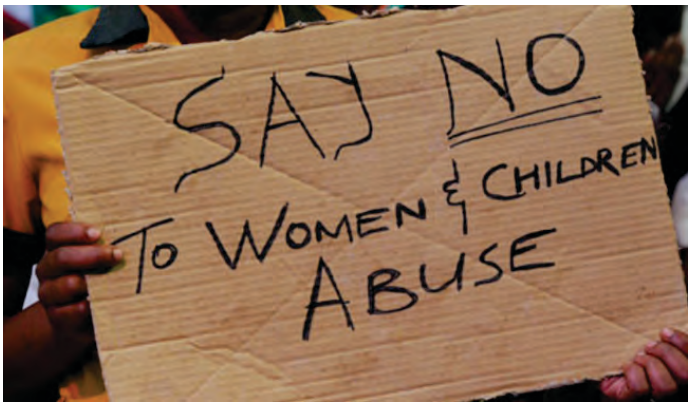
In addition to the impact of sexual violence on the health and wellbeing of survivors, some authors comment on the social and economic costs for society (Morrison and Orlando, 2004). This includes the erosion of social trust (WHO, 2002a) as well as economic costs for the country. The WHO (2002a) claims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



2. Gender-based violence internationally – prevalence and policy frameworks

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

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



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

INTERNATIONAL INSTRUMENT	OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS
CEDAW Convention on the Elimination of All Forms of Discrimination Against Women, 1979	South Africa is a State Party to this treaty which it ratified in 1995 and is therefore obliged to take action on a number of fronts, such as: acting against discrimination against women, which includes implementing legislation that promotes gender equality, and eliminating customary or traditional practices that may be harmful to women and prevent them from realising their human rights. (SAHRC, 2015)
The United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 1985	The needs and rights of victims of domestic crime are recognised internationally and the Declaration sets out principles (for example compassion and dignity) relating to the treatment of victims within the framework of a responsive legal system. South Africa is signatory to this Declaration. (Western Cape Government, 2014)
UNCRC United Nations Convention on the Rights of the Child, 1989	The Convention articulates a number of rights that children have, including the right to be protected against abuse and exploitation. South Africa ratified the UNCRC in 1995 and it has influenced domestic legislation around child protection and child justice. (Western Cape Government, 2014)
The Declaration on the Elimination of Violence against Women, 1993	Article 1 of the Declaration provides a definition of violence against women, while article 2 provides a non-exhaustive list of acts of violence against women occurring at the level of the family, community and State. South Africa ratified this Declaration in 1995. (Western Cape Government, 2014)
Beijing Declaration and Platform for Action, 1995	In 1995 South Africa became a signatory to the Beijing Declaration and Platform for Action which contains 12 thematically organised strategic objectives aimed at the empowerment of women. It recognises the importance of such empowerment for world peace and development. The Declaration and Platform for Action is meant to accompany the provisions of CEDAW. (SAHRC, 2015)
The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, 2000	The Protocol is a supplement to the United Nations Convention against Transnational Organized Crime. It is aimed at lessening and preventing human trafficking in participating States as well as ensuring laws and policies are in place in these States to provide for the security and recovery of victims. (Western Cape Government, 2014)
United Nations World Conference on Racism, Racial Discrimination, Xenophobia and Related Intolerances in Durban in 2001, culminating in the Durban Declaration and Programme of Action	The Declaration was signed by the South African government and recognises that racism and racial intolerance affect women and girls differently to men and can be contributing factors towards the deteriorating wellbeing and status of women leading to violence and other forms of discrimination. It therefore recommends the integration of a gender perspective into policies aimed at eradicating racial and other discrimination. (SAHRC, 2015)

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

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 right to life, integrity and security of person (Article 4), the elimination of harmful cultural practices (Article 5), the right to peace (Article 9), and a comprehensive list of reproductive rights in Article 14 including medical abortion and access to adequate and affordable health services. In Articles 22(b) and 23(b) sexual violence in respect of elderly women and women with disabilities are specifically recognised and States have the obligation to ensure their freedom from violence. (Western Cape Government, 2014; SAHRC, 2015)
SADC Protocol on Women and Development, 2008	South Africa is not only a signatory, put participated in the drafting of this Protocol in 2008. It is 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 gender-based and sexual violence is framed. It has also illustrated the variable, and in many cases high rates of sexual violence, indicating the international scale of the problem. In the section that follows the focus shifts to the nature and extent of gender-based and sexual violence in South Africa and the institutional and legislative frameworks set out to address it.

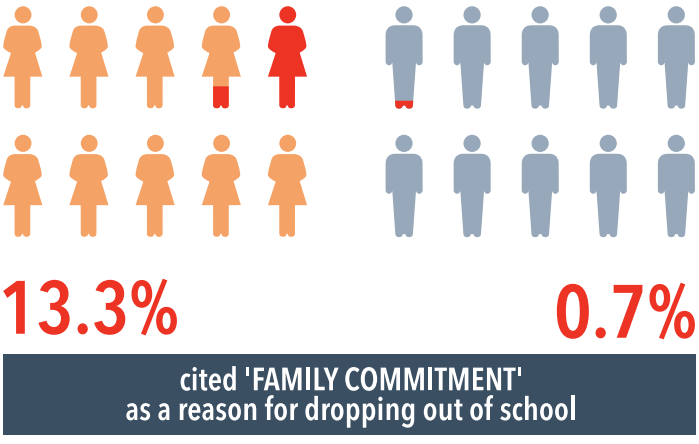
3. Gender-based violence in South Africa – trends, institutional frameworks and quality of care

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

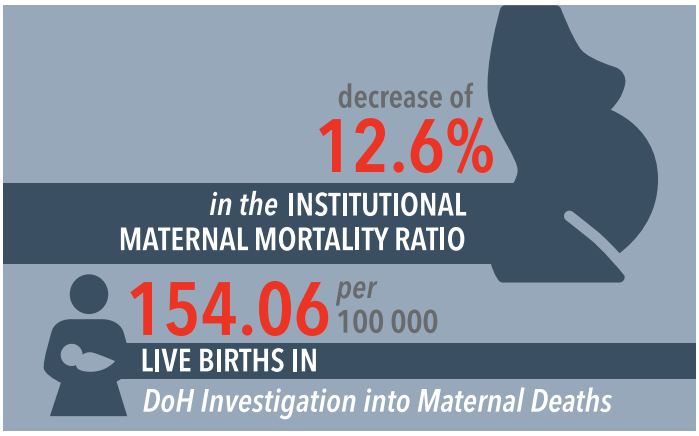
Although great strides have been made as far as women's inclusion in the political and economic sphere in South Africa, statistics indicate that there are many women's rights that remain unattained and that women often still hold a vulnerable position in society. The following description and statistics are not meant to be comprehensive and all inclusive, but rather illustrative of women's socio-economic status in relation to some indicators that expose them to vulnerability.

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

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



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

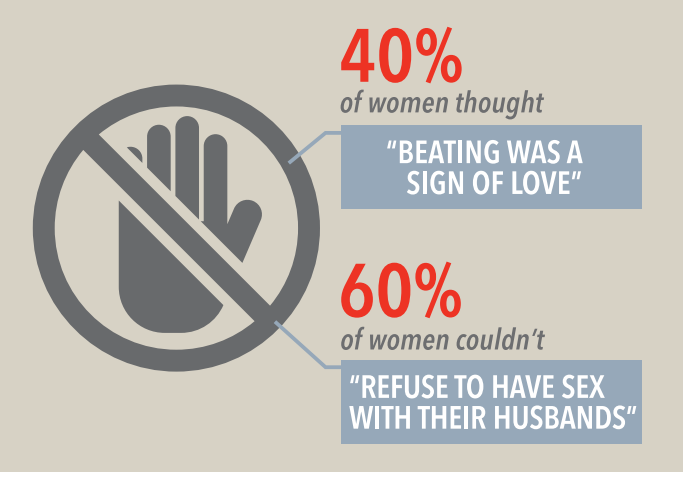


In South Africa (as elsewhere) continued inequity in employment practices, salaries, access to infrastructure and healthcare reduce female autonomy and contribute to the inappropriate societal norms and values discussed elsewhere in this report, in turn increasing women's vulnerability to gender-based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

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

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

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



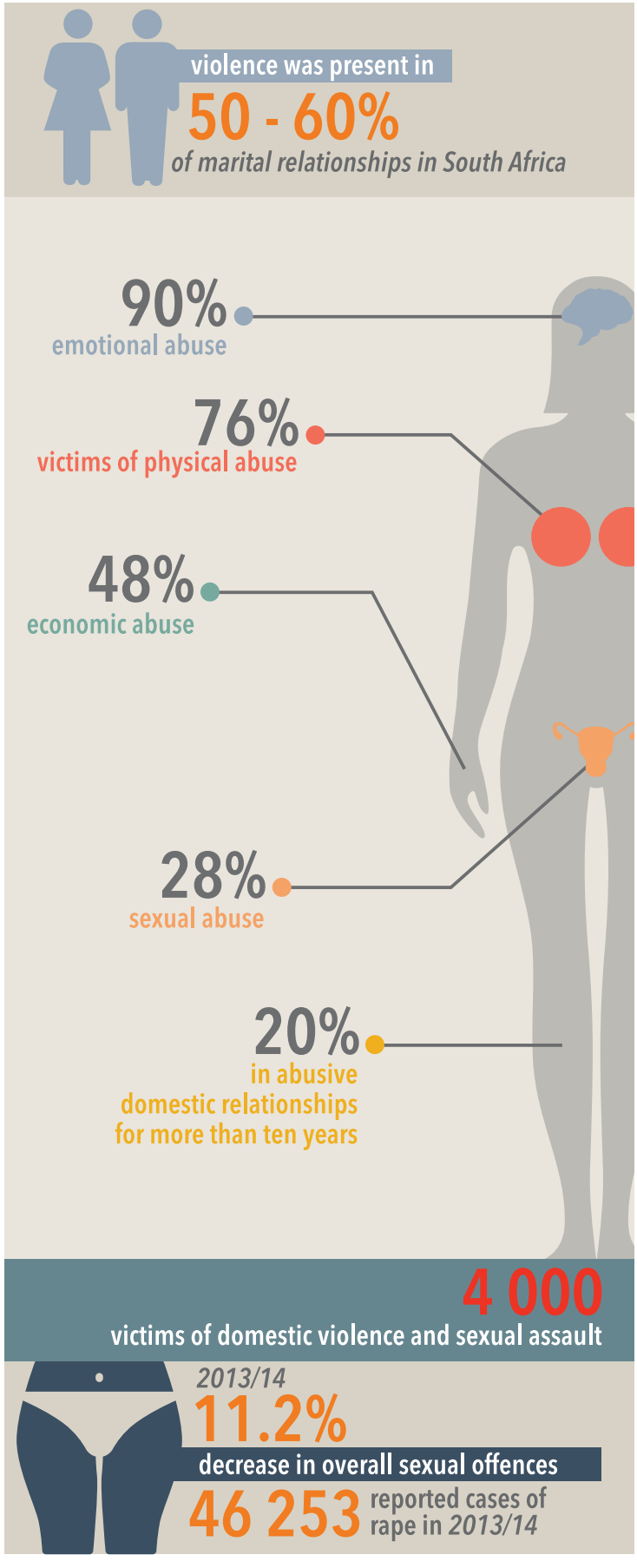
3.2.1 Intimate partner and domestic violence

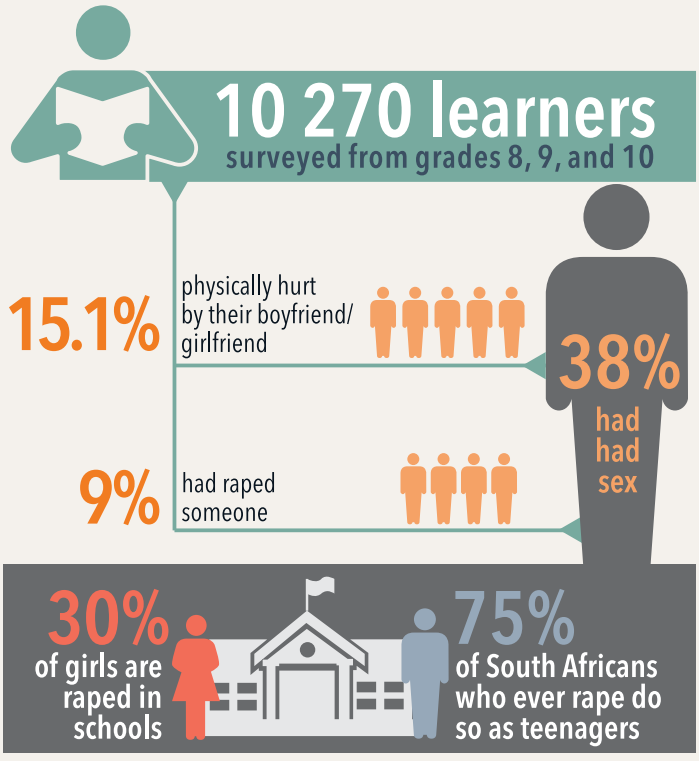
Literature on the prevalence of violence against women over time presents a bleak picture of consistently high rates. A 1991 study reported that violence was present in 50 - 60% of marital relationships in South Africa (Vogelman and Eagle, 1991). A 2002 community-based study of violence against women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

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

3.2.2 Rape and sexual violence

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





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

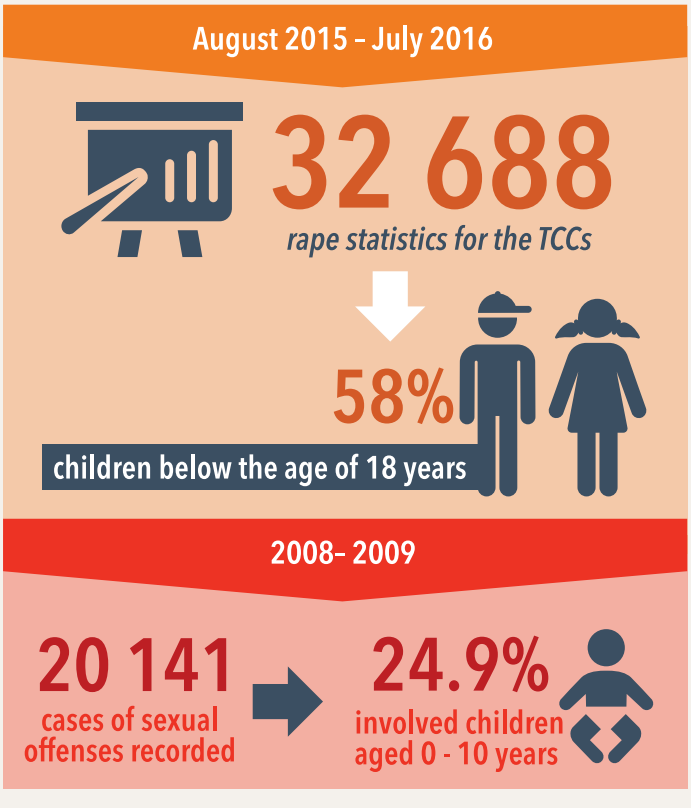
In many countries, including South Africa, Botswana and Namibia, both men and women are often targeted because of sexual identity (being gay or lesbian), (NACOSA, 2015). This is often called "corrective rape". Koraan and Geduld (2015) report that "corrective rape" refers to an instance when a woman is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

3.2.3 Violence against sex workers

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

3.2.4 Violence against children

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



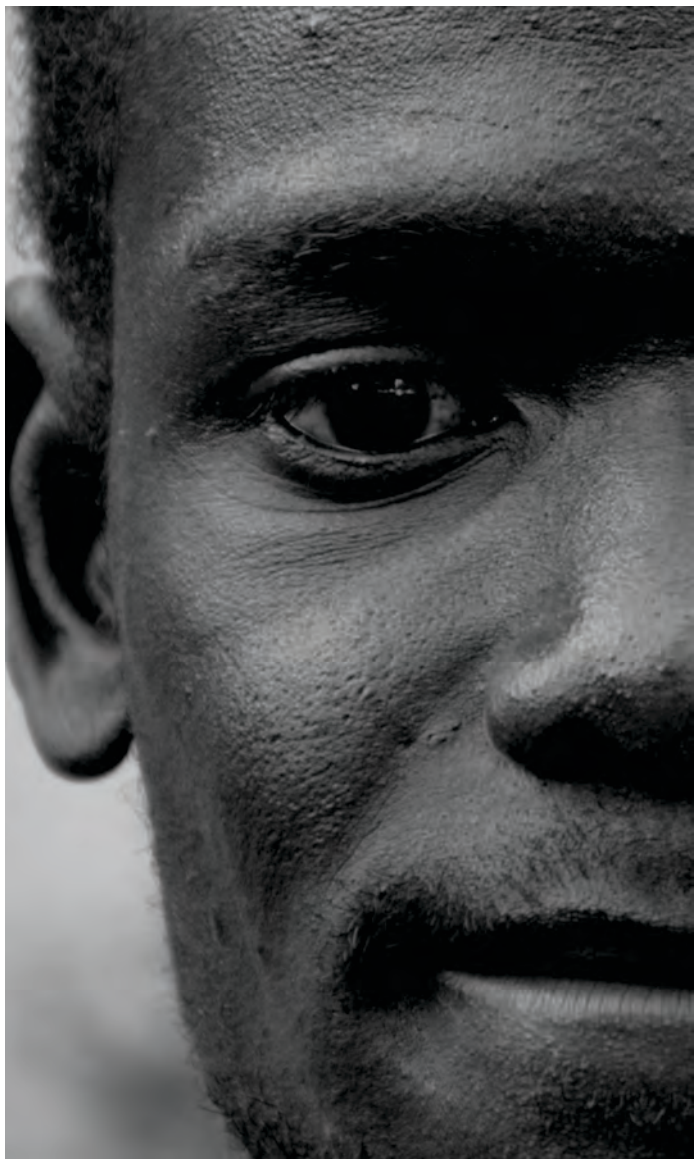
3.3. Legislative and institutional framework aimed at addressing gender-based violence in SA

3.3.1 Legislative and policy framework

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

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

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



Domestic Violence Act, No. 116 of 1998:
The purpose of this Act is to provide maximum protection under law for victims of domestic abuse. It has broadened the definition of domestic violence thereby affording greater protection to victims and also allows for issuing of protection orders.

Service Charter for Victims of Crime in South Africa (referred to as the Victims' Charter), 2004:
The Victims' Charter contains seven key rights that victims have when interacting with services provided to them. It is aligned with both the victim-centred approach of the National Crime Prevention Strategy of the Department of Safety and Security, as well as the 1985 United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. (Western Cape Government, 2014)

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007:
The Act aims to incorporate all sexual crimes into one law and clearly defines sexual crimes and related matters. It also tries to ensure that victims receive adequate and appropriate services and assigns roles and responsibilities to different departments for the implementation of the Act. (NACOSA, 2015)

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

Prevention and Combating of Trafficking in Persons Act, No. 7 of 2013:
This Act gives effect to South Africa's obligations under international agreements to combat trafficking of persons. (Western Cape Government, 2014)

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

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

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

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

In addition to the legislation and policies mentioned above and in some instances as a result of these, various institutions and services exist to respond to gender-based violence in South Africa. Although the following list is not exhaustive, it illustrates the wide ranging legally mandated programmes, as well as the role played by non-governmental organisations (NGOs). The literature also points out some of the successes and challenges of these institutions.

Government departments and national institutions

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

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

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

National Task Team on Gender and Sexual Orientation-Based Violence Perpetrated on LGBTI persons:
This task team was established in 2011 by the Minister of Justice and Constitutional Development with the aim to, among other things, develop a national intervention strategy to address violence against LGBTI persons, including "corrective rape". (Department of Justice and Constitutional Development, 2014)

Criminal justice system

South African Police Service (SAPS):

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

Sexual Offences Courts:

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

Health services/support

Thuthuzela Care Centres:

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

Designated rape care centres:

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

Civil society/NGOs

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

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

3.4. Quality health care and barriers to access

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

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

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

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

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

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

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

Health

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

Police / Justice

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

Social Support

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

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

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

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

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

Department of Health Norms and Standards, 2003

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

Standards and norms for primary healthcare, 2000

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

TCC Blueprint

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

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

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

NACOSA Guidelines

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

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

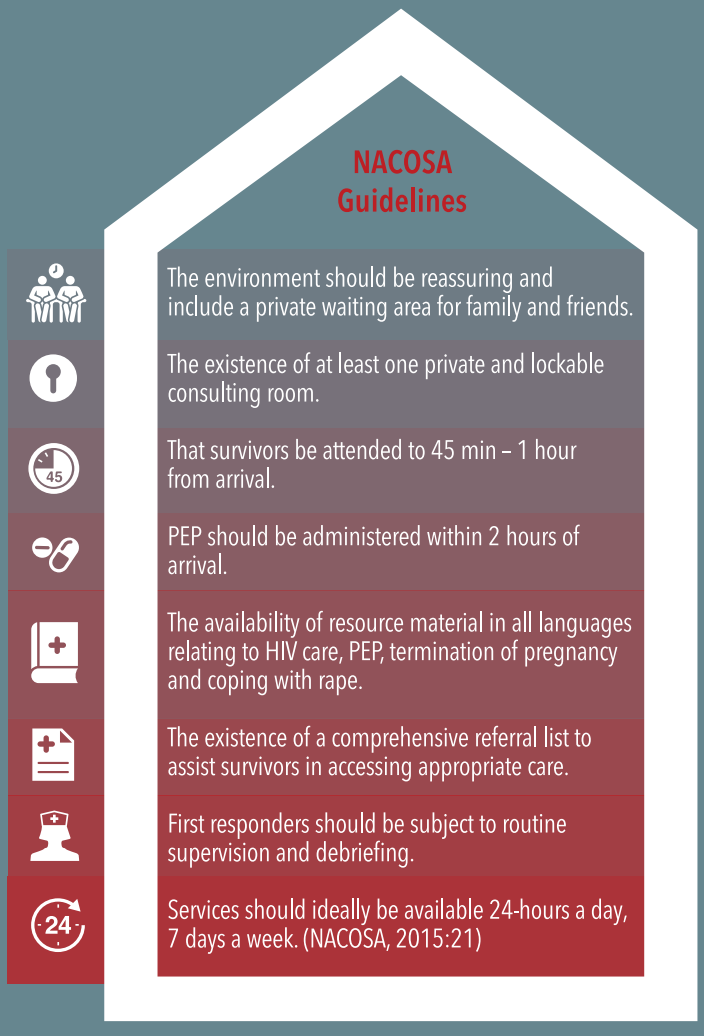
Outline the training and supervision needed to support first responders.

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

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

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

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



Importance of referrals

Resource constraints mean that it is not always possible for all services to be provided at one-stop centres, and services can also be provided at hospitals, community healthcare centres (CHCs) and clinics. The literature suggests that when planning around the provision of services it is necessary to decide what elements of the comprehensive care required by survivors can be provided at facilities and what services need to be referred (Keesbury and Thompson, 2010). Ideally all emergency services should be provided at the health facility, including trauma counselling (Keesbury and Thompson, 2010). When it is not possible for comprehensive services to be provided at facilities, a strong referral system needs to be in place which could include referrals to other healthcare facilities, NGOs, the police, etc. However, Keesbury and Thompson (2010) argue that referral systems are often not given enough attention in the design of post-violence assault services. There are various factors that influence the strength of the referrals system such as: the "proximity of services to one another, attitudes of staff, levels of awareness of services in community, use of standardised referral algorithms, ongoing meetings between stakeholders". (Keesbury and Thompson, 2010: 32)

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

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

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

Sexual violence is not regarded as a serious health issue by staff, and staff sometimes hold discriminatory views towards victims:
Although the first point of call often are the health facilities, sexual violence services are not always prioritised or regarded as a serious health issue (Christofides, et al., 2005) and are not institutionalised within plans and budgets (Kilonzo, 2013). This affects quality of care and could lead to secondary victimisation (Christofides et al., 2005). Other research has shown a lack of willingness by some staff to be involved in certain services (such as termination of pregnancy); a general feeling of discomfort working with victims of trauma; a reluctance to conduct medical exams which would mean staff would need to testify in court; and a lack of sensitivity (WHO, 2003; Christofides et al., 2005; SAHRC, 2015).

Feelings of self-blame, fear, and lack of awareness of facilities and ability to access them (e.g. lack of transport)**:**
Under-reporting and lack of accessing of care occur for reasons such as fear of the perpetrators when they are known to the survivor; acceptance or normalisation of such violence; feelings of self-blame and shame at being exposed in the community as a victim of sexual violence; an inability to access facilities due to lack of transport or the financial means to arrange transport; and the possibility of negative economic consequences if the victim relies financially on the perpetrator. (Weideman, 2008; Keesbury and Thompson, 2010)

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

Lack of resources and infrastructure to provide services:
This could refer to gaps in essential medication, equipment, services, and the infrastructure to treat survivors of sexual violence with sensitivity (Keesbury and Thompson, 2010). The SAHRC (2015) has documented violations of the right to privacy in the provision of healthcare, which in the case of sexual violence includes not having a separate consultation room.

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

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

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

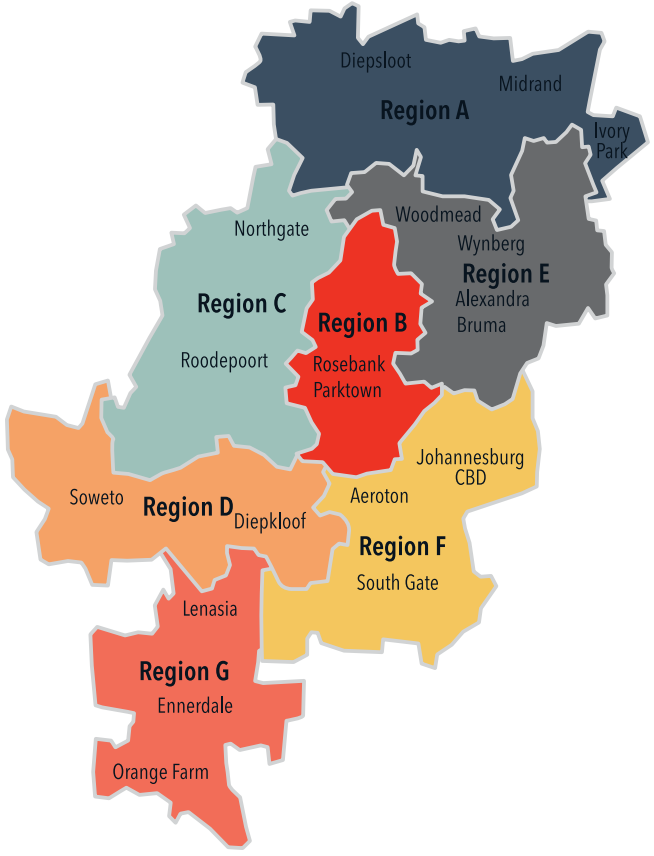
This section of the desk review and situational analysis relates to the geographic area (Gauteng more generally and City of Johannesburg (Regions A, D, E and G specifically)) that is the focus of the rapid assessment of post-violence care at facility level. It provides a brief description of the demographic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

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

Gauteng is one of South Africa's nine provinces and is centrally located, bordering four other (Gauteng Tourism, n.d.). Gauteng is 17 000 km^2 in size, and hosts almost 25% of the South African population. The province is described as the economic hub of South Africa and generates a third of the country's GDP and contributes 47% of the country's economy. The City of Johannesburg (CoJ) is one of Gauteng's five metropolitan regions. Johannesburg has a rich mining history, with the gold rush of 1886 leading to the formation of the city. CoJ's economic sectors are now centred on finance, manufacturing, trade and services (HSRC, 2014).

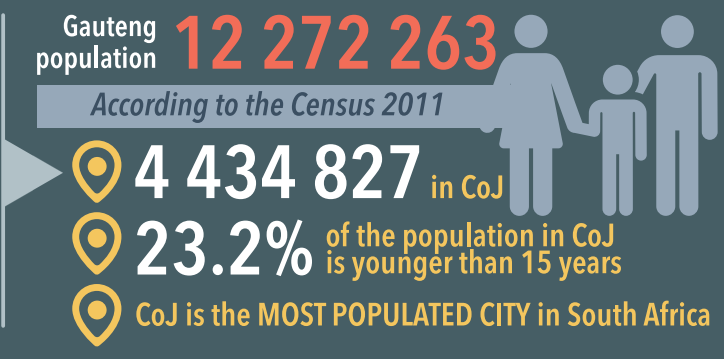
Provincial map of South Africa
Source: Google maps

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

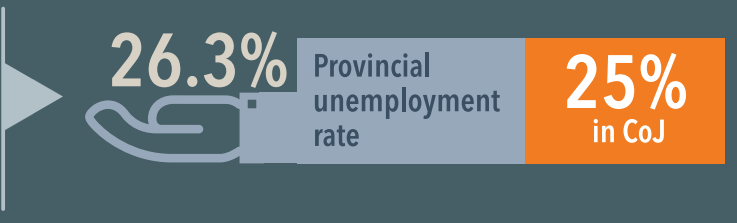


Regional map of City of Johannesburg indicating regions
Source: CoJ – Department of Economic Development

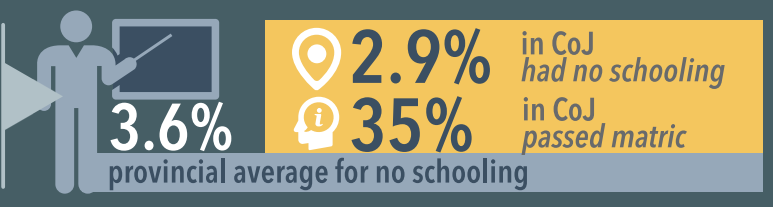
According to the Census 2011 report, Gauteng had a population of 12 272 263 of which 4 434 827 live in CoJ. In the province as a whole, 23.7% of the population are younger than 15. In the CoJ 23.2% of the population are younger than 15. The sex ratio for the province (males per 100 females) is 101.8,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



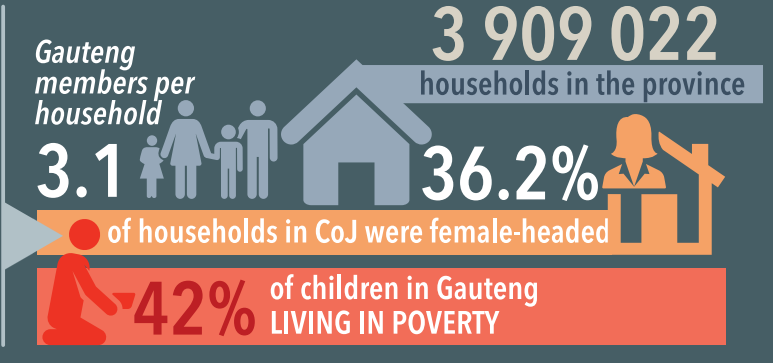
The province had an official unemployment rate of 26.3% (with the CoJ lower at 25%). The official youth (15 - 34 years) unemployment rate is higher than the national average at 34%. At 31.50%, the youth unemployment rate for CoJ was slightly lower than that reported for the province (Stats SA, 2011).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



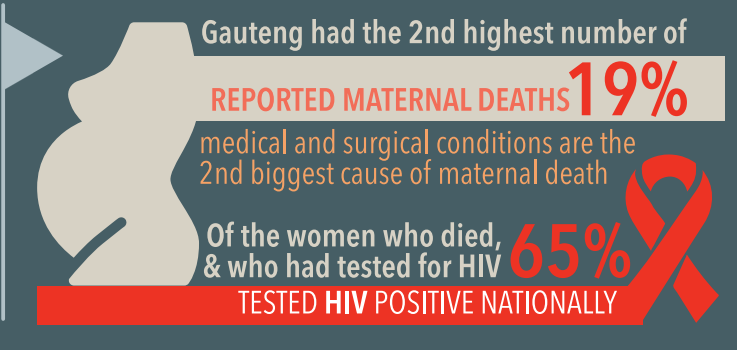
Statistics related to education were better for CoJ than the province as a whole, perhaps as a result of its urban nature. In CoJ only 2.9% had had no schooling, compared to the provincial average of 3.6%. In addition, 35% had passed matric, which is slightly higher than the provincial average of 34.7%.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



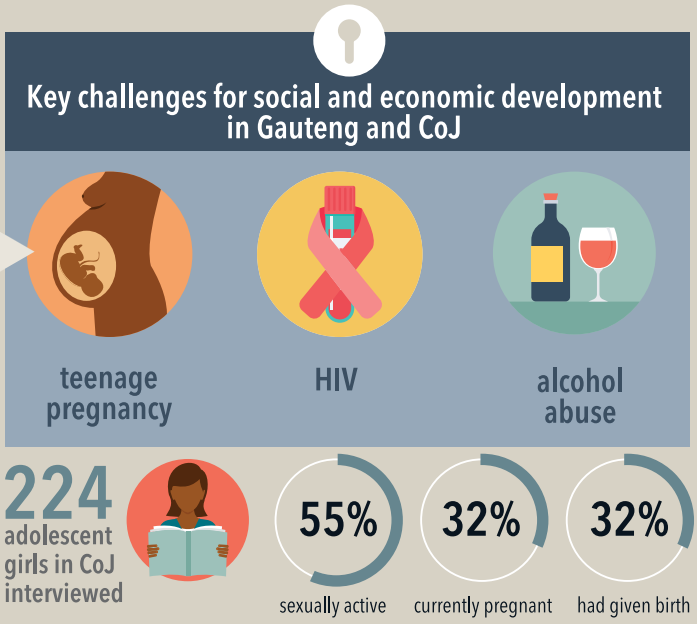
There are 3 909 022 households in the province (1 434 856 for CoJ) with an average size of 3.1 members per household. Thirty-four percent of households were female-headed (36.2% in CoJ) (Stats SA, 2011). According to an SAHRC report, in 2008 42% of children in Gauteng lived in poverty, which was significantly lower than the South African average (64%) but higher than the Western Cape (37%) (SAHRC, n.d.). Region G has the highest number of people living in poverty (HSRC, 2014). However, CoJ saw a 5% increase in human development between 1996 and 2011. Within CoJ, Region B has the highest Human Development Index (HDI) at 0.71 and Region G the lowest at 0.67 (HSRC, 2014).



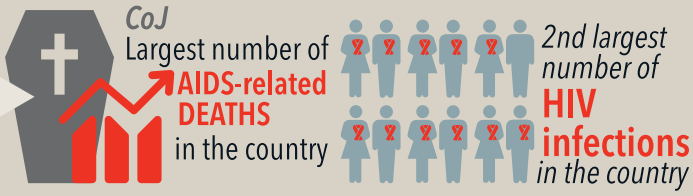
A 2014 Department of Health report on maternal mortality rates for 2011 - 2013 showed that Gauteng had the second highest number of reported maternal deaths (19%) compared to other provinces, and that it is the province (shared with KwaZulu-Natal) in which medical and surgical conditions are the second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



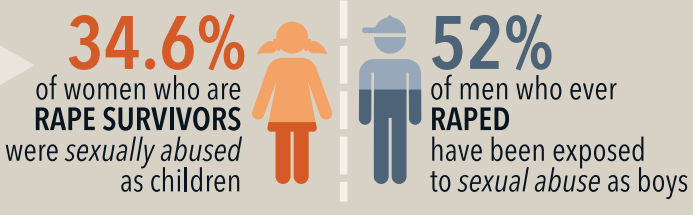
Gauteng and CoJ face a number of social and economic development challenges, of which teenage pregnancy, alcohol abuse and HIV have been identified as some of the key challenges. These are highlighted in this review as they have particular relevance for a discussion on GBV. In CoJ, factors associated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



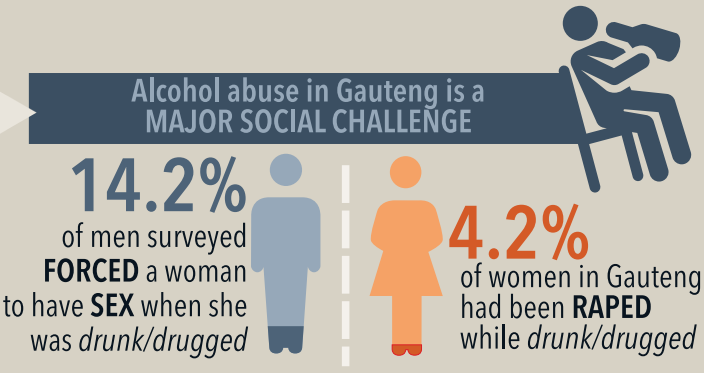
CoJ had the second largest number of HIV infections and the largest number of AIDS-related deaths in the country (compared to other cities). Within the city, region D has the highest number of HIV infections, but this can be contributed to the fact that this is also the most populated region in the city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



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

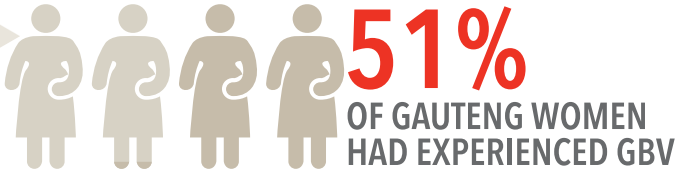


Another major social challenge in the province is alcohol abuse (Machisa et al., 2011). A total of 4.2% of women in Gauteng had been raped while drunk/drugged, and of the men surveyed, 14.2% had admitted to forcing a woman to have sex when she was unable to refuse on account of being drunk/drugged. Men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

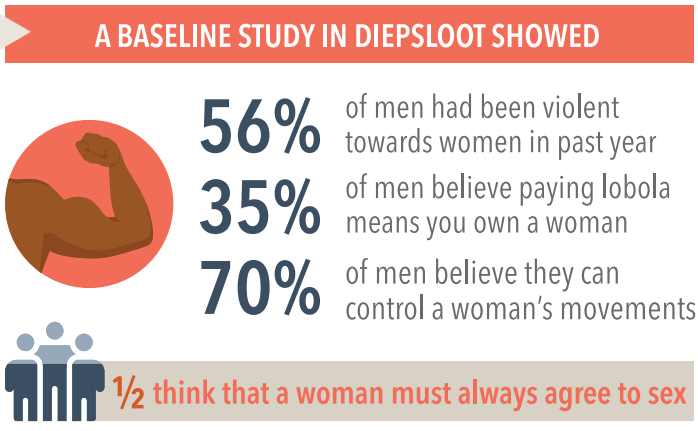


4.2. Gender-based violence in Gauteng and City of Johannesburg

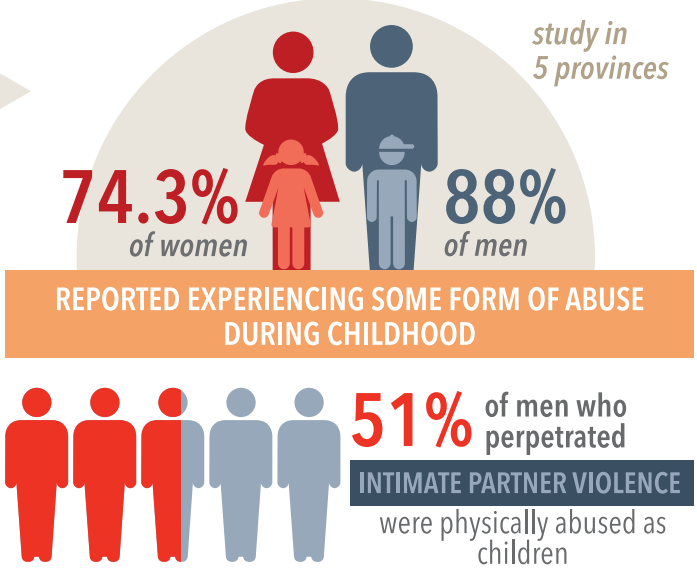
The rates of under-reporting of sexual violence to the SAPS in Gauteng (as in other provinces) have been illustrated by statistically representative surveys of the nature and pervasiveness of GBV. The research indicates that 51% of Gauteng women said that they had experienced GBV (higher than the 36%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



A 2011 survey of Gauteng households indicated that 51% of women in Gauteng had been subjected to intimate partner violence (Machisa et al., 2011), and 76% of men admitted to perpetrating GBV. Approximately 12% of women in Gauteng (compared to 5% in KwaZulu-Natal and 6% in the Western Cape) had been raped (Machisa et al., 2011). HIV infection among women who had been sexually abused by an intimate partner is high, at 35% (Musariri et al., 2013). A baseline study in Diepsloot (Region A) showed that 56% of men in Diepsloot had been violent towards women in the past year, 60% multiple times (Sonke Change Trail, 2016). Cultural beliefs and notions of masculinity are a driving force for GBV in Region A, with 35% of men believing that paying lobola means that you own a woman, 70% believe that they can control a woman's friends and movements, and more than half think that a woman must always agree to sex. Only 0.09% of men and 0.3% of women in Gauteng reported domestic violence, while a total of 18.1% of women said they experienced violence. This indicates that there are high levels of under-reporting of violence against women, while sexual violence by an intimate partner is least reported.

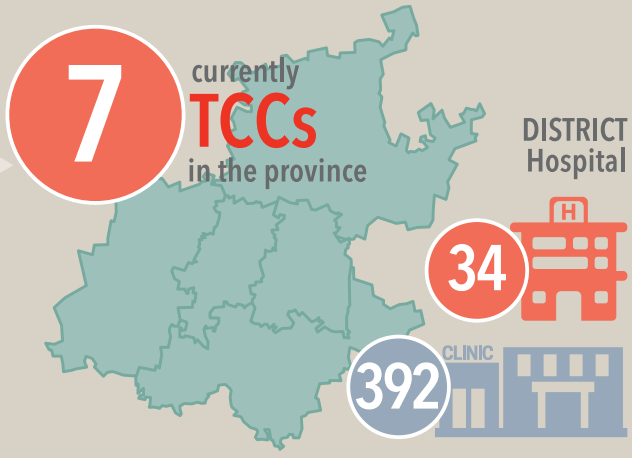


A very high proportion of men and women in Gauteng have been victims of child abuse (Machisa et al., 2011). The majority of women and men who took part in a study on GBV in five provinces in South Africa, had been physically abused as children. A total of 74.3% of women and 88% of men had reported experiencing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



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

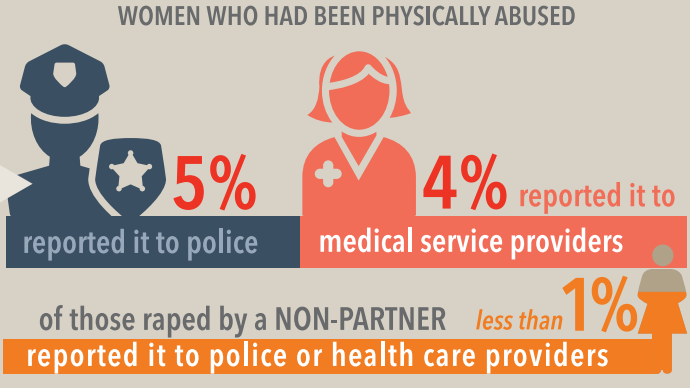
Various institutions and structures exist in the province to support survivors of gender-based and sexual violence. There are currently seven TCCs in the province: (1) Mamelodi TCC at Mamelodi Day Hospital, Mamelodi; (2) Nthabiseng TCC at Chris Hani Baragwanath Hospital, Diepkloof; (3) Lenasia TCC at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



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

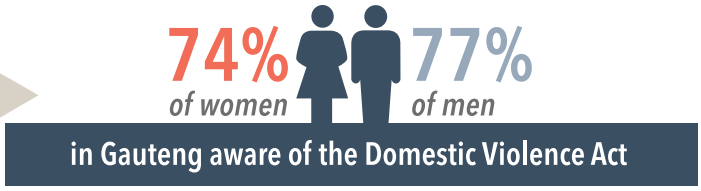
Data from various directories, such as the 2011 GBV Project by FPD, funded by SIDA, that resulted in service directories listing government and civil society resources that assist victims of violence, or the CSVR directory on counselling services, show that there are many NGOs that provide various levels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

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



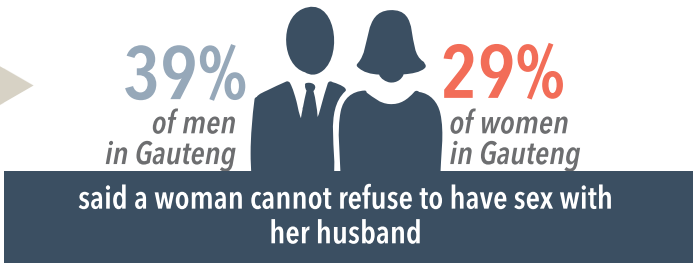
Awareness of legislation and rights:

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



Prevalence of inappropriate and harmful societal norms:

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



Inaccessibility of services and substandard care:

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

5. Conclusion and way forward

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

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

CHAPTER 3: METHODOLOGY

CHAPTER 3: METHODOLOGY

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

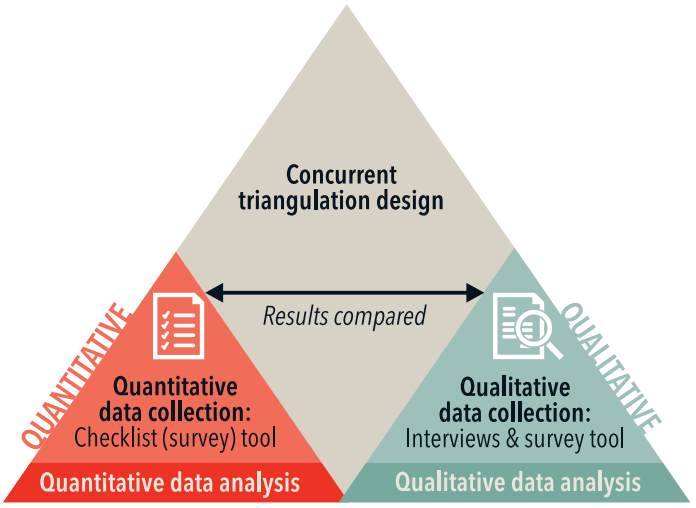
1. Approach

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

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

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

Approach to the rapid assessment



2. Sample

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

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

- **The facility no longer exists**
- **The data collector couldn't locate the facility**
- **Access was denied due to concerns about approvals obtained from the District Health Committee.**

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

3. Situational analysis and desk review

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

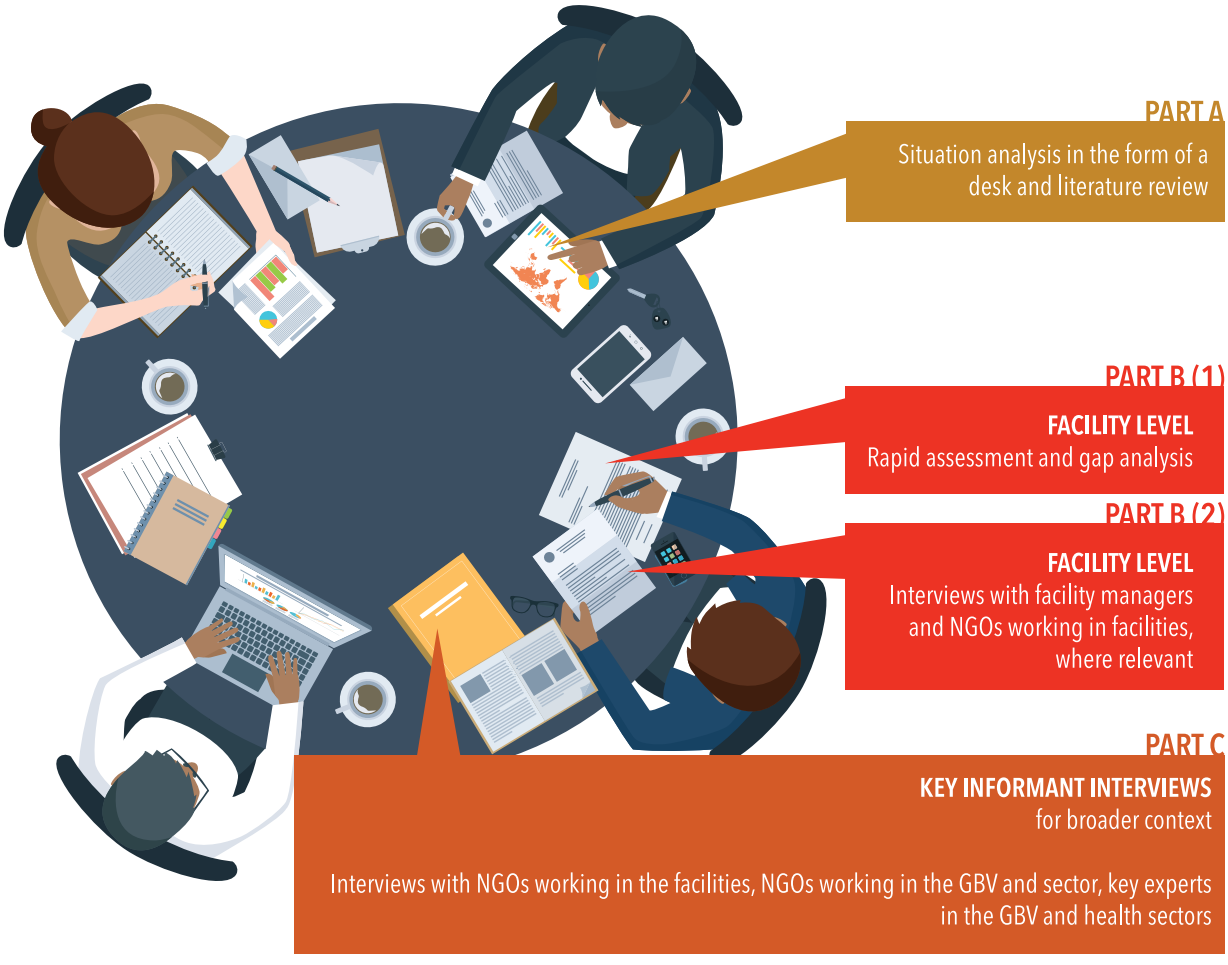
4. Data collection methods, instruments and procedure

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

4.1. Data Collection Methods

It is important to note that no data were collected from survivors, victims or clients of the health facilities. Data were collected in a number of different ways, shown in the figure and detailed below.

Data collection process



4.2. Data collection tools

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

Diagram of data collection tools

PART B (1)

FACILITY LEVEL
Rapid assessment and gap analysis

Relevant tools: Check list

PART B (2)

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

Relevant tools: Interview schedules

PART C

KEY INFORMANT INTERVIEWS
for broader context

Interviews with NGOs working in the facilities, NGOs working in the GBV and sector, key experts in the GBV and health sectors

Relevant tools: Interview schedules

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

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

4.3. Qualitative data acquisition

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

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

5. Data analysis procedure

5.1. Quantitative data analysis

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

5.2. Qualitative data analysis

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

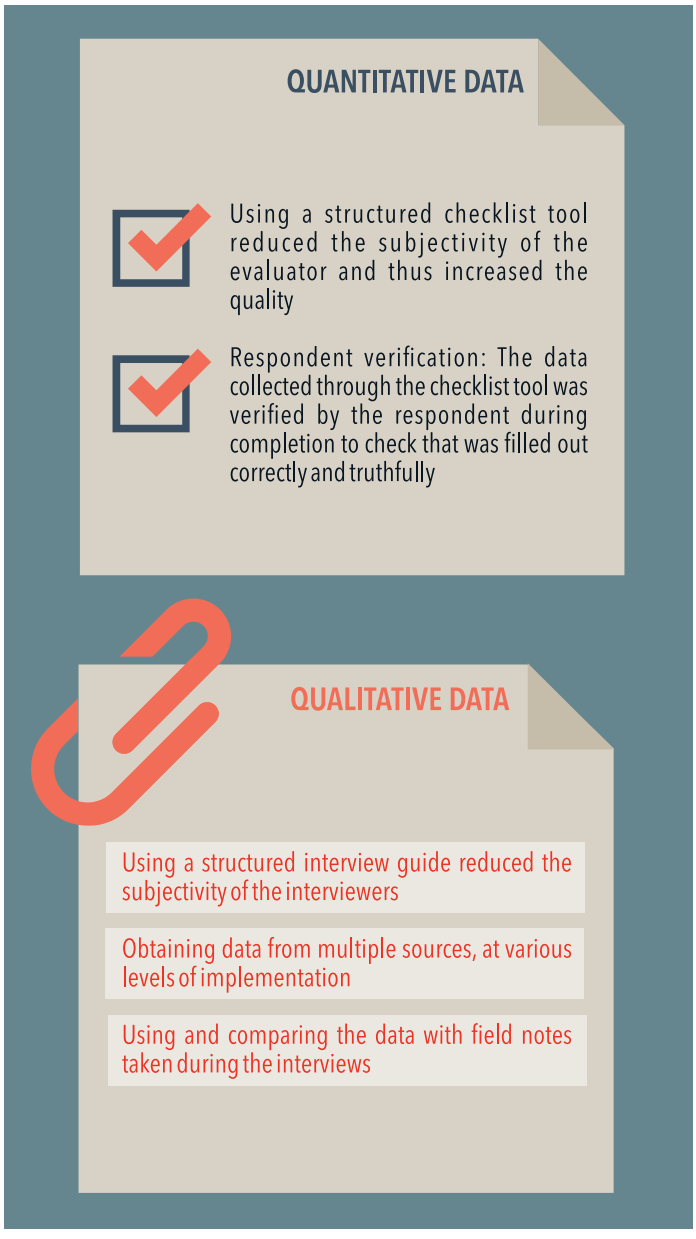
Pattern coding, as Second Cycle coding method, was then used to categorise similarly coded data (Saldaña, 2009). In the Pattern coding method, the First Cycle codes are assessed for commonalities. These commonalities consequently became the Pattern codes that assisted in the development of major themes.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

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

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

6. Data verification and quality assurance

Data verification procedure



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

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

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

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

7. Ethics

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

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

7.1. Respect for persons

According to the Belmont Report, respect for persons has at least two ethical stances. Firstly, participants should be given the opportunity to act autonomously and be capable of deliberation. Secondly, those who cannot act autonomously, such as the mentally handicapped, should be protected (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979).

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

7.2. Beneficence

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

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

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

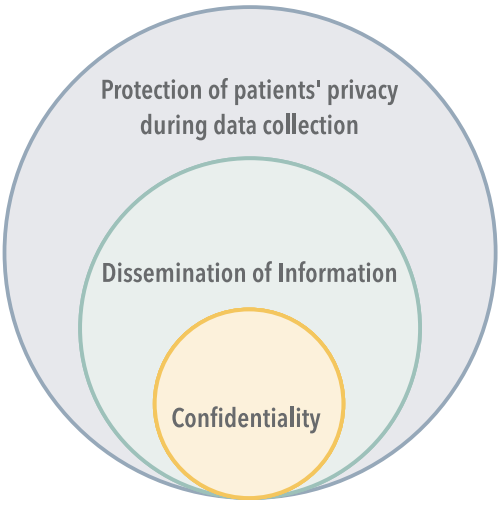
7.3. Justice

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

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

7.4. Other aspects

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



Confidentiality

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

Dissemination of Information

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

Protection of patients' privacy during data collection

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

- Visits to the facilities took place on a day that had been agreed to by the Facility Manager. They were responsible for notifying the staff in the facility/department that the rapid assessment would be taking place on that day.
- The clients who present at the facility on that day were notified that a Rapid Assessment was taking place and that a researcher would be there, but that they were not there to talk or interact with them.
- The researchers had a name badge identifying themselves as a researcher from FPD.
- The researchers were sensitised to the environment of the post-violence care services at the facility and ensured that their presence did not infringe on the patients' care or privacy.
- The researchers were accompanied by the Facility Manager during the Rapid Assessment and only entered rooms that were not being used by clients at the time. Areas such as the waiting room and reception were avoided as much as possible.
- The interviews took place in a room that was not needed by the facility at the time, where privacy could be maintained.

8. Limitations

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

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

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

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

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

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

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

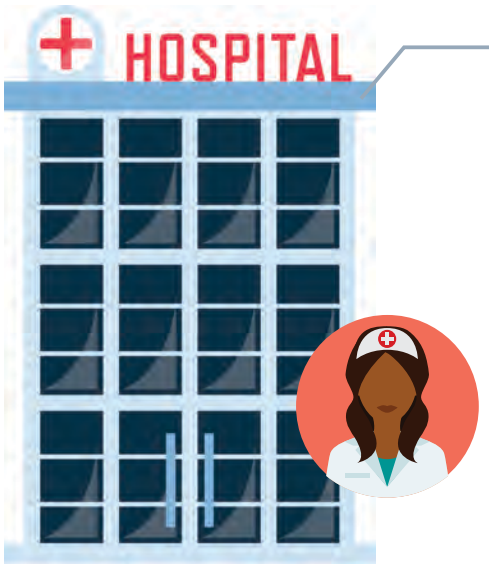
CHAPTER 4: FINDINGS: RAPID ASSESSMENT AND GAP ANALYSIS

CHAPTER 4:
FINDINGS:
RAPID ASSESSMENT AND GAP ANALYSIS

The CoJ Region A rapid assessment and gap analysis findings are divided into two sections. Section 1 is a summary of the general findings of all facilities in CoJ Regions A, D, E and G. This is based on the key informant interviews as well as the survey of 73 facilities. Data were collected from 73 facilities across Region A (14 facilities), D (26 facilities), E (10 facilities) and G (23 facilities) of Johannesburg. Overall, there were 64 primary health clinics (PHCs), 8 community health clinics (CHCs) and 1 hospital. Section 2 is specific to the findings of Region A and is region specific and provide a general overview of the region.

1. City of Johannesburg general findings

Facilities included in data collection



Region D
Bheki Mlangeni Hospital - *Provincial Health Unit*

Region D
Chiawelo CHC - *Provincial Health Unit*
Itireleng CHC - *Provincial Health Unit*
Lilian Ngoyi CHC - *Provincial Health Unit*
Mofolo CHC - *Provincial Health Unit*
Zola CHC - *Provincial Health Unit*
(Zamokuhle Medico-Legal Clinic)

Region E
Alexandra Health Centre - *NGO**

Region G
Lenasia Ext 10 - *Provincial Health Unit*
Lenasia South CHC (TCC) - *Provincial Health Unit***

Region A

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

Region D

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

Region E

4th Avenue Clinic - *Local Authority*
Alexandra 8th Avenue Clinic - *Local Authority*
Alexandra East Bank Clinic - *Local Authority*
Bez Valley Clinic - *Local Authority*
Petervale Clinic - *Local Authority*
Rosebank/Randburg Clinic - *Local Authority*
Sandown Clinic - *Local Authority*
Thoko Mngoma Clinic - *Local Authority*
Wendywood Clinic - *Local Authority*

Region G

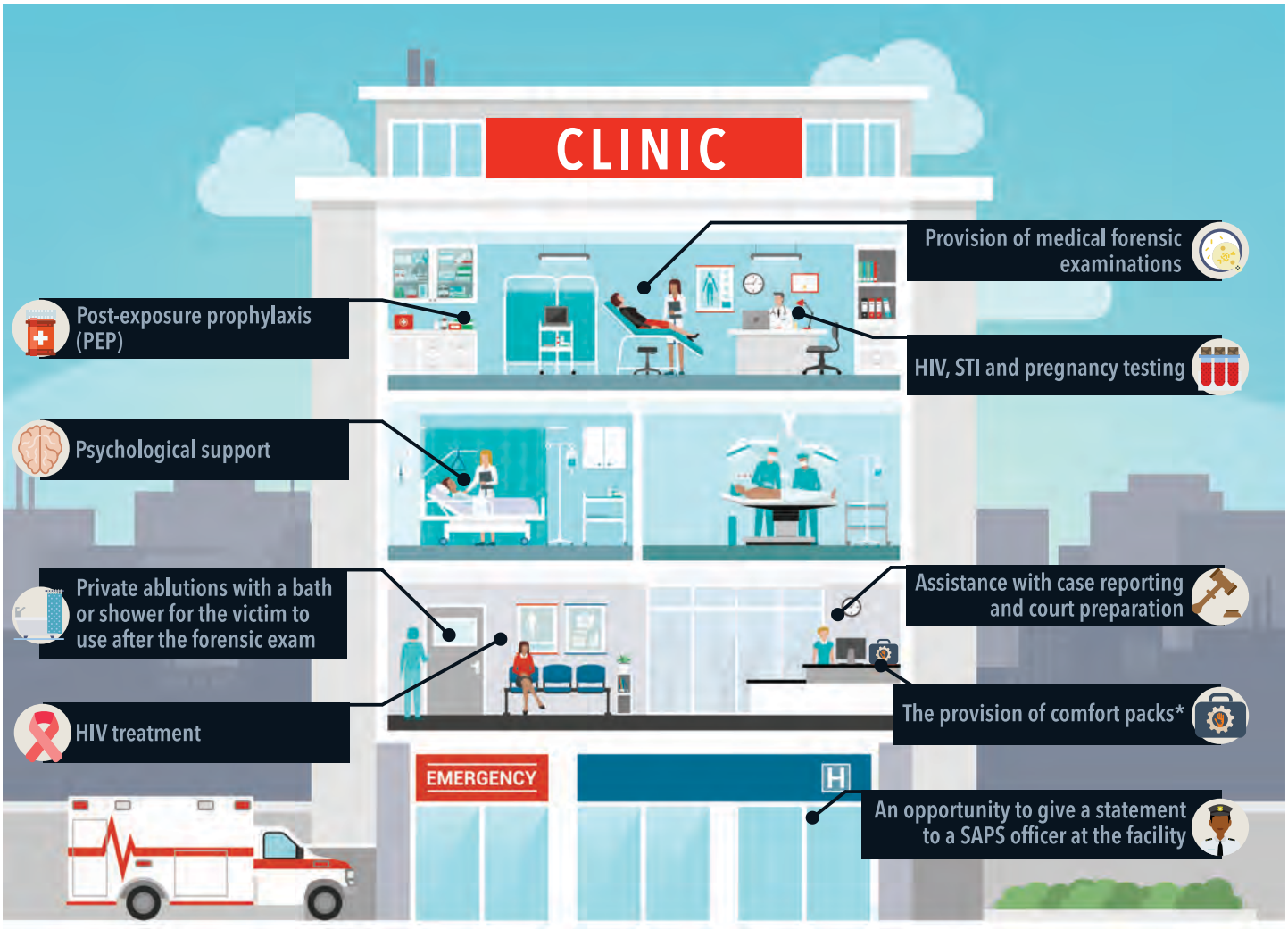
Eldorado Park Ext 9 - *Local Authority*
Ennerdale Ext 8 Clinic - *Local Authority*
Freedom Park Clinic - *Local Authority*
Lawly 1 Clinic - *Local Authority*
Lawly 2 Clinic - *Local Authority*
Lenasia South Civic Clinic - *Local Authority*
Mid Ennerdale Clinic - *Local Authority*
Mountainview Clinic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

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

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

1.1. Findings on post-violence care services

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



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

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

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

"…I don't think that there's been an increase as such…"
– Key informant - facilities

"…we don't have a high rate of sexual assault."
– Key informant - facilities

"Because we don't report. We don't have statistics."
– Key informant - facilities

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

"I feel that maybe there is more hidden cases…"
– Key informant - facilities

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

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

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

Services provided in CoJ (Regions A, D, E and G)

19.18%
Assistance with case reporting and court preparation

69.86%
HIV treatment

63.01%
Post-exposure prophylaxis (PEP)

69.86%
HIV, STI and pregnancy testing

42.47%
Psychological services

9.59%
Opportunity to give a statement to SAPS

4.11%
Provision of comfort packs

9.59%
Private ablutions with bath/shower and toilet

2.74%
Medical forensic exam

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

"I should think we can provide it until the patient is referred."
– Key informant – facilities

"…we wouldn't have any objections to provide the services."
– Key informant – facilities

"We just write a referral letter, take the history from the person, then we refer…"
– Key informant – facilities

"…we need people who are trained for that."
– Key informant – facilities

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

"If a patient comes in they are given priority because we normally know that she *[sic]* has been assaulted…"
– Key informant – facilities

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

"…with sexual violence we don't actually treat them we just refer them to hospital…"
– Key informant – facilities

"No, because they need to be examined first."
– Key informant – facilities

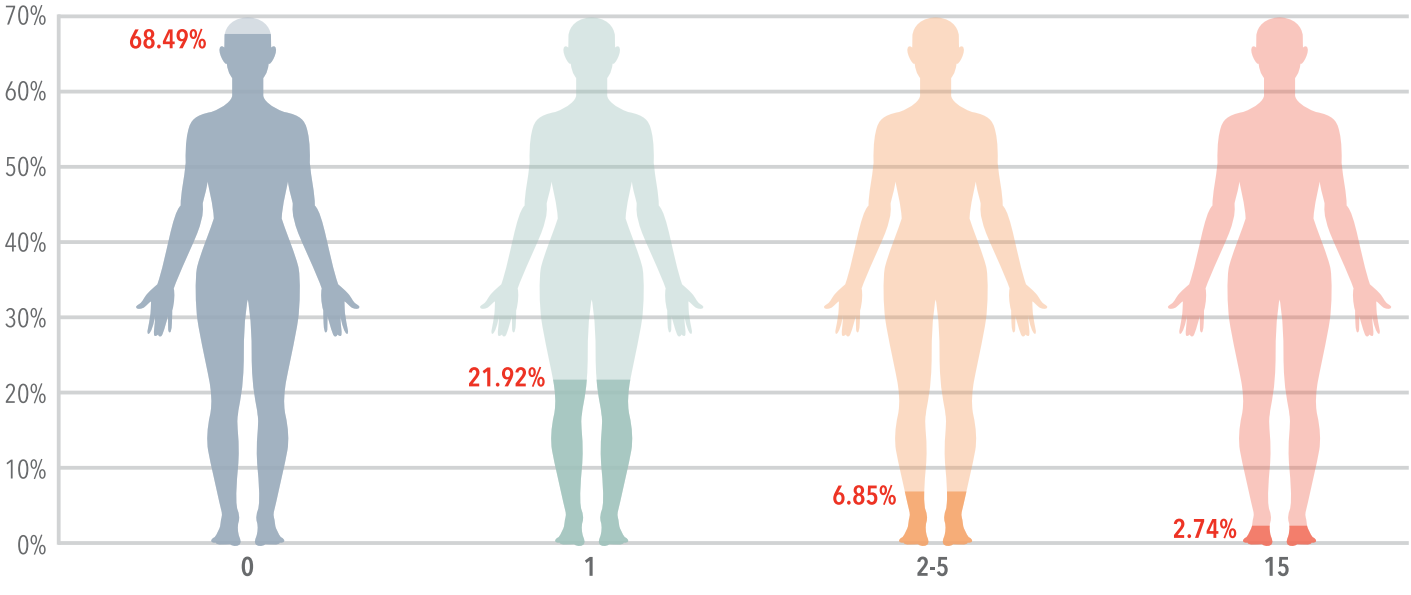
"Remember, as far as I know we shouldn't even tamper with that patients, with the evidence. So we wouldn't even start saying let's examine you then we can refer you. The minute the patient says then you refer so that you don't tamper with the evidence."
– Key informant – facilities

Number of sexual assault cases per week

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

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

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



1.2. Findings on referral pathways

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

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

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

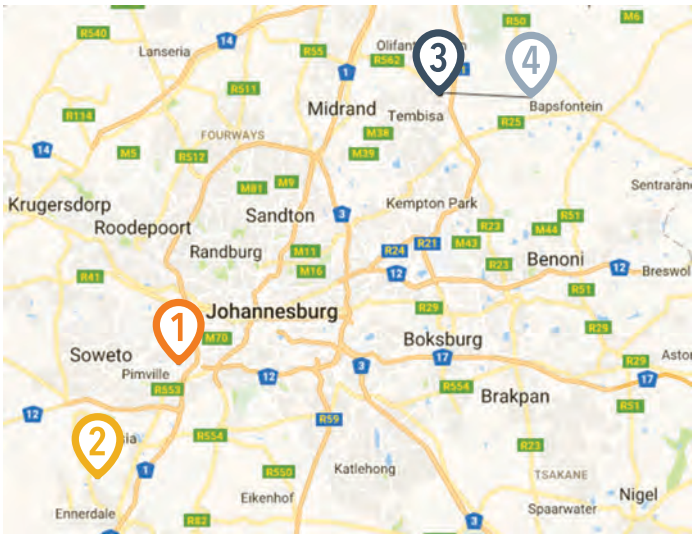
Facilities that receive referrals for post violence care

REFERRAL FACILITY	# facilities that refer
Chris Hani Baragwanath Hospital *(Nthabiseng TCC)**	1 — 19
Lenasia South CHC *(Lenasia TCC)*	2 — 16
Tembisa Hospital *(Masakhane TCC)**	3 — 10
Zola CHC *(Zamokuhle Medico-Legal Clinic)*	4 — 10
Bheki Mlangeni Hospital	7
Alexandra Health Centre	5
Chiawelo CHC	5
Lillian Ngoyi CHC	4
Rahima Moosa Hospital *(children)**	3
Helen Joseph Hospital *(adults)**	3
Leratong Hospital*	3
Hillbrow CHC*	2
Stretford CHC *	2
Dobsonville CHC*	1
Orlando Clinic*	1
Thembelihle Clinic	1
Charlotte Maxeke Hospital*	2
Edenvale Hospital*	1
Dr Yusuf Dadoo Hospital*	1
Discoverers CHC *	1

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

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

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



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

> "It's like you haven't done much and you won't know much about that. And you don't know how did your client--- How did it go - what was the end of it?"
> *– Key informant – facilities*

> "If we can get feedback of what happened to those clients at the end of the day."
> *– Key informant – facilities*

A key informant from Region G highlighted that the SAPS also assist with referrals.

> "…they will obviously go to a police station where they will be referred."
> *– Key informant – facilities*

1.3. Facilities and sites

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

Type of buildings

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

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

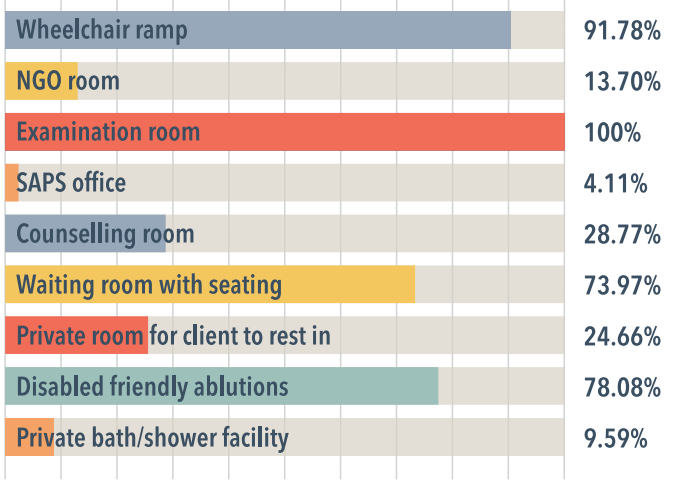
Permanent building	Park home
95.89%	4.11%

Facilities available

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

78% 91.78% 73.97% 100%

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



Equipment and supplies

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

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

- 76.71% *Educational and IEC materials*
- 5.48% *Anatomically correct dolls*
- 13.70% *Toys*
- 5.48% *Comfort packs*
- 10.96% *Clean clothes*
- 5.48% *Refreshments*
- 90.41% *Lockable cabinet*
- 100% *Fire extinguisher*
- 94.52% *Microwave*
- 100% *Fridge for medicine and bloods*
- 76.71% *Heaters*
- 86.30% *Aircon*
- 64.38% *Fans*
- 6.85% *Cameras for evidence*
- 75.34% *Email/Internet*
- 94.52% *Printer*
- 91.78% *Photocopier*
- 52.05% *Fax machine*
- 90.41% *Telephone*
- 100% *Computer*

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

> "…it is a very patchy system, there're some facilities that's under-resourced, and the staff is not sufficiently trained"…."and then there's well-resourced facilities."
> *– Key informant GBV expert*

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

61.64%	Lighting for forensic exam
100%	Sharps container
100%	Pregnancy testing kit
97.26%	Examination gloves
100%	Blood collection tubes
100%	Syringes, needles, etc.
94.52%	Examination room has lockable door
93.15%	Hand washing facility in examination room
80.82%	Gowns
89.04%	Clean bed linen
27.40%	Gyneacological couch
98.63%	Speculums
75.34%	Sterilising equipment
12.33%	Colposcope
97.26%	Blood Pressure monitor
80.82%	Measuring boards for infants
94.52%	Children/infant scale
95.89%	Scale and height measures for adults

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

Space

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

"We are just packed most of the time in one area…"
– Key informant – facilities

"We need an emergency room that is separate…"
– Key informant – facilities

"Space is a major challenge, the space is just too small, and for a counselling set-up you need confidentiality and privacy"
– Key informant – NGO

"…we need maybe a special room just for post-violence cases…"
– Key informant – facilities

"…if we can have a space specifically for that service so that we know that when they come in they don't get to wait in the queue with the rest of the people…"
– Key informant – facilities

Days and hours of service

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

DAYS THAT FACILITIES ARE OPEN IN CoJ (Regions A, D, E and G)

Mon - Sat	21.92%
Mon - Fri	71.23%
7 days a week	6.85%

OPEN HOURS OF FACILITIES IN CoJ (Regions A, D, E and G)

24hours	2.74%
07:00 - 16:00	30.14%
07:30 - 16:00	63.01%
08:00 - 16:00	2.74%
08:00 - 18:00	1.37%

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

"Usually it's at night…" *– Key informant – facilities*

"…during holidays…" *– Key informant – facilities*

"…that December time you know summer time that's where most of [inaudible 00:03] yah that's where we expect that…"
– Key informant – facilities

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

> "…there's a specific nurse, at a certain time, in the afternoon mainly, who provide family planning on a specific day, so it is not every day."
> *– Key informant – NGOs*

Waiting time

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

> "…we are still experiencing [sic] high influx of clients."
> *– Key informant – facilities*
>
> "…according to the head count that we see on the monthly basis we supposed to have at least minimum eight professional nurses but then I have five now…"
> *– Key informant – facilities*

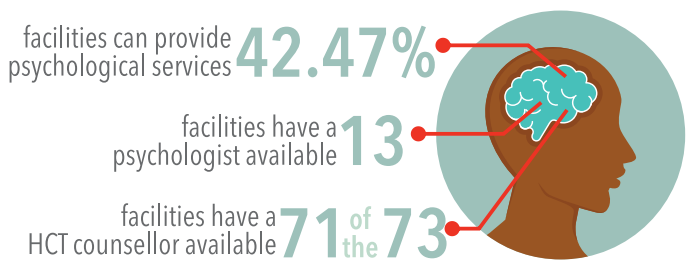
Accessibility

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

> "They don't qualify for the ambulance."
> *– Key informant – facilities*
>
> "…somebody can say to you I don't have money for transport…"
> *– Key informant – facilities*
>
> "…there's no transport…" *– Key informant – facilities*

Psychosocial support

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



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

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

1.4. Factors influencing quality of services delivered

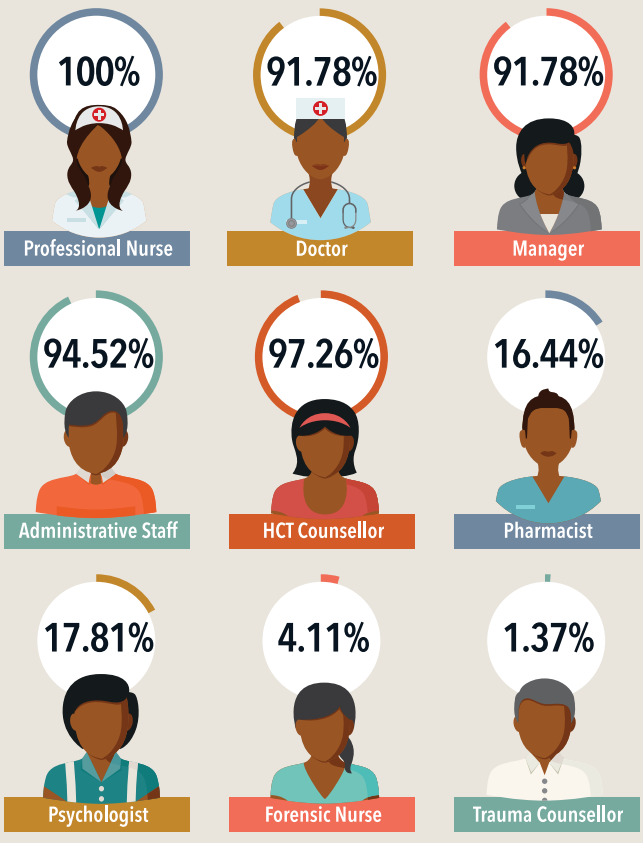
As per the discussion in Section 1.1, most facilities provide most of the services expected from a public health facility, and some have the ability to provide some post-violence care services. However, although the services are available, it is the quality of those services that is the challenge. The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

Human resources

Staff available

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

STAFF AVAILABLE IN CoJ (Regions A, D, E and E)



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

> "…we also need a doctor, a sister and a doctor to do that service."
> *– Key informant – facilities*

> "…we can complain of staff shortage – that is everywhere…"
> *– Key informant – facilities*
>
> "…we don't have doctors coming every day Monday to Friday, so we find most of the time there's no doctor within the clinic…"
> *– Key informant – facilities*

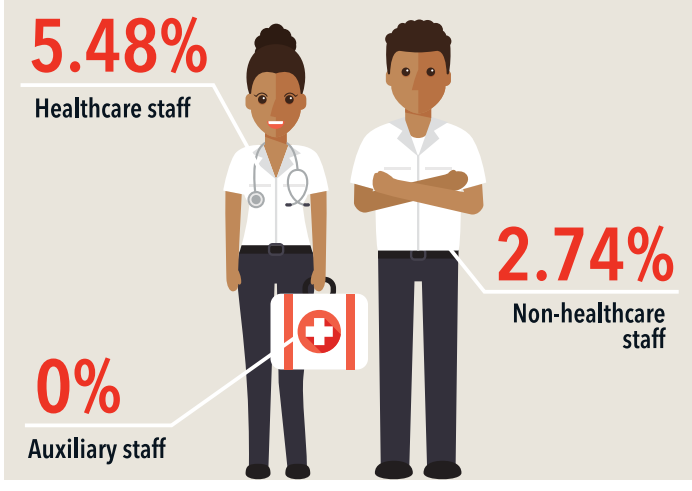
A key informant mentioned that there are enough staff at facilities, but that they are not ready to deal with post-violence care.

> "We need people, not just warm bodies"…"they must be properly trained on post-violence care"
> *– Key informant – NGO*

Training of staff

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

STAFF WHO HAVE RECEIVED REFRESHER TRAINING IN POST-VIOLENCE CARE IN COJ (REGIONS A, D, E AND G)



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

"…but in terms of training all the staff I think that's something that need to be done…"
– Key informant – facilities

"…we need maybe to be trained…" *– Key informant – facilities*

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

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

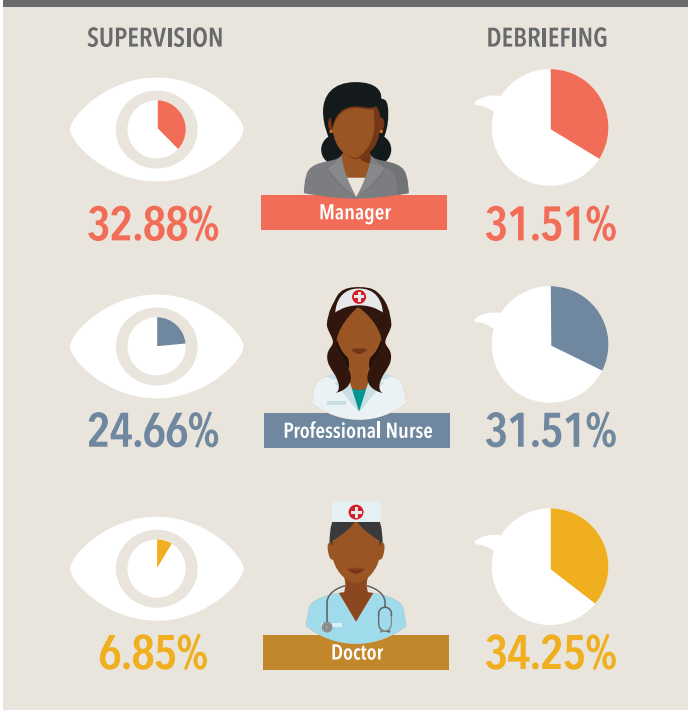
"Because there was no proper training, nobody is really sensitised about dealing with it…"
– Key informant – facilities

"…there were people who work at SAPS and I think these people are not sensitised…"
– Key informant – facilities

Staff supervision and debriefing

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

SUPERVISION AND DEBRIEFING OF STAFF IN COJ (REGIONS A, D, E AND G)

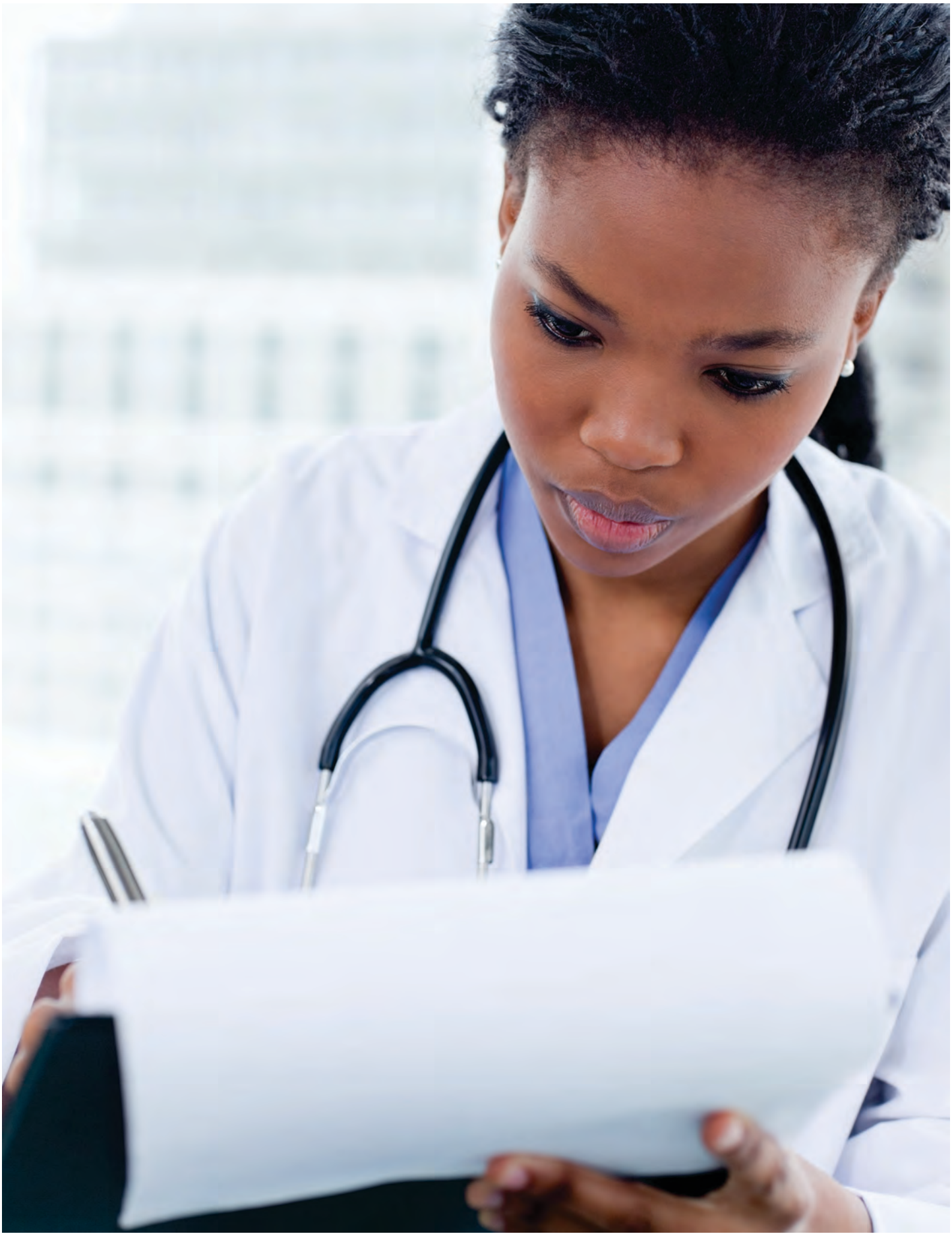


A key informant highlighted that staff in public health facilities are not getting adequate emotional support.

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

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

"Caregivers need care" *– Key informant – GBV expert*



1.5. Victim friendliness and secondary victimisation

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

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

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

"…you know at the clinics, people wait quite long as well…"
– Key informant – facilities

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

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

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

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

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

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

1.6. NGOs as service providers

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

NGOs providing PHC services

Witkoppen Health and Welfare Centre

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

Alexandra Health Centre

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

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

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

AIDS Healthcare Foundation

- HIV Programme support
- HIV/AIDS advocacy

ANOVA

- HIV Programme support
- CCMDT
- Training

CaSIPO (Care and Support to Improve Patient Outcomes)

- HIV Programme support
- Strengthening referral systems

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

- Counselling
- Social Work

Eldorado Park Women's Forum

- Psychosocial support
- Awareness in the community

Hands of Compassion

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

Ikhaya Lothando Community Centre

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

Ikusasa Lethu Youth Project

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

JISS (Johannesburg Institute of Social Services)

- Gender-based violence
- Child and Family Care Units
- OVC support

Jozi Ihlomile

- Awareness campaigns about HIV/AIDS
- Support HIV and TB programmes

Khomanani Campaign

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

Ladies of Hope

- Home-based care
- Counselling
- Feeding scheme

LifeLine

- Counselling

Midrand Association for Home Based Care

- Home-based care
- HCT
- HIV support group
- TB treatment services
- OVC support
- Support for survivors of abuse and rape

New Start

- HCT
- Medical male circumcision
- Parenting support

Nisaa Institute for Women's Development

- Raising public awareness about GBV
- Staff training
- Counselling

Nompilo Home Based Care

- Social services
- Counselling
- Staff training
- HIV/AIDS support

Philani Maternal, Child Health and Nutrition Project

- Support pregnant mothers
- OVC support

PUSH (Persevere Until Something Happens)

- Support HIV+ children and OVCs
- Psycho-social services

Right to care

- HCT services
- Support staff (data capturers)
- Training staff
- Support HIV/AIDS programmes
- Family planning services
- Medical Male Circumcision

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

- Alcohol and drug abuse or dependence

Thibologa Sign Language Institution

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

Ububele

- Early childhood development programmes
- Provide training in early childhood development
- Psychosocial support

Usizo Thuso Community Centre

- Support HIV+ children and OVCs
- Psycho-social services

Witkoppen Health and Welfare Centre

- PHC services

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

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

"…deal with the emotional well-being and the psychological well-being of the person…"
– Key informant – facilities

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

"…usually they come in and help us with the clubs that we are organising at the moment."
– Key informant – facilities

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

"It's so much. The NGO [sic] gives total care to our clients…"
– Key informant – facilities

"…they identify something and they feel that there is a need to refer that patient then [sic] they come and communicate to you…"
– Key informant – facilities

"They've actually helped us to cut the waiting time for patients."
– Key informant – facilities

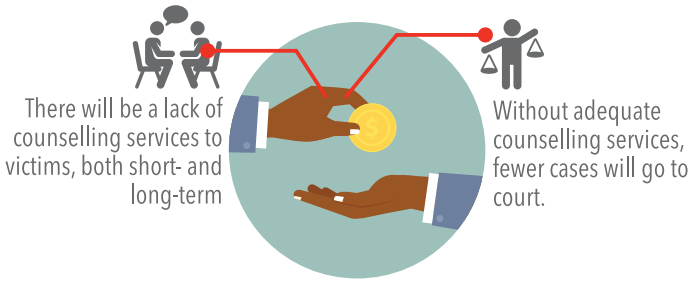
In general, the relationships between the facilities and the NGOs are good, but participants highlighted the value of good communication strategies between the NGOs and the facilities. There were facilities that had challenging experiences with stakeholders such as the NGOs. For example, the NGOs would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

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

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

"NGOs are delivering services that the government should, but can't…"
– Key informant – GBV Expert

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

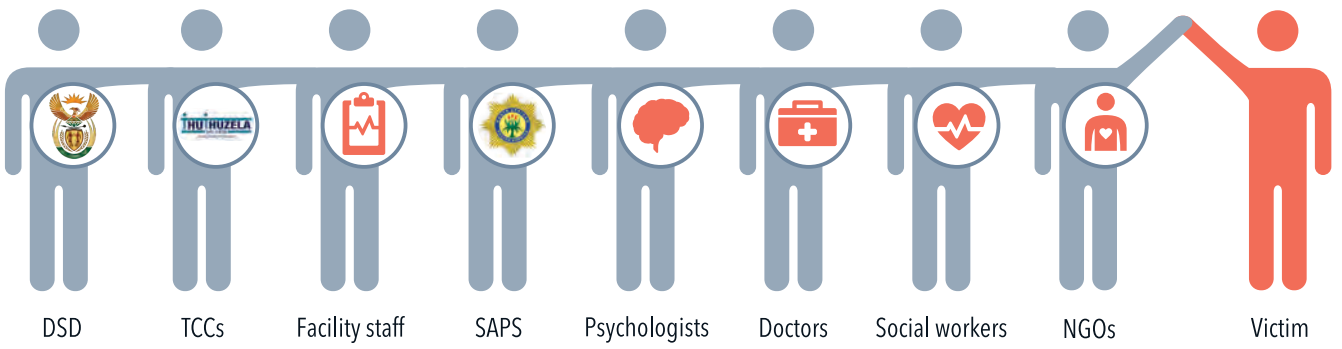


One key informant mentioned that NGOs are have a high turnover of social workers, as they cannot compete with government salaries.

> "You're working in an uncertain environment, now the funding is finished, and then they extend again. You can't put the lives of women on hold".
> *– Key informant – NGO*

1.7. Other stakeholders

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



"I will say like communication – like whoever that we are referring, let us get a feedback…"
– Key informant – facilities

"I think you've just go to work together as a team…"
– Key informant – facilities

"…the police also need to come to the party be part of a parcel [sic] like this…"
– Key informant – facilities

"I need to have a direct number of Thuthuzela where I know am not going through the switchboard to communicate with somebody indirectly…"
– Key informant – facilities

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

"There's just so much petty politics…"
– Key informant – GBV expert

1.8. Overall findings

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

OPENING TIMES			
Facility is open 24 hours a day	2	out of 73	2.74%
Facility is open 7 days a week	5	out of 73	6.85%
Facility is open Monday to Friday	52	out of 73	71.23%
Facility is located in a permanent building	70	out of 73	95.89%
Facility is located in a park home	3	out of 73	4.11%
Average number of Sexual Offence cases per week	0.88	out of 73	--
Average waiting time of 45 minutes	58	out of 73	79.45%

SERVICES PROVIDED			
Medical Forensic Examination	2	out of 73	2.74%
Bath or shower facility	7	out of 73	9.59%
Provision of comfort packs and clean clothes	3	out of 73	4.11%
Statement taken by a SAPS investigating officer	7	out of 73	9.59%
Psychological services	31	out of 73	42.47%
HIV, STI and pregnancy testing	51	out of 73	69.86%
Provision of post-exposure prophylaxis	46	out of 73	63.01%
Referral for HIV treatment	51	out of 73	69.86%
Assistance with case reporting and court preparation	14	out of 73	19.18%

FACILITIES AVAILABLE			
Private ablutions with bath or shower	7	out of 73	9.59%
Disabled-friendly ablutions	57	out of 73	78.08%
Private room for victims to rest in	18	out of 73	24.66%
Waiting room	54	out of 73	73.97%
Counselling office	21	out of 73	28.77%
SAPS office	3	out of 73	4.11%
Examination room	73	out of 73	100%
NGO room	10	out of 73	13.70%
Wheelchair ramp	67	out of 73	91.78%

EQUIPMENT AVAILABLE			
Computers	73	out of 73	100%
Telephones	65	out of 73	90.41%
Fax machines	38	out of 73	52.05%
Photocopiers	67	out of 73	90.41%
Printers	69	out of 73	94.52%
Internet	55	out of 73	75.34%
Camera for evidence	5	out of 73	6.85%
Fans	47	out of 73	64.38%
Air conditioner	63	out of 73	86.30%
Heater	56	out of 73	76.71%
Fridges	73	out of 73	100%
Microwave ovens	69	out of 73	94.52%
Fire extinguishers	72	out of 73	98.63%
Lockable cabinet	66	out of 73	90.41%
Refreshments for victims	4	out of 73	5.48%
Clean clothing	8	out of 73	10.96%
Comfort packs	4	out of 73	5.48%
Toys	10	out of 73	13.70%
Anatomically correct dolls	4	out of 73	5.48%
IEC material	56	out of 73	76.71%
Adult height and weight measures	70	out of 73	95.89%
Children's scale	69	out of 73	94.52%
Childrens measuring board	59	out of 73	80.82%
BP monitors	71	out of 73	97.26%
Syringes, needles, sterile swabs	73	out of 73	100%
Blood collection tubes	73	out of 73	100%
Examination gloves	71	out of 73	97.26%
Sharps container	73	out of 73	100%
Lighting for examination	45	out of 73	61.64%
Gynaecological couch	20	out of 73	27.40%
Speculums	72	out of 73	98.63%
Colposcope	9	out of 73	12.33%
Gown for victim	59	out of 73	80.82%
Clean bed linen	65	out of 73	89.42%

STAFF (FULL/PART TIME)		
Department/ Facility Manager	67 out of 73	91.78%
Professional Nurse	73 out of 73	100%
Forensic Nurse	3 out of 73	4.11%
Doctor	67 out of 73	91.78%
Administrative staff	69 out of 73	94.52%
Trauma Counsellor	1 out of 73	1.37%
HCT Counsellor	71 out of 73	97.26%
Psychologist	13 out of 73	17.81%
Pharmacist	12 out of 73	16.44%
TRAINING IN PROVIDING POST-VIOLENCE CARE		
Healthcare Staff	4 out of 73	5.48%
Non-healthcare Staff	2 out of 73	2.74%
Auxiliary Staff	0 out of 73	0.00%
FACILITIES WITH AN NGO		
Facilities with an NGO	34 out of 73	46.58%

2. City of Johannesburg Region A findings

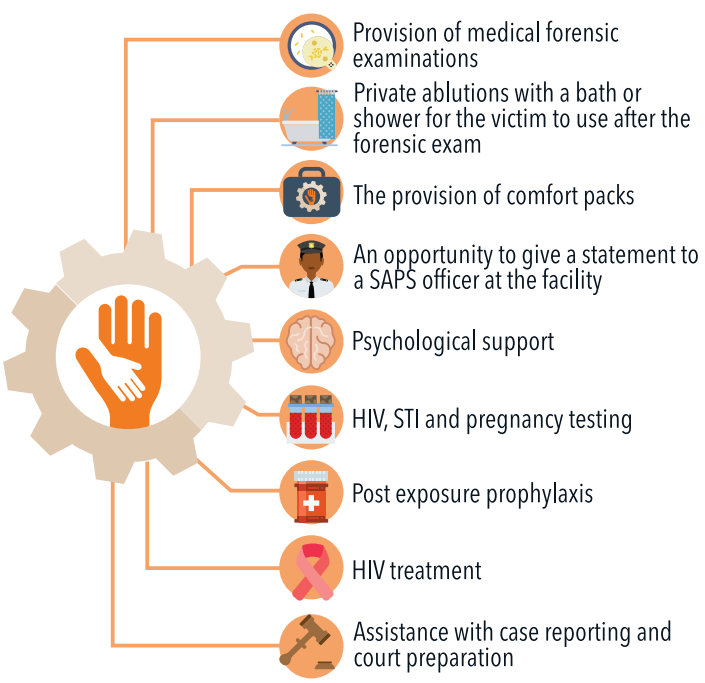
Facilities included in data collection

Region A

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

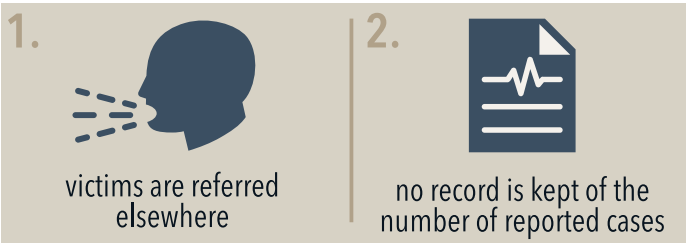
2.1. Findings on post-violence care services

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



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

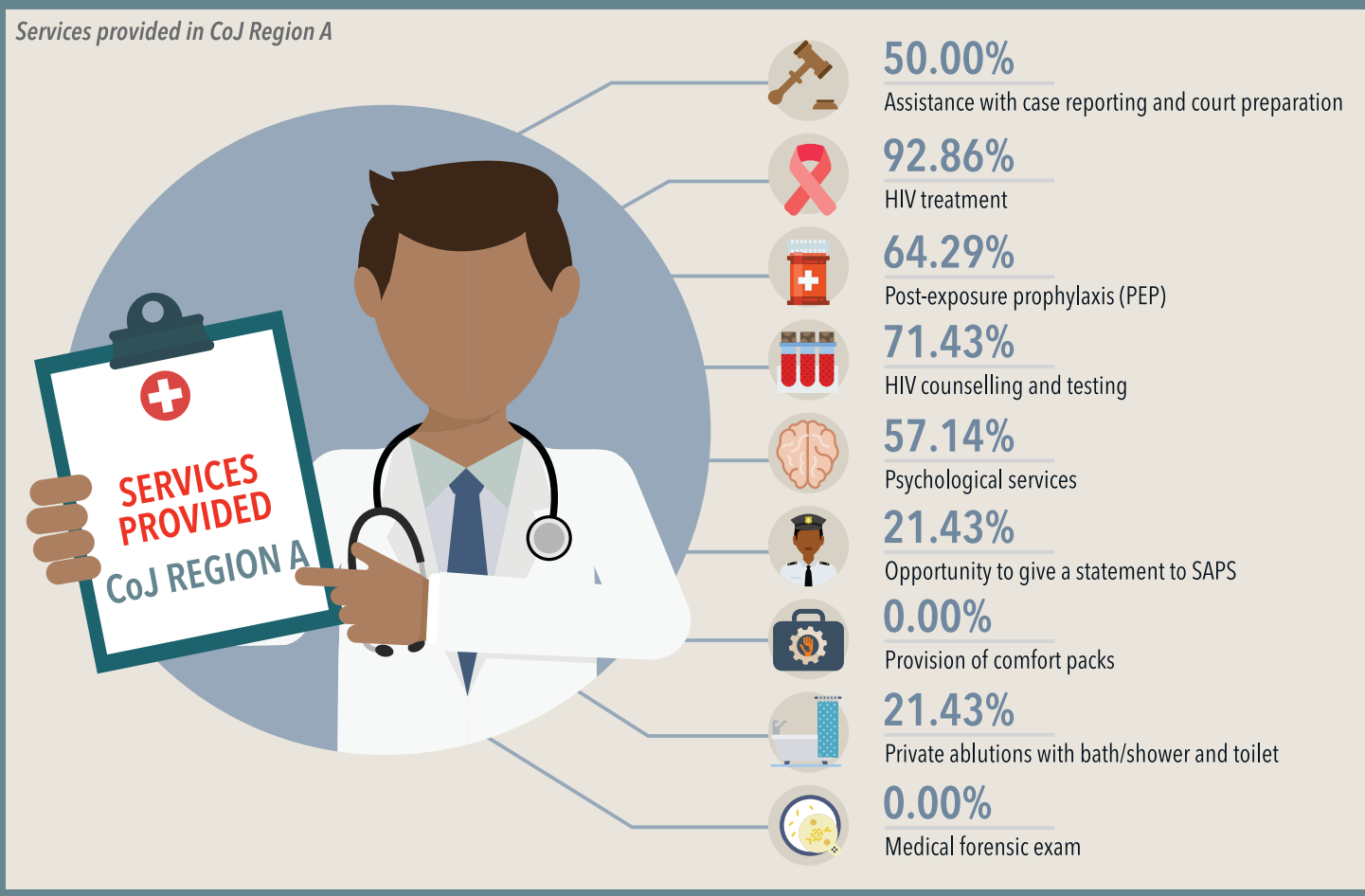
The research team attempted to find out the perceived need for post-violence care services for victims of sexual assault. With a few exceptions, the participants were not aware of an increase in cases of sexual assault. One possible reason for this is that victims are referred elsewhere because the facilities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



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

None of the facilities in Region A provide the medical forensic examination, nor do they provide comfort packs and clean clothes. Only 21.43% (3 facilities) offer bath or shower facilities. In addition, 21.43% (3 facilities) provide the opportunity for an SAPS investigating officer to take a statement. More than half of facilities, 57.14% (8 facilities) provide psychological services. Almost three quarters of facilities, 71.43% (10 facilities) provide HIV, STI and pregnancy testing; 64.29% (9 facilities) provide post-exposure prophylaxis; and 92.86% (13 facilities) provide referral for HIV treatment. Half (7) of facilities are able to assist with case reporting and court preparation. It is noteworthy that this is self-reported. In total, there are eight facilities that indicate that they can provide psychosocial support, but only one facility (Witkoppen Clinic) indicated that they have a part-time psychologist. It is possible that this service is provided by NGOs linked to the facilities.

Services provided in CoJ Region A



From the interviews the research team found that facilities provide the above services to clients in general, but all 14 refer victims of sexual violence to other facilities. The main reasons why the attending staff were referring the clients elsewhere were a lack of forensically trained staff and a lack of equipment and supplies. Some participants thought that their facilities should provide the full range of care available at their facilities to victims of sexual assault. Another very interesting finding was that NGOs working in the region reported that, although PEP is available at facilities, it is used for needle-prick injuries for staff, and not for post-violence care. The research team could not confirm this.

Number of sexual assault cases per week

Five facilities reported seeing one case of sexual assault per week on average. These facilities were:

The remaining nine facilities reported that they don't see any cases of sexual assault. The average across facilities in Region A is 0.35 cases of sexual assault per week. It is important to note that facilities highlighted that this is an average number, as the number of cases differ from week to week. Facilities who do not provide forensic investigation services are not required to record the cases that present at the facilities, and this can also influence the findings. A key informant from an NGO mentioned that they have seen a big increase in sexual assault cases referred to them since mid-2016. One facility highlighted that they see more sexual assault cases during the December holiday period, and two that most of the victims are children and teenagers.

Facilities that receive referrals for post-violence care

REFERRAL FACILITY		Region
CHILDREN: Rahima Moosa Hospital	1	B
ADULTS: Helen Joseph Hospital	2	B
Dr Yusuf Dadoo Hospital	3	West Rand (Mogale City)
Masakhane TCC, Tembisa Hospital	4	Ekurhuleni North

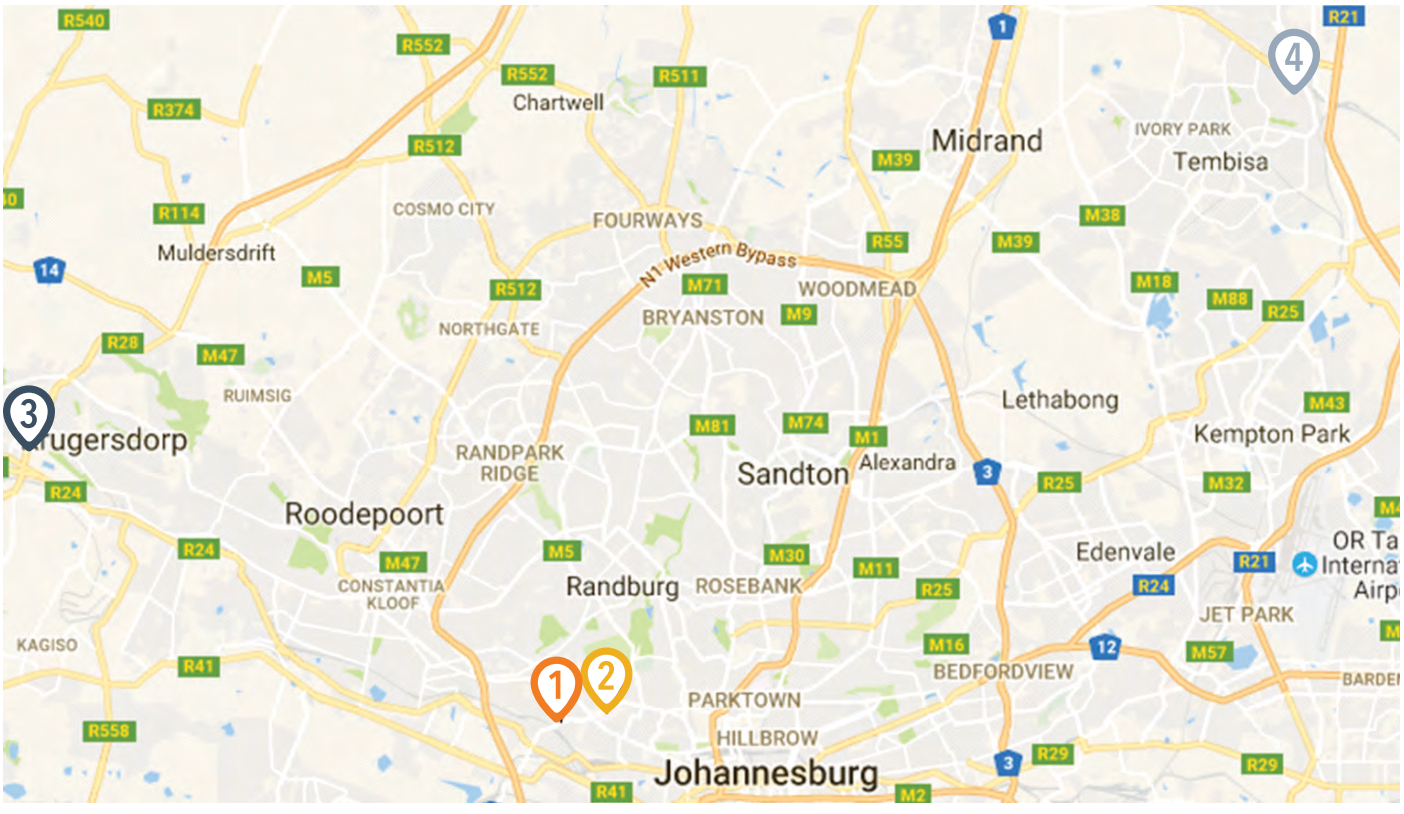
2.2. Findings on referral pathways

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

As there are no facilities in Region A that can conduct forensic investigations, all clients are referred to facilities outside Region A. Children are mainly referred to Rahima Moosa Mother and Child Hospital, and adults are referred to Helen Joseph Hospital, Dr Yusuf Dadoo Hospital and Tembisa Hospital (Masakhane TCC). The TCC provide the full package of post-violence care services (FPD, 2016).

None of these facilities were included in the data collection – they were only reported as facilities where victims are referred for post-violence care. However, during the TCC compliance audit and gap analysis, it was found that Masakhane TCC provides most post-violence care services. It is important to note that many respondents within facilities mentioned that they refer to a TCC. This is an important finding, as it highlights that facilities are aware of the TCCs and their role in the provision of post-violence care. Some key informants mentioned that the TCCs do not have a direct telephone line, and that they need to call the hospital's switchboard and be transferred to the TCC. This process often fails.

Map of CoJ Region A referrals



The referral pathways for Region A is a major problem, because victims need to travel long distances to the referral facilities. This is hampered by access to transport and leads to secondary victimisation. A number of respondents at facilities highlighted that distance to facilities, access to transport and money for transport is a major concern when they refer victims to other facilities.

> "…think about it, from Region A you have to travel to that side. Do you think I will even go if I was a patient?"
> *- Key informant - NGO*

Importantly there are existing referral pathways among the NGOs as well. One key informant highlighted that their organisation refer clients to other NGOs for psychosocial support services, and they also receive referrals from other NGOs. Victims of sexual violence may also present at NGOs as a first response, so NGOs created their own referral pathways. An NGO active in Region A refer victims to Discoverers CHC in Region C, as they have a post-rape care centre during the day. After hours victims are referred to the Nthabiseng TCC at Baragwanath (Region D) hospital or Hillbrow clinic (Region F).

> "If victims from Diepsloot are referred to Hillbrow, how are they supposed to get there? And the clock is ticking…"
> *– Key informant – GBV expert*

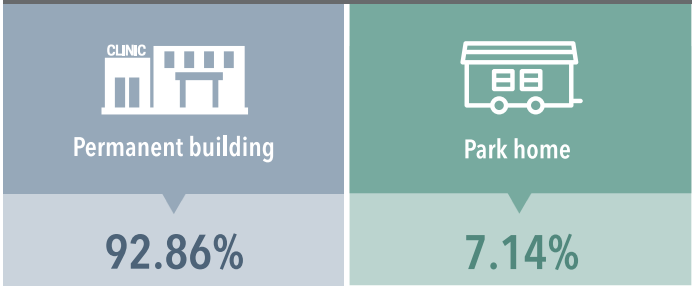
2.3. Facilities and sites

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

Type of buildings

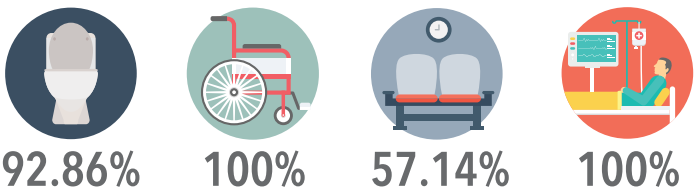
The majority (92.86%) of facilities are located in permanent buildings with only one in a park home.

LOCATION OF FACILITIES IN REGION A

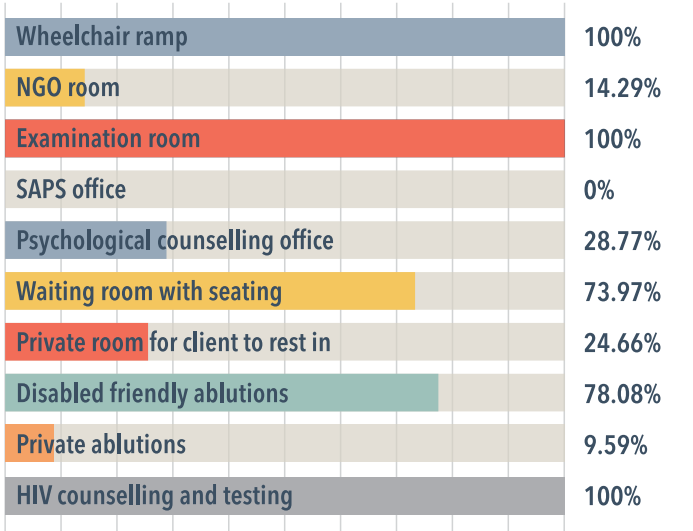


Facilities available

The majority of facilities in Region A have disabled-friendly ablutions (92.86%), wheelchair ramps (100%), waiting rooms with seating (57.14%) and examination rooms (100%).



FACILITIES AVAILABLE IN REGION A



Equipment and supplies

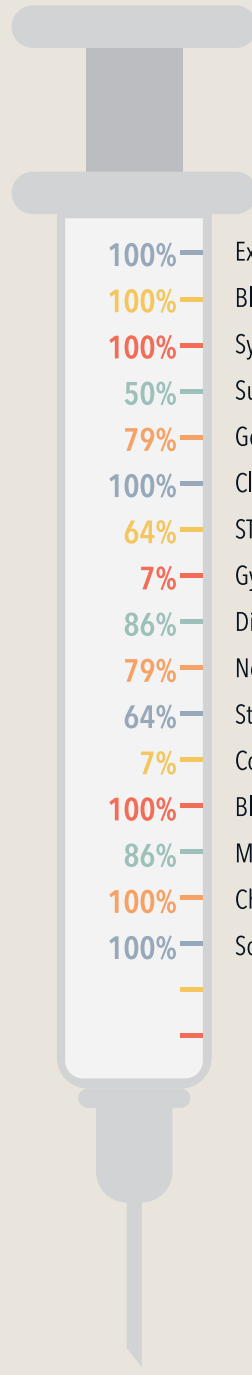
The majority of facilities in Region A have the general equipment necessary to run a clinic. However, specific to post-violence care, none of the facilities have comfort packs, clean clothing, refreshments or evidence cameras. Only four facilities (28%) had toys for children to play with while they are waiting.

GENERAL EQUIPMENT AVAILABLE IN REGION A FACILITIES

78.57% *Educational and IEC materials*	14.29% *Anatomically correct dolls*	28.57% *Toys*
0.00% *Comfort packs*	0.00% *Clean clothes*	0.00% *Refreshments*
92.86% *Lockable cabinet*	100% *Fire extinguisher*	100% *Microwave*
100% *Fridge for medicine and bloods*	57.14% *Heaters*	100% *Aircon*
50.00% *Fans*	0.00% *Cameras for evidence*	85.71% *Email/Internet*
92.86% *Printer*	100% *Photocopier*	57.14% *Fax machine*
92.86% *Telephone*	100% *Computer*	

All of the facilities had the general medical equipment needed for a healthcare facility (sharps container, syringes, needles, BP monitors, etc.). However, specific to post-violence care medical equipment only one facility (7%) has a gyneacological couch and a colposcope, 11 (79%) have speculums and only half (50%) have sufficient lighting to perform a medical examination. Some facilities have some of the medical equipment described in the TCC Blueprint and therefore have the ability to upscale post-violence care services.

MEDICAL EQUIPMENT AVAILABLE IN REGION A



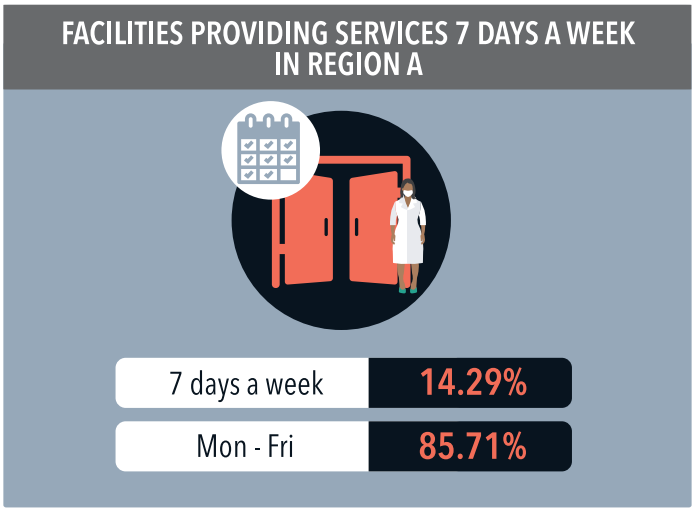
100%	Examination gloves
100%	Blood collection tubes
100%	Syringes, needles, swabs
50%	Sufficient lighting for forensic examination
79%	Gowns
100%	Clean bed linen
64%	STI kits
7%	Gyneacological couch
86%	Disposable speculums
79%	Non-disposable speculums
64%	Sterilising equipment
7%	Colposcope
100%	Blood pressure monitors
86%	Measuring boards for children
100%	Children/infant scale
100%	Scale and height measures for adults

Space

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

Days and hours of service

Only 14.29% of facilities are open 7 days a week. The remaining 85.71% are open from Monday to Friday. None of the facilities are open 24 hours a day – they are all open from 07:30 to 16:00. It is important to note that this is self-reported, as three key informants from two NGOs working in Diepsloot mentioned that the OR Tambo clinic in Diepsloot is functioning 24/7.

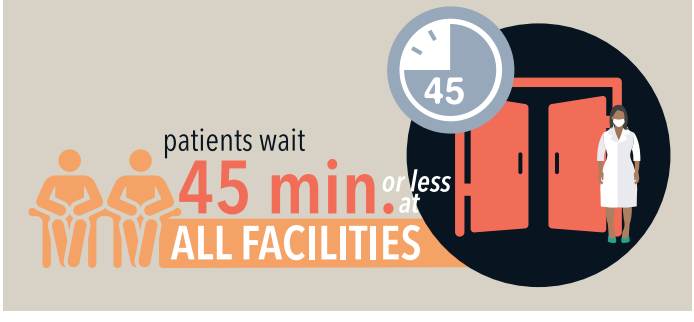


"…rape doesn't only happen during the day." – *Key informant – NGO*

Waiting time

All of the facilities reported that patients wait 45 minutes or less to see a healthcare worker. A high influx of patients was also reported to be a challenge at the facilities as this, combined with a lack of staff, increased the patient waiting time.

"…we are still experiencing [sic] high influx of clients."
– *Key informant – facilities*



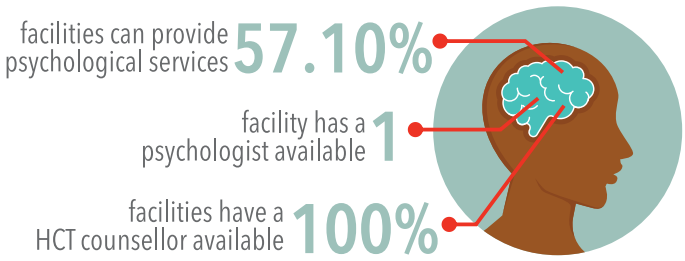
Accessibility

Accessibility to facilities that provide post-violence care services is an important factor in ensuring that the services are used by victims. Across and within regions, there are great variations in opening times, accessibility and awareness of the facilities that do provide the required services. There are victims who arrive at facilities not knowing that the facility in question does not offer forensic examination services; or, there are victims who report to police stations and are consequently referred to the nearest hospital or TCC. Victims who are not tended to immediately have to wait with other outpatients only to be referred to another facility. Not all victims have access to transport to attend the referral facilities. Ambulances are often reserved only for those with medical emergencies. A key informant from Region A reported that in their experience there is not adequate awareness of the post-violence care services delivered by various public health facilities, and this is negatively affecting access to services. A key informant from Region A also highlighted that adolescent girls struggle to access family planning services.

"…When a girl ask for family planning services, she's asked, whose family are you planning?"
– *Key informant – NGO*

Psychosocial support

Many facilities mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support. A total of 57.10% facilities indicated that they can provide psychological services within the facility but only one of the facilities has a psychologist available and none have a trauma counsellor available. It is likely that the psychosocial support is provided by social workers, counsellors and supporting NGOs. All facilities in the sample had an HCT counsellor available.



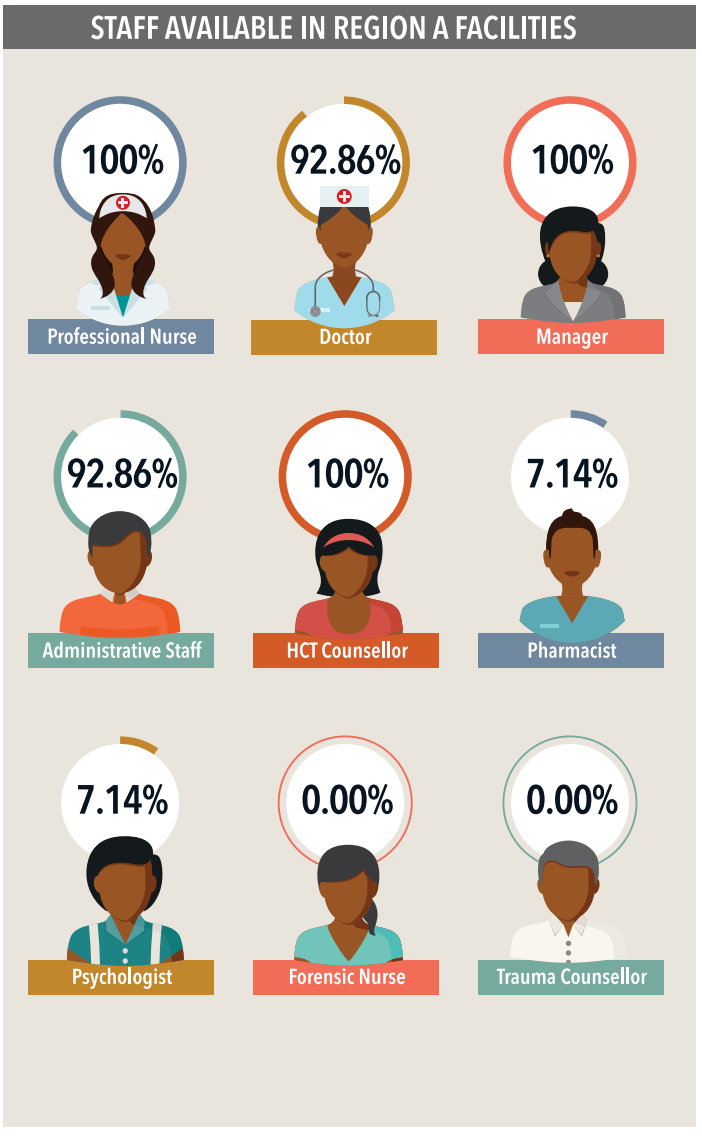
2.4. Factors influencing quality of services delivered

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

Human resources

Staff available

All of the facilities in Region A have a department or facility manager as well as at least one professional nurse. None of the facilities have forensic nurses or trauma counsellors. The majority of facilities have administrative staff and a doctor (92.86%). Only one facility had a psychologist and one a pharmacist (7.14%).

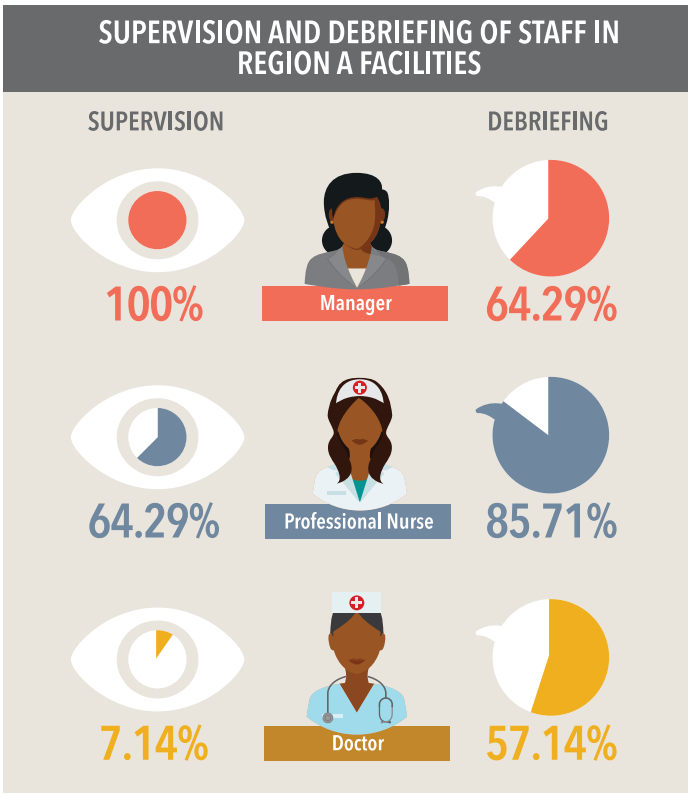


Training of staff

None of the healthcare staff, non-healthcare staff or auxiliary staff at any of the facilities have received training on post-violence care. It is important to note that this is self-reported, as FPD has been involved with training in Region A. A key informant from the region mentioned that doctors and forensic nurses need to be properly trained in completing the required legal documentation in the case of sexual violence (J88 form), as court cases have been struck of the roll due to incomplete J88 forms.

Staff supervision and debriefing

All facilities reported that the facility manager is supervised, 64.29% reported that their professional nurses are supervised and 7.14% that their doctors are supervised. Nine facilities reported that their facility manager receives debriefing (64.29%), 85.71% that their professional nurses receive debriefing and 57.14% that their doctors receive debriefing.



A key informant from region A mentioned that other stakeholders urgently need to have debriefing set up, such as SAPS and the personnel at NGOs to prevent and treat secondary trauma.

2.5. Victim friendliness and secondary victimisation

Victim friendliness is a major challenge for facilities. Most mentioned that victims may experience secondary victimisation as a result of the lack of victim friendliness of the environment. Auxiliary staff lack sensitivity when treating and receiving clients. Other factors that may influence victim friendliness include patient waiting time, the quality of the infrastructure, issues of privacy and stigma. A key informant from Region A mentioned that victims who present at facilities are not prioritised.

> "…No, it is not victim friendly. They first wait in a queue, and if you don't have a file you're going to sit in the queue for a long time."
> *– Key informant – NGO*

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

It was also highlighted that staff at facilities are not adequately trained on secondary victimisation and sensitisation, as well as which evidence to preserve in the case of sexual assault.

A key informant in the region highlighted that there are still judgmental and condescending attitudes from health staff at some facilities. The key informant mentioned that there are also cases of victim blaming from SAPS officers.

> "…a victim was told that she's ruining the perpetrator's life by reporting statutory rape and keeping the baby."
> *– Key informant – NGO*

2.6. NGOs as service providers

A total of 13 facilities (92.8%) reported that they have an NGO providing a service. The only facility that does not have an NGO is Witkoppen Health and Welfare Centre, but they are classified as an NGO funded by USAID. A total of 50% of facilities reported that they can assist with case reporting and court preparation. This might be related to Lawyers Against Abuse, an NGO working in Region A (Diepsloot), but which is not directly linked to a specific facility.

The majority of NGOs are supporting facilities in the provision of HIV programmes. The NGOs that provide services related to post-violence care are Hands of Compassion (place of safety for children), Midrand Association (support group for survivors of abuse and rape), Right to Care (training).

NGOs in Region A facilities

AIDS Healthcare Foundation
- HIV Programme support
- HIV/AIDS advocacy
- CCMDT
- Training

CaSIPO (Care and Support to Improve Patient Outcomes)
- HIV Programme support
- Strengthening referral systems
- Awareness in the community

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

Midrand Association for Home Based Care
- Home-based care
- HCT
- HIV support group
- TB treatment services
- OVC support
- Support for survivors of abuse and rape

New Start
- HCT
- Medical Male circumcision
- Parenting support

Philani Maternal, Child Health and Nutrition Project
- Support pregnant mothers
- OVC support

Right to Care
- HCT services
- Support staff (data capturers)
- Training staff
- Support HIV/AIDS programmes
- Family planning services
- Medical Male Circumcision

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

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

Other NGOs are also actively involved in Region A, and one key informant mentioned that Diepsloot, specifically, have a significant number NGOs and CBOs that are active in the community, while Ivory Park, also in region A, has a much more limited NGO and CBO contribution. Some of the support services delivered by other NGOs in Region A include violence prevention through community awareness campaigns, school campaigns on GBV, training, protection orders, court preparation and other legal aspects as well as psychosocial support. This includes NGOs like Lawyers Against Abuse, Sonke Gender Justice, Childline, SANAC, Afrika Tikun and others.

A key informant from one of the NGOs within Region A highlighted that there is inadequate communication between the various stakeholders, including other NGOs about the interventions within the region.

2.7. Other stakeholders

The aim of the rapid assessment and gap analysis was not to investigate the relationship with other stakeholders, although the key informants did speak of challenges that they experience with other stakeholders. Various role players and stakeholders were identified during the interviews. A key informant highlighted that in Diepsloot in Region A, SAPS is working well with other stakeholders, but there is a high turnover of staff within SAPS. This influences referrals as well relationship building.

In Region A there are a number of stakeholders that work together on social cohesion programmes, and this includes government departments such as SAPS, DoH and DSD, as well as a number of NGOs.

2.8. Overall findings of Region A

Overall findings from Region A

OPENING TIMES

Facility is open 24 hours a day	0	out of 14	0.00%
Facility is open 7 days a week	2	out of 14	14.30%
Facility is open Monday to Friday	12	out of 14	85.70%
Facility is located in a permanent building	13	out of 14	92.90%
Facility is located in a park home	1	out of 14	7.10%
Average number of Sexual Offence cases per week	0.4	out of 14	--
Average waiting time of 45 minutes	14	out of 14	100%

SERVICES PROVIDED

Medical Forensic Examination	0	out of 14	0.00%
Bath or shower facility	3	out of 14	21.40%
Provision of comfort packs and clean clothes	0	out of 14	0.00%
Statement taken by a SAPS investigating officer	3	out of 14	21.40%
Psychological services	8	out of 14	57.10%
HIV, STI and pregnancy testing	10	out of 14	71.40%
Provision of post-exposure prophylaxis	8	out of 14	57.10%
Referral for HIV treatment	13	out of 14	92.90%
Assistance with case reporting and court preparation	7	out of 14	50.00%

FACILITIES AVAILABLE

Private ablutions with bath or shower	3	out of 14	21.40%
Disabled-friendly ablutions	13	out of 14	92.90%
Private room for victims to rest in	3	out of 14	21.40%
Waiting room	8	out of 14	57.10%
Counselling office	4	out of 14	28.60%
SAPS office	0	out of 14	0.00%
Examination room	14	out of 14	100%
NGO room	2	out of 14	14.30%
Wheelchair ramp	14	out of 14	100%

EQUIPMENT AVAILABLE

Computers	14	out of 14	100%
Telephones	13	out of 14	92.90%
Fax machines	8	out of 14	57.10%
Photocopiers	14	out of 14	100%
Printers	13	out of 14	92.90%
Internet	12	out of 14	85.70%
Camera for evidence	0	out of 14	0.00%
Fans	7	out of 14	50.00%
Air conditioner	14	out of 14	100%
Heater	8	out of 14	57.10%
Fridges	14	out of 14	100%
Microwave ovens	14	out of 14	100%
Fire extinguishers	14	out of 14	100%
Lockable cabinet	13	out of 14	92.90%
Refreshments for victims	0	out of 14	0.00%
Clean clothing	0	out of 14	0.00%
Comfort packs	0	out of 14	0.00%
Toys	4	out of 14	28.60%
Anatomically correct dolls	2	out of 14	14.30%
IEC material	11	out of 14	78.60%
Adult height and weight measures	14	out of 14	100%
Children's scale	14	out of 14	100%
Childrens measuring board	14	out of 14	100%
BP monitors	14	out of 14	100%
Syringes, needles, sterile swabs	14	out of 14	100%
Blood collection tubes	14	out of 14	100%
Examination gloves	14	out of 14	100%
Sharps container	14	out of 14	100%
Lighting for examination	7	out of 14	50.00%
Gynaecological couch	1	out of 14	7.10%
Speculums	11	out of 14	78.60%
Colposcope	1	out of 14	7.10%
Gown for victim	11	out of 14	78.60%
Clean bed linen	14	out of 14	100%

STAFF (FULL/PART TIME)		
Department/ Facility Manager	14 out of 14	100%
Professional Nurse	14 out of 14	100%
Forensic Nurse	0 out of 14	0.00%
Doctor	13 out of 14	92.90%
Administrative staff	13 out of 14	92.90%
Trauma Counsellor	0 out of 14	0.00%
HCT Counsellor	14 out of 14	100%
Psychologist	1 out of 14	7.10%
Pharmacist	1 out of 14	7.10%
REFRESHER TRAINING IN SEXUAL ASSAULT		
Healthcare Staff	0 out of 14	0.00%
Non-healthcare Staff	0 out of 14	0.00%
Auxiliary Staff	0 out of 14	0.00%
FACILITIES WITH AN NGO		
Facilities with an NGO	13 out of 14	92.90%

CHAPTER 5: RECOMMENDATIONS

CHAPTER 5: RECOMMENDATIONS

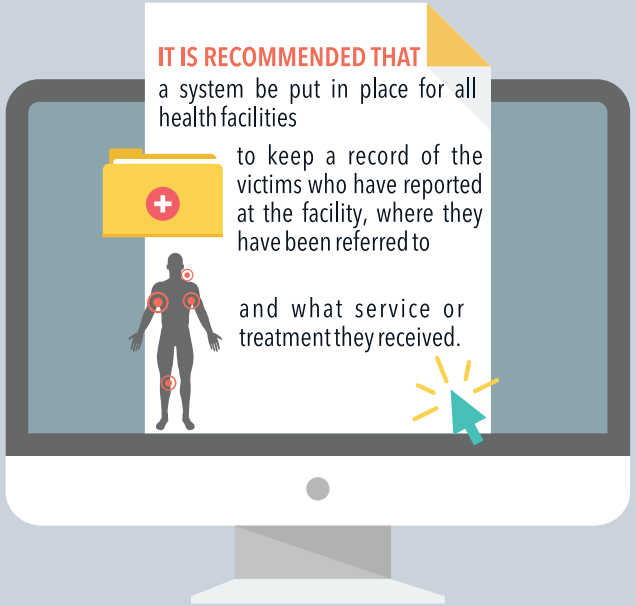
In order to improve the service delivery and functioning of the facilities CoJ (Regions A, D, E and G) and to investigate upscaling of the delivery of post-violence care services, the team have a number of recommendations, structured in the same manner as the findings in the previous chapter.

1. Recommendations on post-violence care services

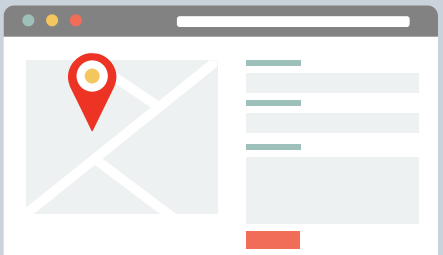
Facilities that do not provide post-violence care do not currently record the sexual assault victims that present to them. This creates two problems;

firstly the number of victims presenting at health facilities is not accurately recorded and

secondly there is no way of knowing whether or not the victim reported at the referral hospital.



This will allow facilities to not only know the true number of victims of sexual violence who report at health facilities,



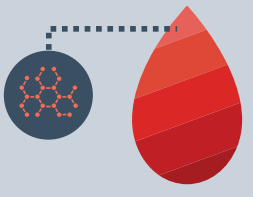
but to track these victims to determine if they received treatment as well as decreasing loss to follow up. This will also assist with linkages into care.

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

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

Only two facilities that were visited in the four regions of CoJ where the study took place provide medical forensic examinations, Zola CHC (Zamokuhle Medico-Legal Clinic, Region D) and Lenasia South CHC (Lenasia South TCC, Region G). Only Lenasia South TCC provides the full package of post-violence care services.

A compliance audit and gap analysis on the TCCs (FPD, 2016) found that Nthabiseng TCC at the Chris Hani Baragwanath hospital (Region D) also provided these services, but the team was refused access to the hospital.



There is no facility in Region A that provide medical forensic investigations.

It is recommended that post-violence care be available in at least one healthcare facility 24 hours a day, 7 days a week.

It needs to be investigated if OR Tambo clinic in Region A is open 24/7, and this facility could then serve as a point to potentially upscale into a crisis centre. This should be piloted and then rolled-out to all facilities that are currently open 24/7.

A major challenge that was consistently reported by facilities was that often victims do not end up reporting at the referred hospital due to a lack of transport and money as the hospital is far away. It is therefore strongly recommended that PHCs be equipped and allowed to provide comprehensive post-violence care services as they are closer to the communities they serve.

Each facility should have a clinical protocol, or standard operating procedure, in place that describes how all sexual assault cases should be managed. This relates to initial intake, the forensic investigation (if done at the facility), or the relevant referral and follow-up care.

2. Recommendations on referral pathways

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

3. Recommendations on facilities and sites

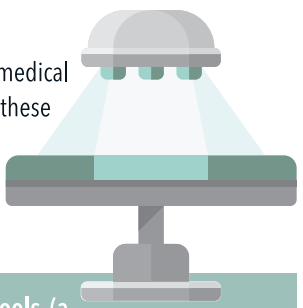
3.1. Facilities

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

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

3.2. Equipment

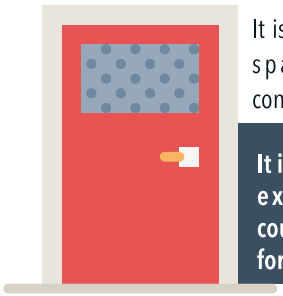
If post-violence care services, including medical examinations, are upscaled at facilities, these facilities need to be supplied with working equipment to ensure that the functioning of the facility is not limited and that post-violence services are delivered.



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



3.3. Space



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

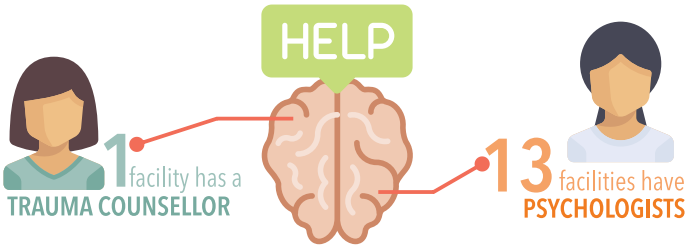
It is preferable to have a private, separate examination room, as well as a counselling room that is used exclusively for sexual assault victims.

3.4. Days and hours of service

Only two facilities are open 24/7, and five facilities are open 7 days a week (but not all 24 hours a day).

In order to upscale post-violence care services, more facilities need to be open 24/7.

3.5. Psychosocial support

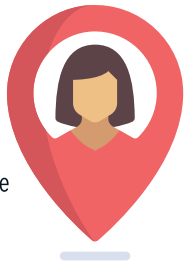


Only one facility in CoJ (Region A, D, E and G) has a trauma counsellor, and only 13 have psychologists available.

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

There needs to be a clear protocol for the services delivered by NGOs and the services delivered by DSD staff.

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



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

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

Services need to be adapted for child victims to ensure a more child-centred approach and better support for mentally challenged victims is required.

4. Recommendations to improve service delivery

4.1. Training

Training should be scaled up to include Primary Health Care facility staff in the management of sexual assault. If post-violence care services are upscaled to other facilities not currently providing this, facility staff need training in

- **conducting forensic investigations**
- **completing the J88 legal form**
- **and the use of the colposcope**

There should be more training on how to deal with child survivors.

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

The training programmes should be

- **broadened**
- **and**
- **developed**
- **and**
- **implemented**

by a recognised training institution that can provide CPD points, specifically for the DoH personnel.

It was reported by key informants in Region A that most operational managers have received training, but that it needs to be broadened to include

FACILITY MANAGERS and PROFESSIONAL NURSES.

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

- **sensitisation training**
- **referral pathways**
- **trauma counselling**
- **post-violence care**

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

4.2. Debriefing

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

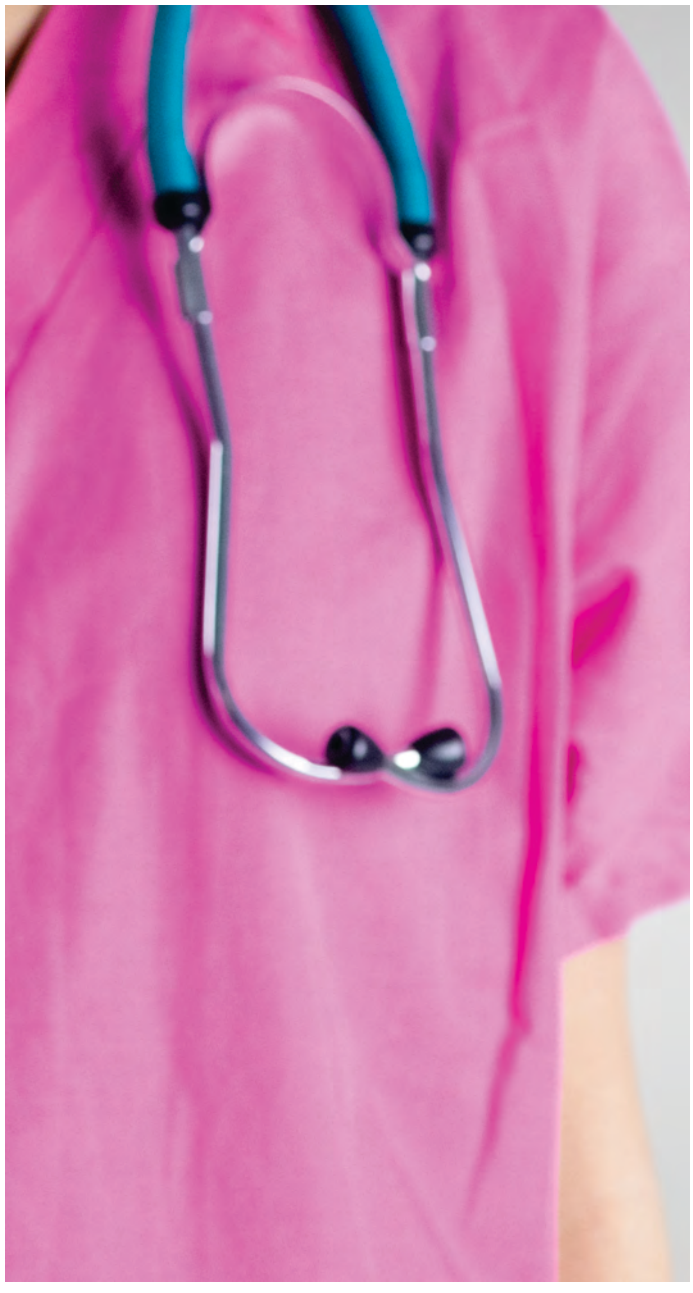
There should be a better structure in place to provide emotional and psychosocial support to all staff members involved in the facilities.

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

4.3. Victim friendliness and secondary victimisation

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

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



5. Recommendations on NGOs

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

advocacy | **community awareness** | **counselling services**

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

Innovation | **greater efficiency** | **capacity development**

is needed to build resilience within the NGO sector.

There should be better communication channels between NGOs and facilities to ensure that their roles and responsibilities are clarified.

6. Other recommendations

All stakeholders should investigate how GBV services can be up-scaled. 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 CoJ Health District should meet with other rape crisis centres to ensure that all services for GBV form part of the GBV package of care in the district.

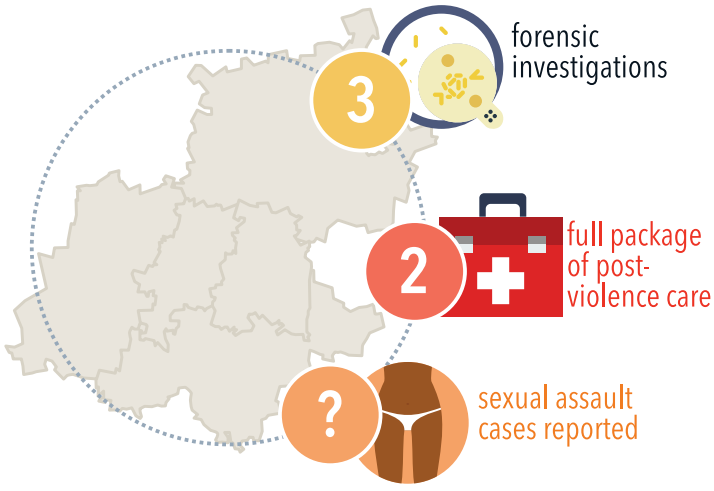
GUIDELINES

Complete guidelines on the **management of sexual assault** **referrals and** **long-term support** are needed. These must also integrate the relevant health related, STI, HIV and PEP guidelines.

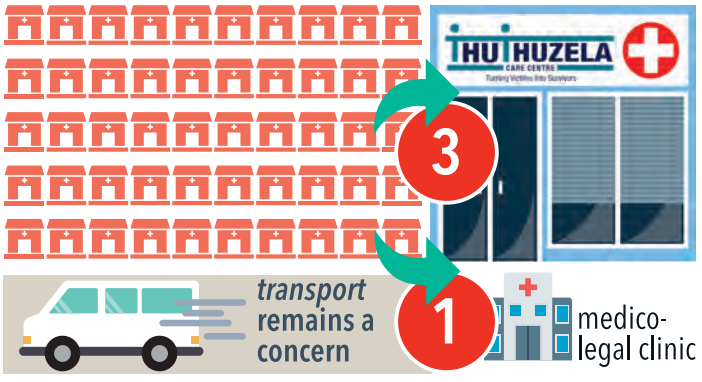
CHAPTER 6: CONCLUSIONS

CHAPTER 6: CONCLUSIONS

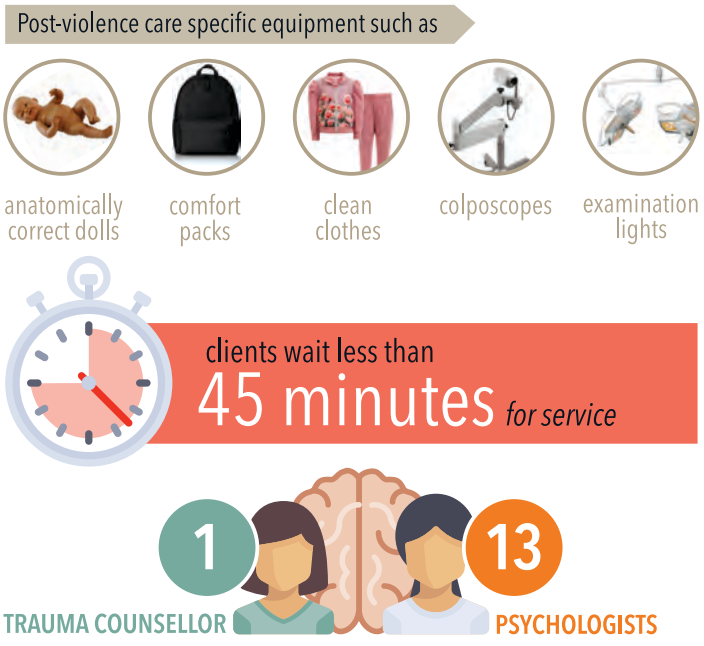
This rapid assessment and gap analysis was conducted between August 2016 and March 2017 using a mixed methods approach of key informant interviews and an application-based survey using tablets. Interviews and data collection took place between November 2016 and March 2017.



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



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



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

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

Human resources

Most facilities are well staffed, although there is a need to increase the number of trauma counsellors and psychologists. Facilities reported that they receive debriefing on a regular basis, but key informants highlighted that this is not adequate in the very stressful and emotional work environment where these staff are working.

Training

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

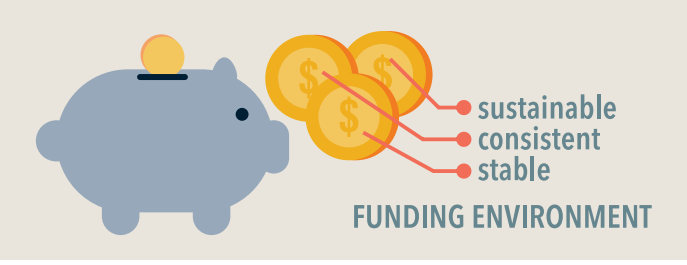
Victim friendliness

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

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

25 NGOs deliver services in > > **46.58%** of the facilities *in CoJ*

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



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

Post-violence care service delivery recommendations

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

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

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

Facility and site recommendations

A telephone dedicated to units who deliver post-violence care services in facilities is required.

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

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

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

Referral pathways recommendations

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

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

Improvement of service delivery recommendations

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

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

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

NGO recommendations

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

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

Communication channels between NGOs and facilities need to be improved.

Other recommendations

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

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

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