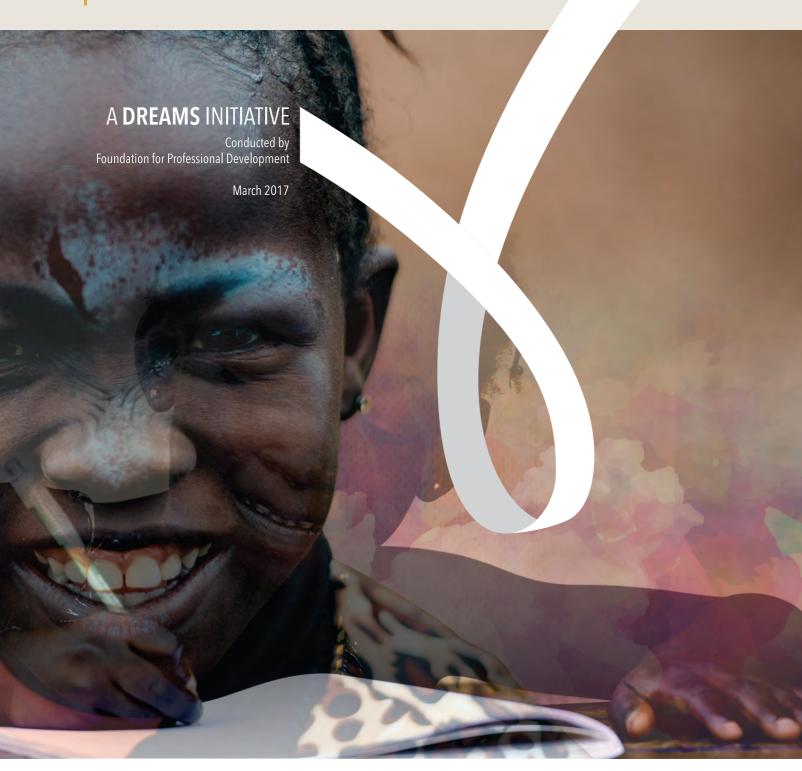
### Rapid assessment and gap analysis: Post-violence care services at public health facilities in

eThekwini (North, South and West)





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Resilient Empowered

AIDS-Free

Mentored











#### **Disclaimer**

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### **ACRONYMS**

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

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



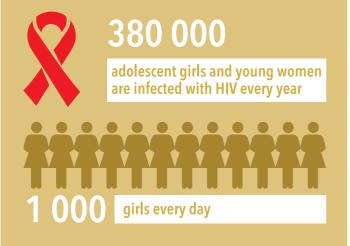
# EXECUTIVE SUMMARY



#### **Background**

This rapid assessment and gap analysis of post-violence care services at public health facilities in eThekwini (North, South and West) is grounded in the DREAMS initiative. The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, Safe) initiative aims at reducing HIV infections among adolescent girls and young women in ten Sub-Saharan African countries, of which South Africa is one (DREAMSa, n.d.)¹. The target group is adolescent girls and young women because despite the considerable progress in the global HIV/AIDS response, gender and age disparities in the high-HIV burden DREAMS countries remain almost unchanged – approximately 380 000 adolescent girls and young women are infected annually, which is the equivalent of around 1 000 girls daily (DREAMSa, n.d.). This translates into nearly half of all new HIV infections in 2014 among adolescent girls and young women coming from the ten DREAMS countries (DREAMSa, n.d.).

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



<sup>i</sup>The other nine countries are Kenya, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

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

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

As a component of the technical assistance provided, FPD conducted a rapid assessment and gap analysis of public healthcare facilities in eThekwini (North, South and West).



#### **Purpose**

The purpose of this rapid assessment and gap analysis is to identify where post-violence care services are available (mapping), identify what is/is not working, identify available structures, and assess services against a comprehensive package of post-violence care services. The rapid assessment and gap analysis focuses on all the components related to the functioning of post-violence care services at public health facilities in eThekwini (North, South and West). It assess the quality of services provided, the equipment at facilities, the staffing and qualifications of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working within the facility.

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





#### Methodology

The objective of the rapid assessment and gap analyses was to assess the provision of post-violence care at all 112 public health facilities in eThekwini (North, South and West). The data collection team was able to access and collect data from 101 facilities (reasons for not being able to access the remaining 11 facilities are given in the Overview of Findings section of this report).

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



Data collection at facility level consisted of a check list completed by the facility manager with the assistance of a data collector to answer questions about the provision of post-violence care at the facility, as well as questions about equipment and staffing at the facility more broadly. 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<sup>TM</sup>, where it was cleaned, coded and descriptively analysed. No inferential analyses were conducted.

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

The study was conducted between September 2016 and February 2017.





#### Majorfindings

The researchers noticed that facilities had different "assessments" or definitions of what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations, for example. Additionally all of the facilities are able to provide some services, such as HIV testing, but they do not always provide this service to victims of sexual violence because their understanding is that they should refer victims, in order not to interfere with the collection of evidence.



Only five facilities (4.9%) provided all of the services related to post-violence care. These facilities were:

- · Addington Hospital Crisis Centre (eThekwini South)
- Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South)
- · RK Khan Hospital TCC (eThekwini South)
- · Tongaat CHC (eThekwini North)
- St Anne's Clinic (eThekwini West)



Nine facilities (8.91%) are able to provide a medical forensic examination:

- · Tongaat CHC (eThekwini North)
- · Addington Hospital Crisis Centre (eThekwini South)
- Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South)
- · RK Khan Hospital TCC (eThekwini South)
- · Clermont-Ferrand Clinic (eThekwini West)
- · St Anne's Clinic (eThekwini West)
- · Umlazi V Clinic (eThekwini South)
- · Pinetown Clinic (eThekwini West)
- · Maphephetheni Clinic (eThekwini South)

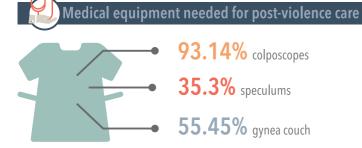
The services most often provided across facilities were HIV, STI and pregnancy testing (88.12%), HIV treatment (87.13%) and PEP (71.29%), which means that these services are potentially available to victims of sexual violence at most facilities, irrespective of their ability to provide the full package of care.



The services least often provided include the medical forensic examination (8.91%) and the provision of comfort packs (6.93%).



While the majority of facilities have the general medical equipment required of a healthcare facility, the majority did not have the medical equipment needed for post-violence care. The greatest need is for colposcopes, lacking in 93.14% of facilities. Speculums are not available in 35.3% of facilities, and just more than half of facilities (55.45%) don't have a gynea couch.



Overall, 25 facilities (24.75%) deliver a 24-hour service and 39 facilities (38.24%) are open 7 days a week, which shows potential for upscaling as post-violence care should ideally be available to victims 24/7. The majority of facilities reported that they have very limited space inside their facilities. For example, 75% do not have private ablutions with a bath or shower, 36% do not have waiting rooms, and 83% do not have a room for counselling.





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

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

The majority of referrals for post-violence care are made to Addington Hospital Crisis Centre (eThekwini South), Mahatma Ghandi Hospital (Phoenix TCC) (eThekwini North), Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South), and RK Khan Hospital TCC (eThekwini South). It is very encouraging that many facilities are referring victims to places where they can access the full package of post-violence care. However, there are other facilities that are reportedly able to provide the full package of post-violence care or medical forensic examinations that are not used as referral centres.

Seventy-eight facilities (77.23%) have an NGO providing services within the facility. However, none of these relate directly to the provision of post-violence care. It is important to note that the NGOs are contributing to the continuum of care for victims of sexual assault and how they can offer support for the provision of post-violence care should be explored.





#### Recommendations

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



#### General

Strengthen facilities that are already doing good work in providing post-violence care.

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

Equip and allow all PHCs and CHCs to provide post-violence care as distance to hospitals and TCCs is a barrier to care.

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

Considering the widespread provision of HIV testing, treatment and PEP, nearly all facilities have the potential to provide these services to victims of sexual violence.

Many facilities are already open 24/7, but are not equipped to provide post-violence care. These could be considered for upscaling so that uninterrupted services are available to victims.



#### Space and equipment

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

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



#### **Community interventions**

There should be awareness-raising in the community on gender-based violence.



#### **Staffing**

Staffing gaps identified are specifically for forensic nurses, trauma counsellors and psychologists.

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

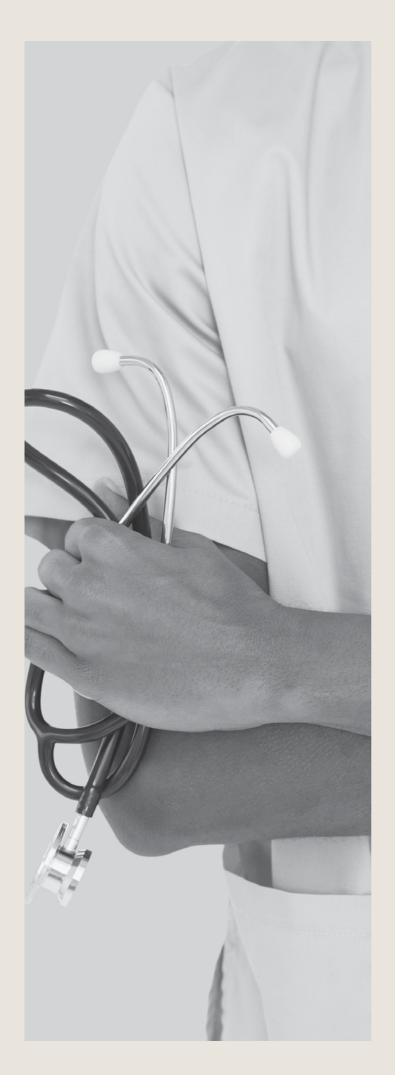


#### Referral pathways

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

The existing referral pathways should be maximised. Victims should be referred to facilities where they are able to receive comprehensive care, and referrals should be made to all facilities that are equipped to provide such care.

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



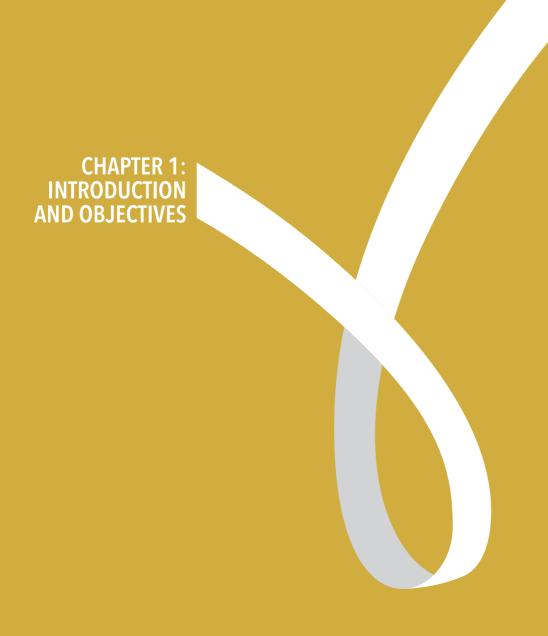


#### **NGOs**

Some NGOs at facility level already provide some form of counselling or psychological support in relation to HIV and they should be provided with further training, if needed, so they can support facilities by providing victims of sexual assault with psychological support.

There are existing facilities in eThekwini (North, South and West) that are already providing comprehensive services to victims of sexual assault. These facilities should be commended for their work and further strengthened to sustain these services. In addition, post-violence care services need to be upscaled in order to provide services closer to the community. It is clear that some facilities have the potential for upscaling. The team believes that if the recommendations are adhered to all post-violence care services in eThekwini (North, South and West) will be strengthened.





# CHAPTER 1: INTRODUCTION AND OBJECTIVES

# Contextual background to the rapid assessment and gap analysis

This rapid assessment and gap analysis of post-violence care services at public health facilities in eThekwini (North, South and West) is grounded in the DREAMS initiative. The DREAMS (<u>Determined, Resilient, Empowered, AIDS-free, Mentored, Safe</u>) initiative aims at reducing HIV infections among adolescent girls and young women in ten sub-Saharan African countries, of which South Africa is one (DREAMSa, n.d.). The target group is adolescent girls and young women because despite the considerable progress in the global HIV/AIDS response, gender and age disparities in the high-HIV burden DREAMS countries remain almost unchanged – approximately 380 000 adolescent girls and young women are infected annually, which is the equivalent of around 1 000 girls daily (DREAMSa, n.d.). This translates into nearly half of all new HIV infections in 2014 among adolescent girls and young women coming from the ten DREAMS countries (DREAMSa, n.d.).

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



"Many adolescent girls and young women lack a full range of opportunities and are too often devalued because of gender bias, leading them to be seen as unworthy of investment or protection. Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence, and school drop-out all contribute to girls' vulnerability to HIV." (DREAMSb, n.d: 1)

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

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

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



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

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

# Purpose of the rapid assessment and gap analysis

The purpose of this rapid assessment and gap analysis is to identify where post-violence care services are available (mapping), identify what is/is not working, identify available structures, and assess services against a comprehensive package of post-violence care services. The rapid assessment and gap analysis focuses on all the components related to the functioning of post-violence care services at public health facilities in eThekwini (North, South and West). It assess the quality of services provided, the equipment at facilities, the staffing and qualifications of the facility personnel (and therefore future training needs), as well as the relationship between the facility and any NGOs working within the facility.

<sup>&</sup>lt;sup>2</sup>The other nine countries are Kenya, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe

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

3 Objectives of the rapid assessment and gap analysis

The rapid assessment and gap analysis has 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 qualifications



To review if the health facilities offer youthfriendly 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 learnt and make recommendations on areas of improvement for the functioning of the health facilities for delivering a comprehensive package of post-violence care services

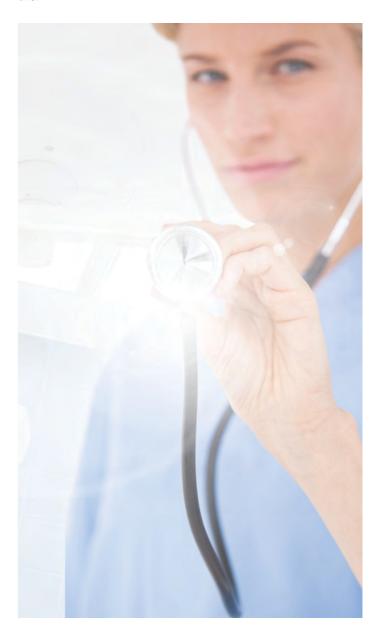
The rapid assessment and gap analysis was conducted between September 2016 and February 2017 and included a survey of 112 health facilities in

eThekwini (North, South and West). The data collection team was able to access and collect data from 101 facilities (see Overview of Findings for more detail).

As the services delivered are of a highly sensitive nature, information collected in this survey has been handled with high levels of confidentiality.

Intended users of the rapid assessment and gap analysis

This rapid assessment and gap analysis was conducted to serve the needs of specific stakeholders and 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.



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

# ETHERWINI HUNICIPALITY

#### **eTHEKWINI METROPOLITAN MUNICIPALITY**

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



#### **MatCH SYSTEMS AND OTHER IPs**

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



### PROVINCIAL DEPARTMENT OF HEALTH, KWAZULU-NATAL 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 EDUCATION**

Improved support to children who are victims of sexual assault



#### **FUNDER: USAID**

O Decisions on future funding of TCCs



#### **NGOS WORKING WITH HEALTH FACILITIES**

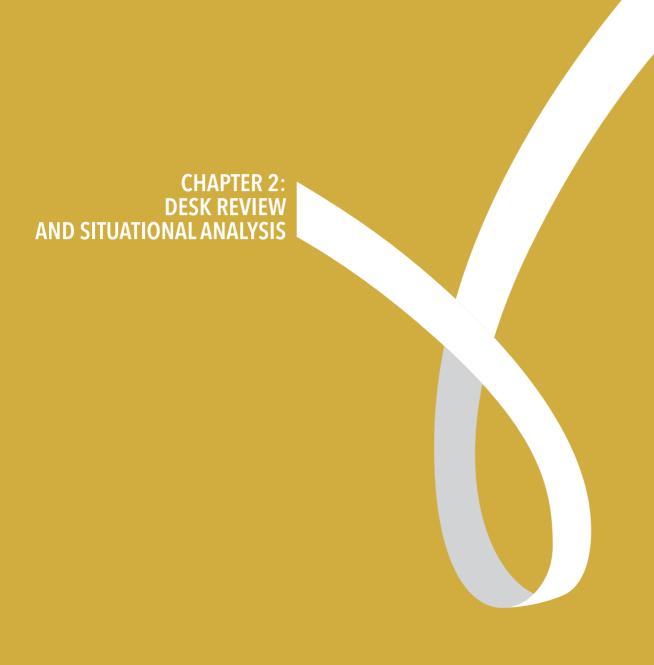
Assurance that the health facilities are functioning as required and that improvement plans are in place for the facilities that are not functioning to the required standards



#### **NGOS WORKING WITHIN HEALTH FACILITIES**

Improved engagement between NGOs and the health facilities.





#### CHAPTER 2: DESK REVIEW AND SITUATIONAL ANALYSIS

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

# Defining gender-based violence • and sexual violence

#### .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 focused 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 discriminatior 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 its wide spectrum:



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

The broad range of activities that constitute GBV is captured in the literature, which at different times refer to various definitional subtypes that include 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.).



the type

of violence





the setting and the relationship with perpetrator

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 in the 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 as follows.

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



#### Inappropriate societal norms and standards

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



#### **Destructive masculine identities**

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





#### **Gender inequality**

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



### Ineffective legislative and policy contexts and ineffective interventions

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





#### **Poverty**

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

poverty can result in men feeling emasculated which can result in

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).

of men admitted to forcing a women to have sex when she was drunk/drugged

4.2% of women had been raped while drunk/drugged



#### **Access to firearms**

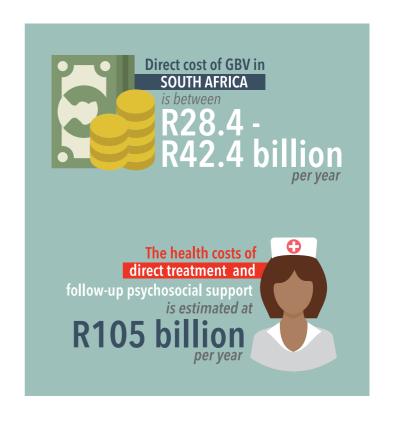
A number of research initiatives (Krug et al., 2002; RAPCAN and MRC, n.d.; Weideman, 2011) have demonstrated a relationship between access to firearms (and other weapons) and GBV.

#### 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 followup psychosocial support is estimated at R105 billion per year (Hwenha, 2014). The costs related to the prosecution and rehabilitation of perpetrators is not included in this amount and relates to the government services from SAPS, the justice system as well as the correctional services system.



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

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

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



OVERVIEW OF THE INSTRUMENT AND SOUTH AFRICA'S STATUS

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

#### INTERNATIONAL INSTRUMENT

#### **CEDAW**

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



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

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



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

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



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

The Declaration on the Elimination of Violence against Women, 1993



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

Beijing Declaration and Platform for Action, 1995



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

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



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

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



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

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



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



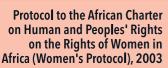
Similar to the UNCRC, the ARCWC is a regional instrument to protect the rights of children, including their right to safety and security. It was ratified by South Africa in 2000. (Western Cape Government, 2014)

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



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

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





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

SADC Protocol on Women and Development, 2008



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

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

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

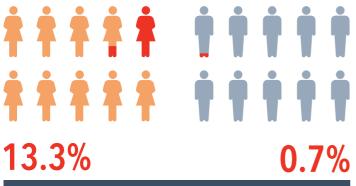
3.1. The socio-economic and political status of women in South

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.

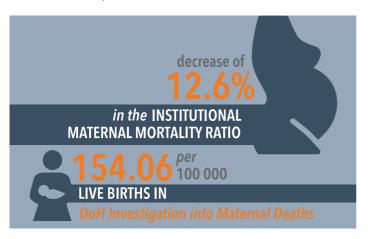
A contributing factor to the higher poverty rate among female-headed households is that women continue to earn less than men do (Stats SA, 2013). An audit conducted by PricewaterhouseCoopers (PwC) showed that on average women earn 28.1% less than their male counterparts and that black women are most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

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



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

With regards to healthcare, improvements have been made in maternal mortality rates in South Africa as reflected in an investigation by the Department of Health into maternal deaths for the period 2011 to 2013. This investigation showed a decrease of 12.6% in the Institutional Maternal Mortality Ratio (iMMR) reflected in an iMMR of 176.22 per 100 000 live births in 2008-2010 to 154.06 per 100 000 live births in 2011 - 2013. This decrease was attributed to an overall decrease in deaths resulting from pregnancy-related infections and an increased willingness of mothers to test and get treated for HIV (Department of Health, 2014). However, avoidable factors that contributed to 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).

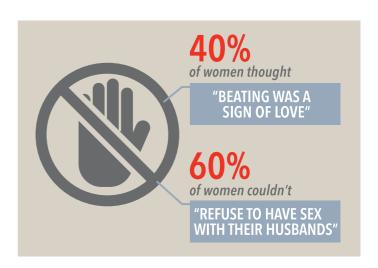


In South Africa (as elsewhere) continued inequity in employment practices, salaries, access to infrastructure and healthcare reduce female autonomy and contribute to the inappropriate societal norms and values discussed elsewhere in this report, in turn increasing women's vulnerability to gender-based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

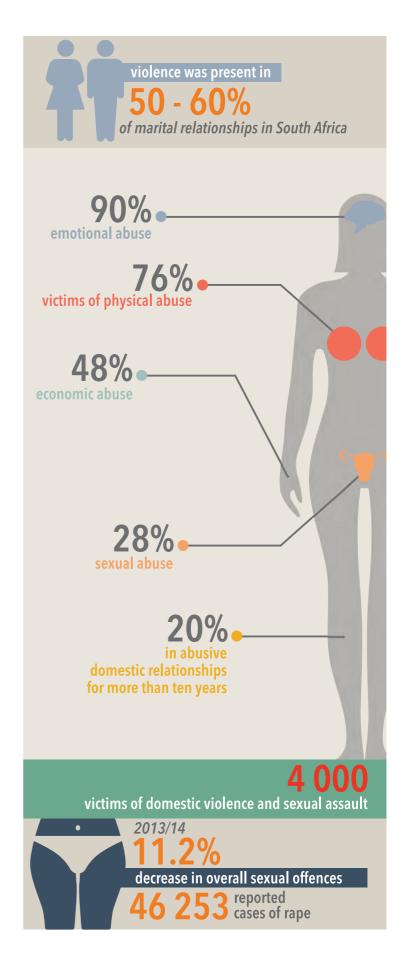
Literature on the prevalence of violence against women over time presents a bleak picture of consistently high rates. A 1991 study reported that violence was present in 50 - 60% of marital relationships in South Africa (Vogelman and Eagle, 1991). A 2002 community-based study of violence against women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

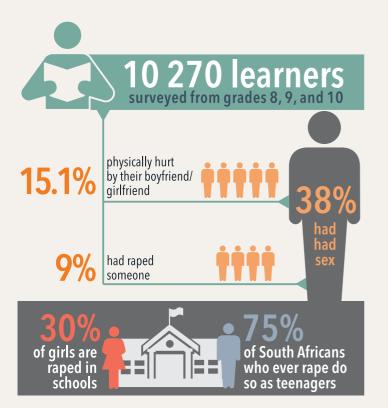
Another indication of the prevalence of violence against women is utilisation of the legal system in order to obtain protection orders. For example, in 2011, 217 987 new protection orders were granted against domestic violence, a further 87 711 protection orders were finalised, and 31 397 warrants of 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 preteens and teens.

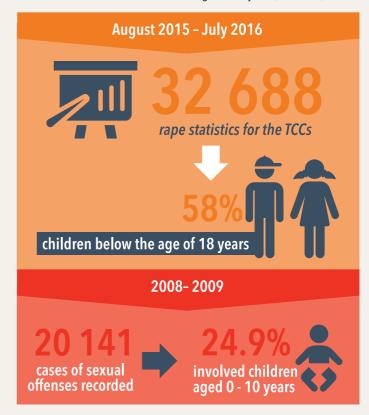
In many countries, including South Africa, Botswana and Namibia, both men and women are often targeted because of sexual identity (being gay or lesbian), (NACOSA, 2015). This is often called "corrective rape". Koraan and Geduld (2015) report that "corrective rape" refers to an instance when a woman is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

#### 3.2.3 Violence against sex workers

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

#### 3.2.4 Violence against children

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



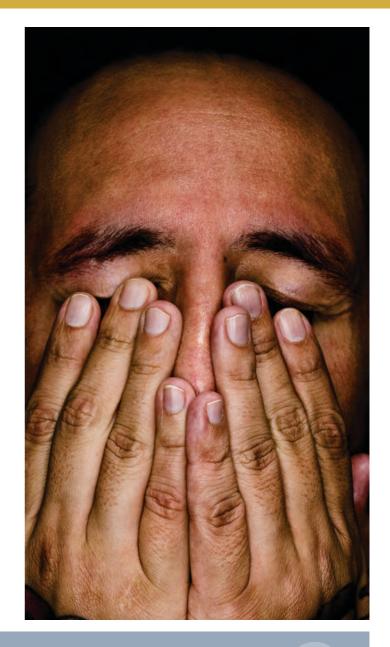
## 3.3. Legislative and institutional framework aimed at addressing gender-based violence in SA

#### 3.3.1 Legislative and policy framework

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

It is the responsibility of governments to create and implement laws to protect their citizens from sexual violence (Kilonzo, 2013) and there have been profound legislative and policy changes with regard to violence against women in South Africa since 1998 (Weideman, 2014; SAHRC 2015).<sup>3</sup>

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





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

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



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

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



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

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



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

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

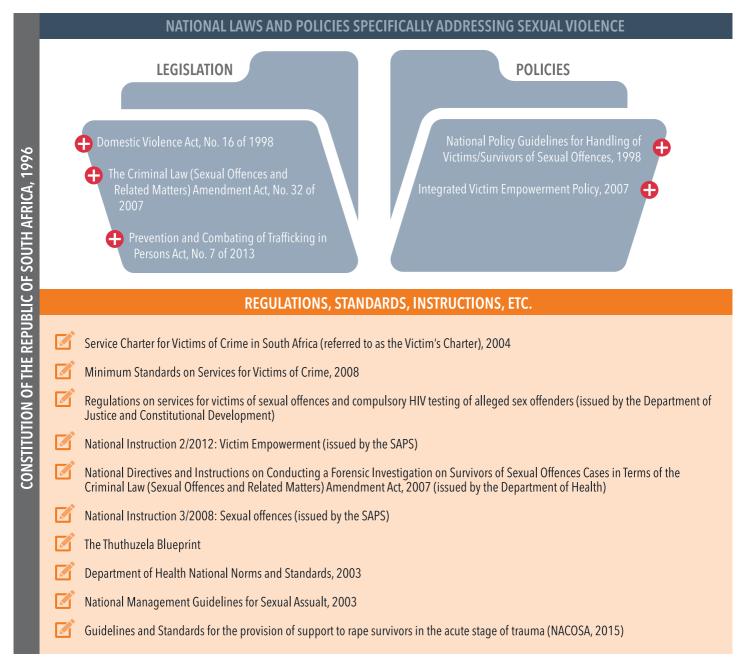


#### Prevention and Combating of Trafficking in Persons Act, No. 7 of 2013:

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

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

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



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

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

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

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





### Government departments and national institutions



### Ministry for Women in the Presidency:

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



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

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



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

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



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

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



### Criminal justice system



### South African Police Service (SAPS):

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



#### **Sexual Offences Courts:**

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





### Health services/support



#### **Thuthuzela Care Centres:**

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



### Designated rape care centres:

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



#### Civil society/NGOs

South African civil society, primarily through non-governmental organisations (NGOs), has played a crucial and sustained role in the provision of developmental social welfare services and other socio-economic development and support initiatives. Their role in the provision of services to survivors of sexual violence is crucial and needs to be acknowledged as in many communities NGOs are either the only source of assistance to rape survivors (NACOSA, 2015) or provide a "24-hour 'first response' service to support survivors through the initial trauma process of forensic examination, HIV counselling and testing, provision of post-exposure prophylaxis (PEP), giving a statement and linking with other services and the justice system" (NACOSA 2015:0). NGOs therefore offer a variety of services such as counselling, health services, referrals, shelters, legal support services, research into gender-based violence, etc. Within the broader framework of responses to gender-based violence, some literature reflects on the roles and responsibilities of the church in South Africa in the prevention of violence and the provision of support to survivors (Tearfund, 2013).

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

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

### 4.1 International and national quidelines and standards in

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

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

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



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

(within 120 hours)..." (Keesbury and Thompson 2010: 4)

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

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

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



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



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



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

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

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

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



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

### Department of Health Norms and Standards, 2003

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

### Standards and norms for primary healthcare, 2000

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

### **TCC Blueprint**

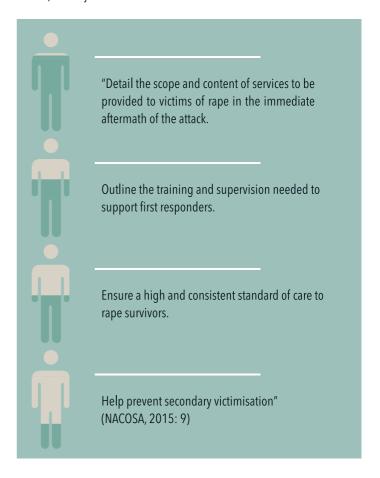
The objectives of the TCC Blueprint are to help limit or prevent the secondary victimisation suffered by many victims of sexual assault in their interaction with the health and criminal justice system; to improve on the timeframe within which cases are concluded (the objective is within 9 months); and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

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

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

### **NACOSA Guidelines**

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



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 by erlap with the TCC Blueprint and include:

NACOSA
Guidelines

The environment should be reassuring and include a private waiting area for family and friends.

The existence of at least one private and lockable consulting room.

That survivors be attended to 45 min – 1 hour from arrival.

PEP should be administered within 2 hours of arrival.

The availability of resource material in all languages relating to HIV care, PEP, termination of pregnancy and coping with rape.

The existence of a comprehensive referral list to assist survivors in accessing appropriate care.

First responders should be subject to routine supervision and debriefing.

Services should ideally be available 24-hours a day, 7 days a week. (NACOSA, 2015: 21)

### **Importance of referrals**

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

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

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

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



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

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

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

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

### Feelings of self-blame, fear, and lack of awareness of facilities

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

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

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

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

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)

# Overview of KwaZulu-Natal province and eThekwini district – socio-demographic and GBV profile

This section of the desk review and situational analysis relates to the geographic area (KZN more generally and eThekwini Metropolitan Municipality (North, South and West) 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 gender-based violence (prevalence rates, services available and barriers to care).

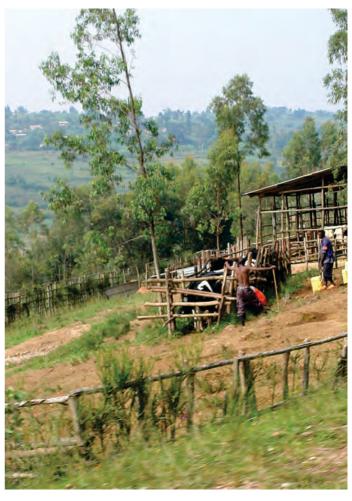
### 4.1. Demographic and socio-economic profile of KZN and eThekwini

KZN is one of South Africa's nine provinces and is located on its east coast, bordering the Eastern Cape Province to the south, southern Mozambique to its north, and the Free State and Mpumalanga provinces to the west (KZN Tourism, n.d.). eThekwini Metropolitan Municipality is one of its districts and is also the district in which Durban harbour is located. The port of Durban is South Africa's main cargo and container port and a strategic location on international shipping routes that is visited by 4 500 commercial vessels annually (South Africa.net, n.d.).





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



Some also draw the link between the harbour and sex work in Durban, see for example Gedey, L. (2012) Durban communities face harbour 'creep' http://mg.co.za/article/2012-09-27-durban-communities-face-harbour-creep

According to the Census 2011 report, KZN had a population of 10 267 300 of which 3 442 361 live in eThekwini. The percentage of the population younger than 15 years of age in the province is 31.9%, and the average in eThekwini is slightly lower at 25.2%. The sex ratio for the province (males per 100 females) is 90.5, while eThekwini stood at 95.6 (Stats SA, 2011). The eThekwini population accounts for 33% of the population of KZN and 7% of the population in South Africa (eThekwini District Municipality, 2015).

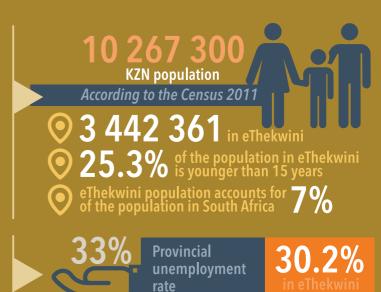
The province has an official unemployment rate of 33% (lower for eThekwini at 30.2%) with the official youth (15 - 34 years) unemployment rate being higher than the average rate at 42.1%. At 39.0%, the youth unemployment rate for eThekwini was lower than that reported for the province. (Stats SA, 2011)

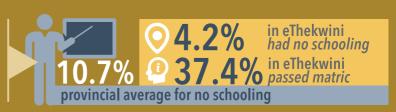
Statistics related to education were better for eThekwini than for the province as a whole, perhaps as a result of its more urban nature in some areas. In eThekwini only 4.2% had had no schooling, compared to the provincial average of 10.7%. In addition, 37.4% had passed matric which is higher than the provincial average of 31.1%. (Stats SA, 2011)

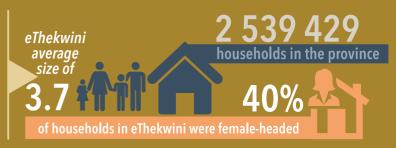
The province has a total of 2 539 429 households (956 713 for eThekwini) with an average size of 4.0 (lower in eThekwini at 3.7); and 46.6% of households were female-headed (40% in eThekwini) (Stats SA, 2011).

According to an SAHRC report, in 2008 70.9% of children in KZN lived in poverty, which was much higher than the South African average (64%) and figures for other provinces such as the Western Cape (36.7%) and Gauteng (42.2%) (SAHRC, n.d.). However, in eThekwini the overall percentage of people living in poverty (children and adults) has declined from 32.7% in 2011 to 32.3% in 2012 (eThekwini District Municipality, 2015). But compared to other metros, eThekwini has the lowest Human Development Index (HDI) at 0.68.

A 2014 Department of Health report on maternal mortality rates for 2011-2013 reported that KZN had the highest number of reported maternal deaths (964; or 22%) compared to other provinces, and that it is the province in which medical and surgical conditions are the second biggest cause of maternal death. This is in contrast to other provinces where non-pregnancy related infections are the most common causes of maternal deaths (Department of Health, 2014). Of the women who died, and who had tested for HIV, 65% tested HIV positive (nationally). In KZN the figure was 74%, above the national average and the highest for any province (Department of Health, 2014).







eThekwini's overall percentage of people living in poverty

32.7% in 2011 32.3% in 2012

KZN had the highest number of reported MATERNAL DEATHS

**22%** compared to other provinces

Of the women who died, 45% and who had tested for HIV TESTED HIV POSITIVE NATIONALLY

KZN and eThekwini 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 (eThekwini District Municipality, 2015) – and these are highlighted in this review as they have particular relevance for a discussion on GBV. Factors associated with teenage pregnancy are social and cultural (e.g. living up to accepted gender norms, patriarchy, rites of passage) as well as economic (e.g. pregnancy as a means through which to secure economic stability) (eThekwini District Municipality, 2015). Age at first sexual experience is also a behavioural risk factor associated with HIV incidence, together with lack of access to condoms and their use, large age differences between sexual partners, large number of partners in the past year, and a "high proportion of sexually active males with concurrent partners" (eThekwini District Municipality, 2015: 23).

HIV/AIDS infection rates have been increasing for all population groups in eThekwini despite measures and campaigns to address behaviour and to prevent infection. As at March 2013, eThekwini was reported as having the highest number of patients (207 091) on ARV treatment. KZN also has higher than the national average numbers of HIV infections among those between 15 and 45 years – extrapolation of annual HIV sero-prevalence results to the general population puts the national average for this group at 17 - 18%, and KZN at 25% (eThekwini District Municipality, 2015). Tuberculosis (TB) is still the leading opportunistic infection among those who are HIV positive and in 2012 eThekwini metro had almost double the South African average of TB incidence (1 126 per 100 000 people as opposed to the national incidence rate of 687.3 per 100 000 (eThekwini District Municipality, 2015).

Another major social challenge in the province is alcohol abuse (eThekwini District Municipality, 2015). A number of surveys have indicated a prevalence rate of current drinking (which is defined as the past week or past month) of 24 - 30% with the highest rate in the 20 - 34 year old group, and is more common in men than in women (eThekwini District Municipality, 2015). 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: 10), in a 2011 survey of KZN households, found a link between alcohol and drug use in intimate partner violence where they found that a "significantly higher proportion of men who drank alcohol (30%) [in the 12 months before the survey] perpetrated IPV when compared to men who did not drink (14%)".





of men who drank alcohol of men who did not drink
PERPETRATED INTIMATE PARTNER VIOLENCE



### Gender-based violence in KZN and eThekwini

The rates of underreporting of sexual violence to the SAPS in KZN (as in other provinces) has been shown in surveys on the nature and pervasiveness of GBV. For example, 36% of KZN women said that they had experienced GBV (lower than the 51% in Gauteng and 45% in the Western Cape) (Machisa et al., 2011). A 2011 survey of KZN households indicated that 31% of women in KZN had been subjected to intimidate partner violence (Musariri et al., 2013). The predominant form of violence within intimate relationships in KZN is psychological (25%), followed by physical (24%), economic (15%) and sexual (12%) (Musariri et al., 2013: 7). Approximately 5% of women in KZN (compared to 12% in Gauteng and 6% in the Western Cape) had been raped (Machisa et al., 2011). HIV infection among women who had been sexually abused by an intimate partner is high, at 35% (Musariri et al. 2013: 13).

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

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

Data released in 2014 by the Office of the Premier compiled using SAPS and other data illustrate the prevalence of sexual and gender-based violence crimes for the 2013/14 financial year for the KZN province and for eThekwini. These only reflect reported incidents and the actual number is therefore likely to be higher. Of all the districts in the province eThekwini had the highest number of sexual crimes (4 560) but was second to Ugu in the district ranking of sexual crimes as a percentage of population (1:755). eThekwini had 11 areas in the top 31 highest number of total sexual crimes reported to the police – these included Durban Central (672); Umbila (383); Inanda (353); Umlazi (340); Ntuzuma (214); Phoenix (207); KwaMakhuta (156); Bellair (154); Marianhill (154); KwaMashu (144); Bhekitima (136) (Office of the Premier, 2014). Many of these areas fall within the geographic scope of the rapid assessment and gap analysis of post-violence care

### The predominant form of violence within INTIMATE RELATIONSHIPS in KZN is:









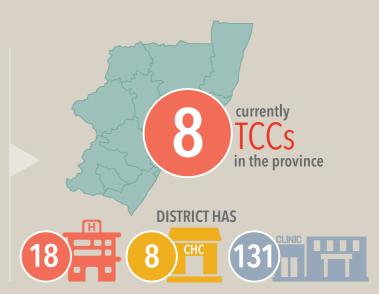
services. With respect to sexual assaults on children under the age of 12 years, the report ranked eThekwini 8th highest (out of 11) with a rate of 34% between April 2013 and March 2014 (Office of the Premier, 2014).

Various institutions and structures exist in the province to support survivors of gender-based and sexual violence. There are currently eight TCCs in the province: (1) Edendale TCC at Edendale Hospital, Pietermaritzburg; (2) Madadeni TCC at Madadeni Hospital, Newcastle; (3) Empangeni TCC at Ngwelezana Hospital, Empangeni; (4) Phoenix TCC at Mahatma Gandhi Memorial Hospital, Phoenix; (5) Port Shepstone TCC at Port Shepstone Regional Hospital, Port Shepstone; (6) RK Khan TCC at RK Khan Hospital, Durban; (7) Stanger TCC at Stanger Provincial Hospital, Stanger; and (8) Umlazi TCC at Prince Mshiyeni Memorial Hospital, Umlazi (UNICEF, n.d.; FPD, 2016). Of these, three are located in eThekwini: Phoenix TCC, RK Khan TCC, and Umlazi TCC. In terms of public healthcare facilities, there are 18 hospitals (including provincial, district and specialised); eight Community Health Centres (CHCs); and 131 Primary Healthcare Clinics (PHCs) in eThekwini (KZN DoH, 2016).

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

Data from various directories, such as the 2011 Gender Based Violence Project by FPD, funded by Sida, that resulted in service directories listing government and civil society resources that assist victims of violence, or the CSVR directory on counselling services (CSVR, n.d.) show that there are many NGOs that provide various levels of assistance (such as counselling, legal assistance, shelters) to victims of gender-based and sexual violence both outside of the health facilities as well as working in close partnership with facilities (or being based there). Examples of some of these CSOs include: The Advice Desk for Abused Women, Chatsworth Community Care Centre, LifeLine, Childline, The Open Door Crisis Centre, Umbilo Care Centre, etc.

Despite the support services that are available, there is still under-reporting of incidences of gender-based and sexual violence and poor access to services in KZN. Research has indicated that the majority of female victims do not report violence to police, seek medical attention or legal recourse. Five percent of women who had been physically abused reported it to police, while just 4% reported the incident to medical 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 KZN are similar to reasons in South Africa more generally (mentioned earlier in this report), although it is worth highlighting research in KZN that specifically focuses on reporting and accessing of services.











of those raped by a NON-PARTNER less than reported it to police or health care providers

### Awareness of legislation and rights:

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



in KZN aware of the Domestic Violence Act

of women in KZN



of men

received information about GBV from a television programme

of men

in KZN

agreed that a man could use violence as a punishment to a wife for wrongdoing

of men

of women

a woman cannot refuse to have sex with her husband



blame the rape survivor for the rape

### Prevalence of inappropriate and harmful societal norms:

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

### Inaccessibility of services and substandard care:

Coupled with these negative community attitudes, other barriers to accessing care include inaccessible services, e.g. not close to a transport route, women not having the financial means to get to a facility, as well as the possibility of secondary victimisation by service providers (Musariri et al., 2013). Although not speaking about GBV service provision specifically, there is some acknowledgement in the 2014/15 Annual Review of the eThekwini Integrated Development Plan (IDP) that challenges exist in relation to the quality of services provided, the level of infrastructure, human resources challenges, and disparities in service provision between suburban and previously disadvantaged areas (eThekwini District Municipality, 2015). And although not documented systematically, incidents of substandard care at KZN facilities and secondary victimisation have been reported in the media (Nxumalo, 2016).



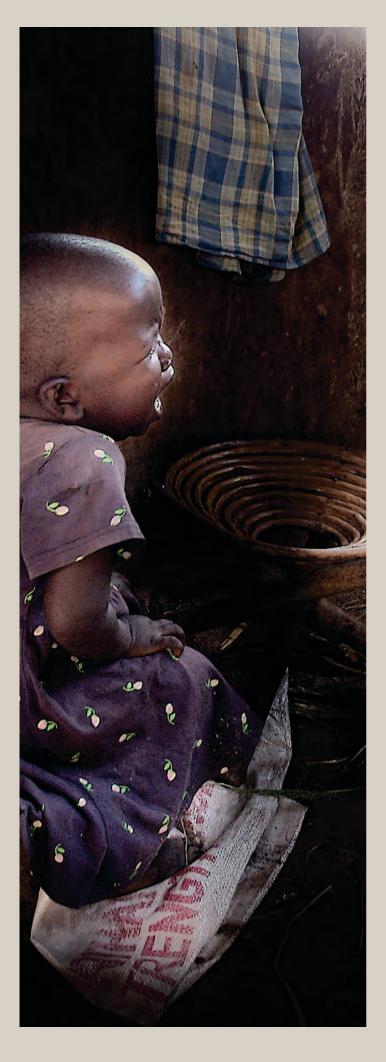
inaccessible services



women not having the financial means to get to a facility



secondary victimisation by service providers

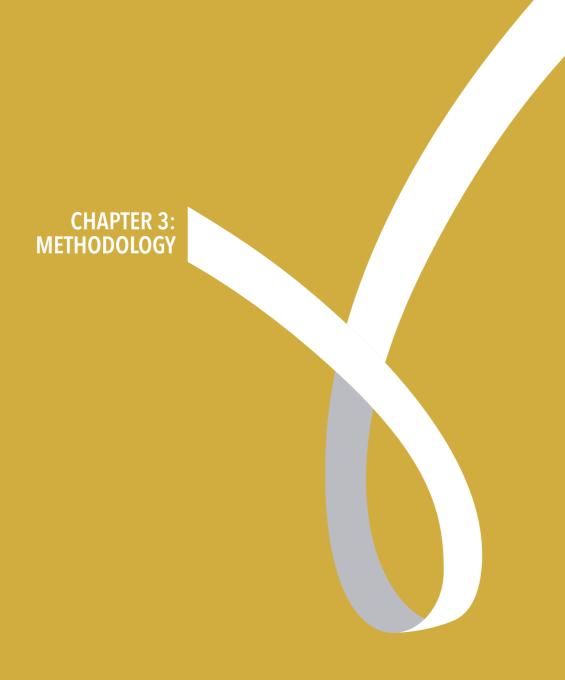


## **5.** Conclusion and way forward

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

Clear guidelines exist on the comprehensive, quality care that survivors should receive, including quality healthcare. These guidelines have been presented in this review. The rapid assessment and gap analysis of facilities in eThekwini that follows will compare elements such as resources and skills against internationally accepted guidelines and identify areas where improvements can be made in the short- and longer-term.





## CHAPTER 3: METHODOLOGY

The rapid assessment and gap analysis assessed the provision of post-violence care at 101 public health facilities in eThekwini (North, South and West). The study was conducted in three phases. Phase one involved conducting a desk review to inform a situational analysis, the second phase was field work and data collection, and the third phase is reporting. It is important to note that data were not collected from survivors, victims or clients of the health facilities who make use of any of the post-violence care services. Data were collected on services provided at the facilities and from key informants.

### Approach

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

## 2. Sample

All existing health facilities, including Primary Healthcare Clinics (PHCs), Community Healthcare Centres (CHCs) and hospitals, in the public sector were selected to participate in the rapid assessment and gap analysis. A list of health facilities was compiled from a number of different sources, which were cross-referenced. These included lists of facilities available on the provincial department of health website and the National Health Research Database (NHRD). MatCH Systems also made available a list of facilities, and the researchers furthermore drew on other publicly available directories such as the 2011 Gender Based Violence Project by FPD, funded by Sida. A total of 112 facilities were identified, and the research team was able to collect data from 101 of these. Facilities were contacted before a site visit and an appointment made with the facility manager to administer the survey.

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

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



Metropolitan/municipal managers



Managers from our implementing partner organisations



NGOs working in the field of GBV.

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

## 3 Situational analysis and desk review

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

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

## Data collection methods, instruments and procedure

Data were collected through a number of different mechanisms.

### Study design

### PARTA(1)

#### **FACILITY LEVEL**

Rapid assessment and gap analysis

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

An Application (ODK App) and survey tool was developed in collaboration with Medical Practice Consulting that uses TRISCOMS cloud hosting technology, to allow the team to collect data electronically using tablets. The ODK App allows users to customize survey tools based on the data that needs to be collected and automatically uploads the data onto a secure cloud-based database. The initial survey tool (Gap Analysis 1.1) was developed and piloted during the first week of data collection and no changes were needed.

One (or more) respondent(s) from each facility aided each data collector in the completion of the checklist. The data collectors were also required to use their own discretion to validate the information given by the respondents.



#### **FACILITY LEVEL**

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

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

Despite these reassurances, many staff at facilities and NGOs were reluctant to be interviewed and audio recorded and this has affected the amount and quality of qualitative data collected for this study. It is unclear what the reasons for this reluctance was, e.g. time constraints on the part of facility staff, anxiety about being held to account for their answers, etc. Lack of accurate and in-depth information does limit understanding of the challenges faced in facilities and staff should therefore be encouraged by DoH to share these experiences.

### PART B

#### **KEY INFORMANT INTERVIEWS**

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

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

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

## 5. Data analysis procedure

### 5.1. Quantitative data analysis

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

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

### Data verification procedure

### 5.2. Qualitative data analysis

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



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

The data collection team reported the processes of this evaluation in detail so that future researchers can repeat the work. Specifically, they provided a

description of the evaluation design, how it was executed and how effective it was. This is reported in order to enhance the dependability of the evaluation.

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

### 7. Ethics

### 7.1. Ethical clearance and letters of support

FPD has an in-house Research Ethics Committee, registered with the National Research Ethics Council of South Africa, who reviewed the proposal and provided approval based on the risk, duration and budget of the gap analysis. The evaluation team worked in close collaboration with the FPD Research Ethics Committee to ensure that all measures were taken to protect the rights of the respondents. The committee met on 10 May 2016 and requested a few small changes. These were implemented and the committee approved the study on 30 May 2016.

Afurther ethics approval process for the Provincial Department of Health was also followed. First, letters of support for the research were obtained from the DoH district and municipal offices. These were then used to request approval for the study through the online NHRD service. Data collection only started once approval had been received.

### 7.2. Principles of ethical conduct

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

### 7.2.1 Informed consent and right to withdraw

The evaluator explained the gap analysis to all interviewees, as well as the meaning of informed consent and confidentiality. Each interviewee was provided with an informed consent form that explained the process of the interview and what the data will be used for, as well as their right to refuse to participate or withdraw at any time. They were also made aware that their refusal or withdrawal would not have any negative impact on them or their employment.

#### 7.2.2 Anonymity

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

### 7.2.3 Confidentiality

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

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

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



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



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



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



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



If the researcher needed to move through the facility, he/she was accompanied by someone from the facility and would only enter 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 were to take place in a room that was not needed by the facility at the time, where privacy could be maintained.

### 7.2.5 Dissemination of information

The data from this Gap Analysis will be used to compile a National and Facility-Specific Report (this report). USAID may use the information from the report for various purposes such as decision making. However, they will not have access to any information that the researchers have declared as confidential. The Report will not contain the names of the respondents, unless they have consented to having their name published.



## 8 Challenges and limitations

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



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



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



Not all facilities were willing to participate in the study and data were collected at 101 of the 112 facilities in the sample.



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



The data collectors experienced a reluctance by some facility managers to be interviewed, and none were willing to be recorded.

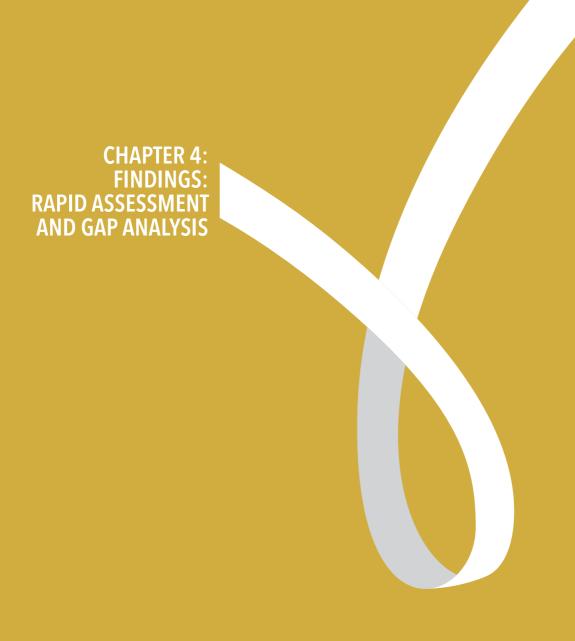


Due to the sensitive nature of the research and due to the focus of the study on the ability of facilities to provide post-violence care, no victims of violence were interviewed. Although this is appropriate for the study design and focus, it means that the perceptions of clients of the victim friendliness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



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





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

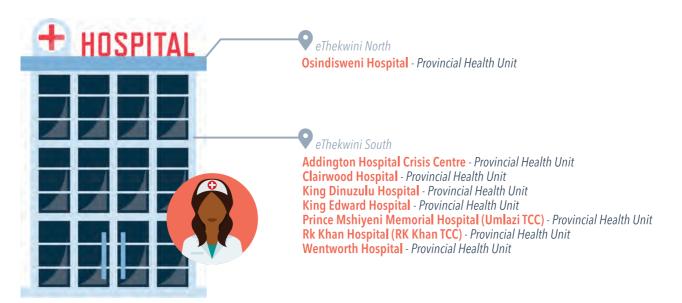
## Overall findings

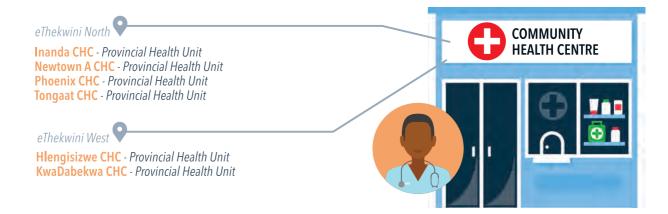
### 1.1. Facilities included in the data collection

Data were collected from 101 facilities across eThekwini North, South and West. There were 87 Primary Healthcare Clinics (PHC), six Community Health Centres (CHC) and eight hospitals, two of which have Thuthuzela Care Centres attached to them. Forty-eight of the facilities are municipal and 53 are provincial health units. Not all sub-districts have CHCs and hospitals. In eThekwini North data were collected from 24 PHCs, four CHCs and one hospital. In eThekwini South data were collected from 33 PHCs and seven hospitals. In eThekwini West data were collected from 30 PHCs and two CHCs.

When the sample for the study was compiled it was not intended to include TCCs as a comprehensive national assessment of the functioning of TCCs had recently been conducted by FPD (2016). However, the TCCs are linked to hospitals that had been included in the sample, and when fieldworkers attempted to administer the survey to assess the delivery of post-violence care, they were referred by the hospital staff to the TCC as that is where cases of sexual assault are referred to. The findings presented in this report therefore include data collected from RK Khan TCC at RK Khan Hospital and Umlazi TCC at Prince Mushiyeni Memorial Hospital. The fieldworkers were not granted permission to administer the survey at Mahatma Gandhi Memorial Hospital, and therefore no data were collected from Phoenix TCC based at that hospital. By nature TCCs provide a more comprehensive package of care and in order to ensure that findings from the TCCs do not skew the statistics presented, data from these facilities are highlighted where relevant.

#### Facilities included in data collection





eThekwini South

Adams Clinic - Municipal Health Unit Addington Gateway Clinic - Provincial Health Unit Amazimtoti Clinic - Provincial Health Unit Austerville Clinic - Municipal Health Unit Bluff Clinic - Municipal Health Unit Chatsworth Town Centre Clinic - Municipal Health Unit Craigieburn Clinic - Municipal Health Unit Danganya Clinic - Provincial Health Unit Ekupholeni (Umlazi L) Clinic - Provincial Health Unit Folweni Clinic - Provincial Health Unit Ispingo Clinic - Municipal Health Unit Kingsburgh Clinic - Municipal Health Unit KwaMakhutha Clinic - Provincial Health Unit Lamontville Clinic - Municipal Health Unit Lancers Road Clinic - Municipal Health Unit Magabheni Clinic - Provincial Health Unit Maphephetheni Clinic - Provincial Health Unit Nsimbini Clinic - Provincial Health Unit Osizweni (Umlazi Q) Clinic - Provincial Health Unit Overport Clinic - Municipal Health Unit Shallcross Clinic - Municipal Health Unit Umbumbulu Clinic - Provincial Health Unit **Umkomaas Clinic** - Municipal Health Unit Umlazi AA Clinic - Provincial Health Unit Umlazi D Clinic - Provincial Health Unit Umlazi G Clinic - Provincial Health Unit Umlazi K Clinic - Provincial Health Unit Umlazi N Clinic - Provincial Health Unit Umlazi U21 Clinic - Provincial Health Unit Umlazi V Clinic - Provincial Health Unit Umnini Clinic - Provincial Health Unit Umzomuhle (Umlazi H) Clinic - Provincial Health Unit Woodhurst Clinic - Municipal Health Unit

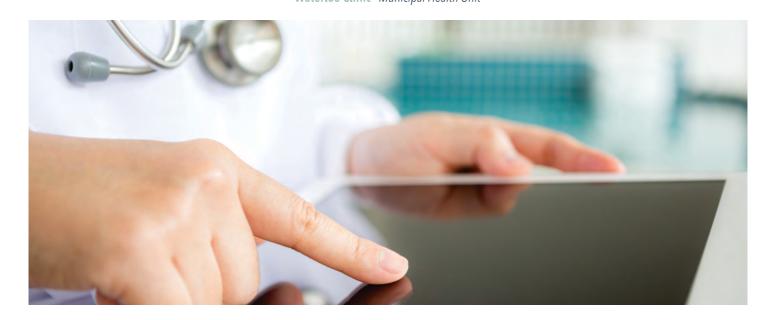


eThekwini North

Amaoti Clinic - Provincial Health Unit Besters Clinic - Municipal Health Unit Caneside Clinic - Municipal Health Unit Glen Earle Clinic - Municipal Health Unit Goodwins Clinic - Provincial Health Unit Grove End Clinic - Municipal Health Unit Hambanathi Clinic - Municipal Health Unit Inanda Seminary Clinic - Municipal Health Unit KwaMashu B Clinic - Municipal Health Unit La Lucia Clinic - Municipal Health Unit Lindelani Clinic - Provincial Health Unit Matikwe Clinic - Provincial Health Unit Newlands West Clinic - Municipal Health Unit Ntuzuma Clinic - Provincial Health Unit Ottawa Clinic - Municipal Health Unit Qadi Clinic - Provincial Health Unit Redcliff Clinic - Municipal Health Unit Redhill Clinic - Municipal Health Unit Sea Cow Lake Clinic - Municipal Health Unit Sivananda Clinic - Provincial Health Unit Stonebridge Clinic - Municipal Health Unit Trenance Park Clinic - Municipal Health Unit Verulam Clinic - Municipal Health Unit Waterloo Clinic - Municipal Health Unit

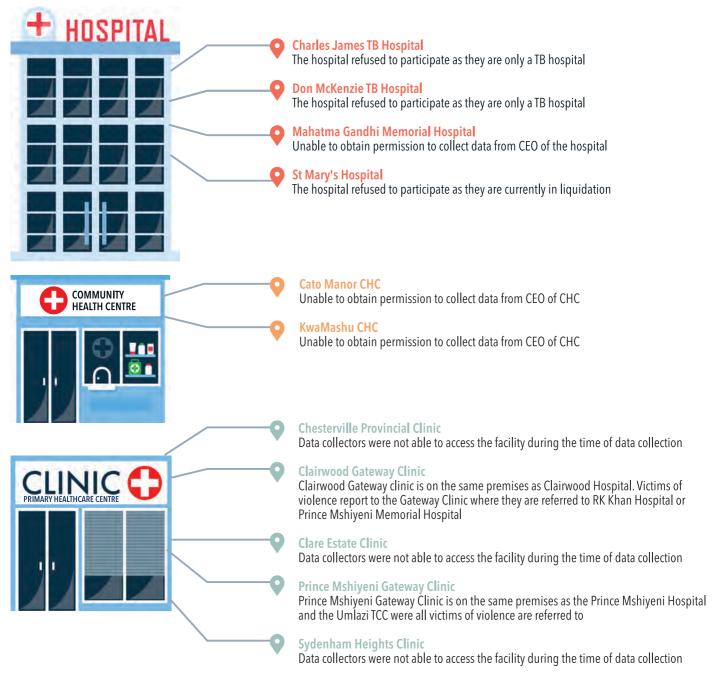
eThekwini West

Chesterville Clinic - Municipal Health Unit Clermont-Ferrand Clinic - Provincial Health Unit Fredville Clinic - Provincial Health Unit Halley Stott Clinic - Provincial Health Unit Illovo Clinic - Municipal Health Unit Klaarwater Clinic - Municipal Health Unit Kloof Clinic - Municipal Health Unit KwaNdengezi Clinic - Provincial Health Unit KwaNgcolosi Clinic - Provincial Health Unit Luganda Clinic - Municipal Health Unit Mariannridge Clinic - Municipal Health Unit Molweni Clinic - Provincial Health Unit Mpola Clinic - Municipal Health Unit Mpumalanga Clinic - Provincial Health Unit Msunduze Clinic - Provincial Health Unit Mzamo Clinic - Municipal Health Unit Nagina Clinic - Municipal Health Unit New Germany Clinic - Municipal Health Unit Ntshongweni Clinic - Provincial Health Unit Peaceville Clinic - Provincial Health Unit Pinetown Clinic - Municipal Health Unit Queensburgh Clinic - Municipal Health Unit Reservoir Hills Clinic - Municipal Health Unit Savannah Park Clinic - Municipal Health Unit St Anne's Clinic - Provincial Health Unit Tshelimnyama Clinic - Municipal Health Unit Waterfall Clinic - Municipal Health Unit Westville Clinic - Municipal Health Unit Wyebank Clinic - Municipal Health Unit Zwelibomvu Clinic - Provincial Health Unit



The following facilities were initially allocated to be included in the rapid assessment, however the data collectors were not able to access them for various reasons listed below.

#### Facilities where data were not collected





Overall, the study has a 90% response rate and fieldworkers were not able to obtain permission to administer the survey in only six of the 11 facilities listed in above.

1.2. Summary of findings  Summary of findings	CLINIC CO	Out of 87 facilities	COMMUNITY MEANN CASTE	Out of 6 facilities	+ HOSPITAL	Out of 8 hospitals*	TOTAL
Facility is open 24 hours a day	12	13.79%		100%		87.50%	24.75%
Facility is open 7 days a week	25	28.74%	0000	100%		100%	38.61%
Facility is located in a permanent building	78	89.65%		66.66%		100%	87.12%
Average waiting time of 45 minutes	80	91.95%		83.33%		100%	92.07%
SERVICES PROVIDED							
Medical Forensic Examination	5	5.57%		16.67%		37.50%	8.91%
Bath or shower facility	7	8.05%		16.67%		50.00%	11.88%
Provision of comfort packs and clean clothes	3	3.45%		16.67%		37.50%	6.93%
Statement taken by a SAPS investigating officer	18	20.69%		33.33%		50.00%	23.76%
Psychological services	52	59.77%	0000	66.67%		<b>75.00</b> %	61.39%
HIV, STI and pregnancy testing	78	89.66%		83.33%		<b>75.00</b> %	88.12%
Provision of post-exposure prophylaxis	61	70.11%		83.33%		<b>75.00</b> %	71.29%
HIV treatment	76	87.36%		83.33%		87.50%	87.13%
Assistance with case reporting and court preparation	34	39.08%		50.00%		62.50%	41.58%
FACILITIES AVAILABLE							
Private ablutions	17	19.54%		66.67%		62.50%	25.74%
Disabled-friendly ablutions	55	63.22%		83.33%		62.50%	83.17%
Private room for victims to rest in	24	27.59%		33.33%		<b>75.00</b> %	31.68%
Waiting room	56	64.37%		50.00%		<b>75.00</b> %	64.36%
Counselling office	13	14.94%		33.33%		62.50%	16.83%
SAPS office	1	1.15%		0.00%		25.00%	2.97%
HCT room	82	94.25%		66.67%		100%	93.07%
Examination room	87	100%		66.67%		100%	98.02%
NGO room	22	25.29%		50.00%		25.00%	26.73%
Wheelchair ramp	74	85.06%		66.67%		87.50%	84.16%
EQUIPMENT AVAILABLE							
Computers	85	97.07%		83.33%		100%	97.03%
Telephones	85	97.70%		83.33%		<b>75.00</b> %	95.05%
Fax machines	43	49.43%		83.33%		50.00%	51.49%
Photocopiers	53	60.92%		83.33%		<b>75.00</b> %	63.37%

	CLINIC 🛟		COMMUNITY HALIH CHINE	+ HOSPITAL	
	PS BARTY HALTHCOPS CENTS	Out of	Out of	Out of	TOTAL
		87 facilities	6 facilities	8 hospitals*	TOTAL
Printers	70	80.46%	83.33%	75.00%	80.20%
Internet	50	57.47%	83.33%	87.50%	61.39%
Camera for evidence	0	0.00%	66.67%	25.00%	5.94%
Fans	64	73.56%	66.67%	25.00%	69.31%
Air conditioner	70	80.46%	83.33%	87.50%	81.19%
Heater	28	32.18%	33.33%	25.00%	31.68%
Fridges	84	96.55%	83.33%	87.50%	95.05%
Microwave ovens	68	<b>78.16</b> %	83.33%	50.00%	76.24%
Fire extinguishers	87	100%	83.33%	100%	99.01%
Lockable cabinet	75	86.21%	66.67%	87.50%	85.15%
Refreshments for victims	3	3.45%	16.67%	12.50%	4.95%
Clean clothing	6	6.90%	33.33%	25.00%	9.90%
Comfort packs	4	4.60%	16.67%	0.00%	4.95%
Toys	4	4.60%	50.00%	50.00%	10.89%
Anatomically correct dolls	1	1.15%	50.00%	12.50%	4.95%
IEC material	57	65.52%	83.33%	100%	69.31%
Adult height and weight measures	85	97.70%	83.33%	100%	97.03%
Childrens scale	83	75.58%	83.33%	62.50%	92.08%
Childrens measuring board	79	90.80%	83.33%	50.00%	87.13%
BP monitors	86	98.85%	83.33%	100%	98.02%
Syringes, needles, sterile swabs	87	100%	83.33%	100%	99.01%
Blood collection tubes	86	98.85%	83.33%	100%	98.02%
Examination gloves	87	100%	83.33%	100%	99.01%
Sharps container	87	100%	83.33%	100%	99.01%
Lighting for examination	62	71.62%	50.00%	100%	72.28%
Gynaecological couch	25	28.47%	83.33%	37.50%	44.55%
Speculums	55	63.22%	66.67%	75.00%	64.36%
Colposcope	2	2.30%	16.67%	50.00%	6.93%
Gown for victim	73	83.91%	66.67%	87.50%	83.17%



Out of 87 facilities



Out of



Out of 8 hospitals\*

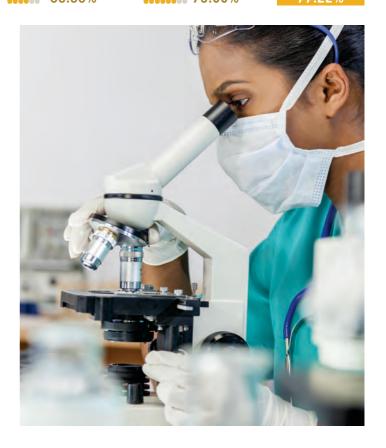
OTA

STAFF (FULL/PART TIME)					
Department/ Facility Manager	84	96.50%	83.33%	1111111 100%	97.02%
Professional Nurse	87	100%	83.33%	1111111 100%	100%
Forensic Nurse	0	0.00%	0.00%	37.50%	2.97%
Doctor	79	90.80%	83.33%	1111111 100%	91.08%
Administrative staff	86	98.85%	66.70%	75.00%	94.05%
Trauma Counsellor	2	2.29%	0.00%	37.50%	4.95%
HCT Counsellor	80	91.95%	83.33%	25.00%	85.14%
Psychologist	5	5.74%	33.33%	62.50%	11.88%
Pharmacist	33	37.93%	83.33%	50.00%	41.58%
TRAINING IN PROVIDING POST-VIC	LENCE CARE				
Healthcare Staff	10	11.45%	16.67%	44.45%	12.87%
Non-healthcare Staff	5	9.19%	16.67%	44.45%	7.92%
Auxiliary Staff	1	1.14%	0.00%	0.00%	0.99%
FACILITIES WITH AN NGO					
Facilities with an NGO	68	78.10%	66.66%	75.00%	77.22%

<sup>\*</sup>The eight hospitals include RK Khan TCC and Umlazi TCC.

## 2. Findings related to post-violence care

The researchers noticed that facilities had different assessments or definitions of what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations, for example. Additionally all the facilities are able to provide some services, such as HIV testing, but they do not always provide this service to victims of sexual violence because their understanding is that they should refer victims in order not to interfere with the collection of evidence.



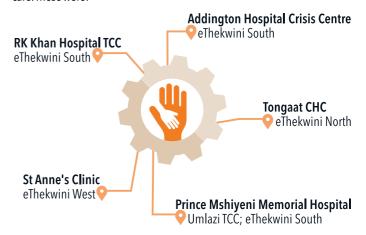
For the purposes of this rapid assessment, drawing on the TCC Blueprint and NACOSA Guidelines, we are defining post-violence care as the following package of services provided to victims of sexual violence:



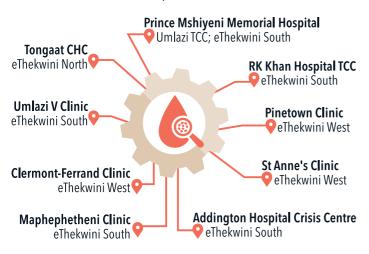
\*A comfort pack is a small package or kit that is given to victims or survivors. It usually contains age and gender appropriate items such as underwear, sanitary pads for women and girls, toothbrush and toothpaste, soap, a facecloth and possibly a non-perishable snack.

If a facility provides all of these services to victims of violence, they are said to provide post-violence care. It is noteworthy that facilities responded positively to the question of whether they provide post-violence care even if they do not provide the full package as this might indicate that some awareness raising is necessary on what the full package of care entails. This response also indicates that victims of violence are inconsistently cared for if they are referred by some facilities, but receive only basic care at others. This points to a need to strengthen the referral pathways.

Only five facilities (4.9%) provided all of the services related to post-violence care. These were:

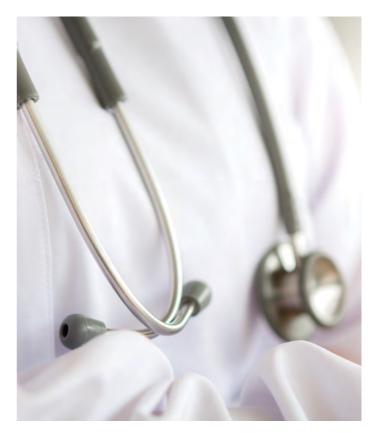


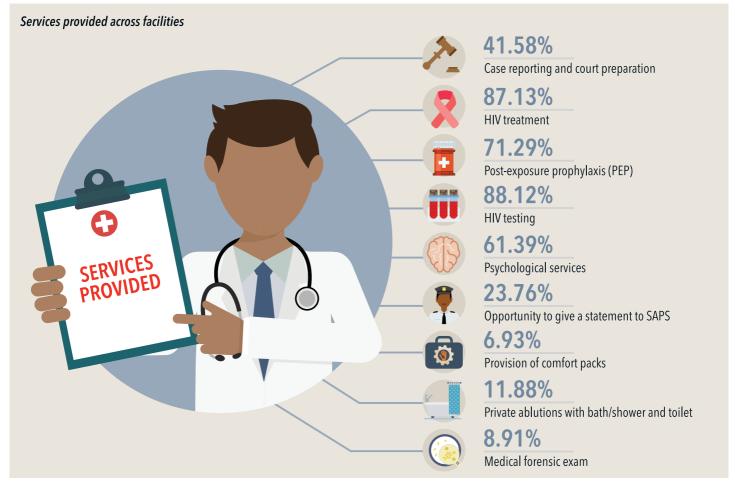
Nine facilities (8.91%) are able to provide a medical forensic examination:



The services most often provided across facilities are HIV, STI and pregnancy testing (88.12%), HIV treatment (87.13%) and PEP (71.29%), so these services are potentially available to victims of sexual violence at most facilities, irrespective of their ability to provide the full package of care.

The services least often provided include the medical forensic examination (8.91%) and the provision of comfort packs (6.93%).





The only PHC to provide all 10 services (the full package of care) was St Anne's Clinic. Five PHCs (5.75%) provide medical forensic examinations – Pinetown Clinic, Maphephetheni Clinic, Umlazi V Clinic, Clermont-Ferrand Clinic and St Anne's Clinic. Seven clinics (8.05%) are able to provide bath or shower facilities, three (3.45%) can provide comfort packs and clean clothes, and in 18 clinics (20.69%) the patient can make a statement to a SAPS investigating officer, 52 (59.77%) are able to provide psychological services, 78 (89.66%) can provide testing for HIV, STIs and pregnancy, 61 (70.11%) can provide post-exposure prophylaxis, 76 (87.36%) can provide treatment for HIV, and 34 (39.08%) can assist with case reporting and court preparation.

Primary Healthcare Centre					
5.75%	Provide medical forensic examinations				
8.05%	_Are able to provide bath or shower facilities				
3.45%	Can provide comfort packs and clean clothes				
20.69%	The patient can make a statement to a SAPS investigating officer				
	_Are able to provide psychological services				
89.66%	_ Can provide testing for HIV, STIs and pregnancy				
70.11%	_ Can provide post-exposure prophylaxis				
87.36%	_ Can provide treatment for HIV				
39.08%	_ Can assist with case reporting and court preparation				

Only one CHC (Tongaat CHC) provides the full package of care, and they are also the only CHC to provide the medical forensic examination. A total of 16.67% of CHCs are able to provide bath or shower facilities, 16.67% are able to provide comfort packs and clean clothes. In 33.33% of CHCs the patient can make a statement to a SAPS investigating officer, 66.67% are able to offer psychological services, 83.33% are able to offer testing for HIV, STIs and pregnancy, 83.33% are able to provide post-exposure prophylaxis, 83.33% can provide HIV treatment, and 50% can assist with case reporting and court preparation.

proparation	
Communi	ty Health Centre
<b>(a)</b> 16.67%	Provide medical forensic examinations
16.67%	Clinics are able to provide bath or shower facilities
<b>16.67</b> %	Clinics can provide comfort packs and clean clothes
	Clinics the patient can make a statement to a SAPS investigating officer
	Are able to provide psychological services
83.33%	Can provide testing for HIV, STIs and pregnancy
<b>83.33</b> %	Can provide post-exposure prophylaxis
	Can provide treatment for HIV
50%	Can assist with case reporting and court preparation

Of the hospitals in the sample 37.5% can provide a medical forensic examination. These are Addington Hospital Crisis Centre, Prince Mshiyeni Hospital (Umlazi TCC) and RK Khan Hospital TCC. Fifty percent can provide bath/shower facilities, and 37.5% can provide comfort packs and clean clothes. In 50% of hospitals victims can make a statement to SAPS, 75% can provide psychological services, HIV testing, and PEP, 87.5% can provide HIV treatment and 62.5% can assist with case reporting and court preparation.

Hospitals	
37.5%	Provide medical forensic examinations
<b>50</b> %	Are able to provide bath or shower facilities
37.5%	Can provide comfort packs and clean clothes
<b>50</b> %	The patient can make a statement to a SAPS investigating officer
	Are able to provide psychological services
<b>75</b> %	Can provide testing for HIV, STIs and pregnancy
<b>75</b> %	Can provide post-exposure prophylaxis
	Can provide treatment for HIV
	Can assist with case reporting and court preparation

Of the municipal facilities, only 2% provide the medical forensic examination; 4.17% are able to offer bath or shower facilities and comfort packs and clean clothes, 20.83% of facilities allow patients to make a statement to a SAPS investigating officer; 26.19% offer psychological services, 97.9% can test for HIV, STIs and pregnancy; 77.08% can offer post-exposure prophylaxis; 85.42% can offer treatment for HIV; and 41.67% can assist with case reporting and court preparation.

Of the provincial facilities, 15% can provide the medical forensic examination; 18.87% can provide a bath or shower; 9.43% can provide comfort packs and clean clothes; in 26.42% of facilities patients can give a statement to a SAPS investigating officer; 75.47% can provide psychological services, 88.68% can offer testing for HIV, STI and pregnancy; 66.04% can offer post-exposure prophylaxis; 88.68% can offer HIV treatment; and 41.51% can assist with case reporting and court preparation.

There appears to be a clear difference in the current ability of municipal and provincial facilities to provide psychological services, bath and shower facilities, and the medical forensic examination.

Municipal Facilities			Provincial Facilities		
Provide medical forensic examinations	2.08%		15.09%	Provide medical forensic examinations	
Are able to provide bath or shower facilities	4.17%		18.87%	Are able to provide bath or shower facilities	
Can provide comfort packs and clean clothes	4.17%		9.43%	Can provide comfort packs and clean clothes	
The patient can make a statement to a SAPS investigating officer	20.83%		26.42%	The patient can make a statement to a SAPS investigating officer	
Are able to provide psychological services	26.19%		<b>75.47</b> %	Are able to provide psychological services	
Can provide testing for HIV, STIs and pregnancy	91.67%		84.91%	Can provide testing for HIV, STIs and pregnancy	
Can provide post-exposure prophylaxis	77.08%		66.04%	Can provide post-exposure prophylaxis	
Can provide treatment for HIV	85.52%	7	88.68%	Can provide treatment for HIV	
Can assist with case reporting and court preparation	41.67%		41.51%	Can assist with case reporting and court preparation	

Facilities were assessed on what they are able to offer against the comprehensive package of care provided for in the TCC Blueprint and NACOSA Guidelines. Key informant interviewees (with DoH, DSD, and NGOs working in the field of GBV) were asked the same questions – what services should be provided and what immediate steps can be taken that will improve the provision of post-violence care at facilities. They spoke of the importance of staff sensitisation, a strong referral pathway, and the need to decentralise services to make them more accessible to all.





'At these smaller facilities [PHCs] staff should be sensitised, know the referral pathway, and nurses should know not to tamper with the evidence.'

DoH key informant

'It is also an option that in peri-urban areas to have special units that provide these specialised services. These are hotspots where people take drugs and use alcohol and don't know one another, and where there are many taverns. All of these are things that put people at risk of GBV.'

DoH key informant

'Decentralisation provides equality [in people's access to services]. Transport is an issue.' DSD key informant

'Resources – PHCs and CHCs do not have resources. Rape cases are referred to the TCC and often therein lies a transport issue and people don't have the money to go.' NGO key informant

'It's important to remember that GBV is a spectrum and therefore to look at what elements can be managed at PHC level. What can a CHC manage?

Maybe at PHC it's important to be able to identify clients and to let them know what services are available to them.' NGO key informant

When talking about the more immediate improvements in facilities that would make a difference to the provision of PVC: 'All consulting rooms should have a safe space. There should be a proper triage system that identifies victims early. Triage with a named nurse. And a separate waiting area in the clinic.' NGO key informant

'There should be a police officer at each crisis centre as police station is a not a conducive environment...there should be female police officers.'

NGO key informant

'There should be a first assessment check list for post-violence care.' NGO key informan

### 2.1 Number of sexual offence cases per week

### Cases reporting to facilities

51 facilities (50%) reported that they do not see any cases of sexual offences. 34% reported one case per week, 11% reported 2 - 9 cases per week, 4% reported having 10-20 cases per week and 1% did not know how many cases presented in a week. The average across facilities is 1.35 cases per week.



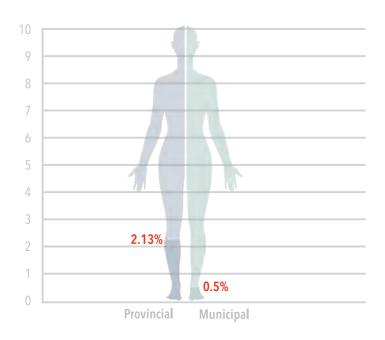
### **AVERAGE NUMBER OF SEXUAL ASSAULT CASES PER WEEK**



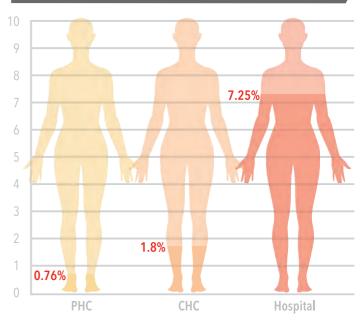
The average number of sexual assault cases per week was highest in provincial (2.13) facilities when compared to municipal (0.5) facilities.

The average number of sexual assault cases seen per week is highest in hospitals when compared to CHCs and PHCs. The average in hospitals is 7.25 (without the TCCs the average is 3.8, while TCCs on their own average 17.5), in CHCs 1.83 and in PHCs 0.76. The two TCCs had the highest average of 17.5 cases per week.

### AVERAGE NUMBER OF SEXUAL ASSAULT CASES IN MUNICIPAL VS PROVINCIAL FACILITIES



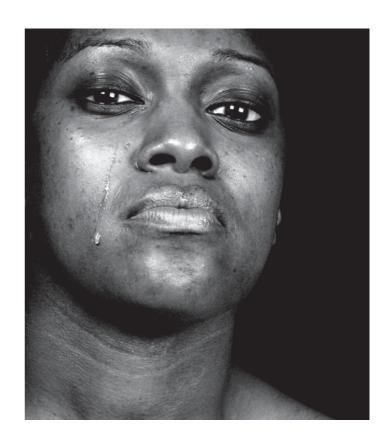
### AVERAGE NUMBER OF SEXUAL ASSAULT CASES IN PHCs, CHCs AND HOSPITALS



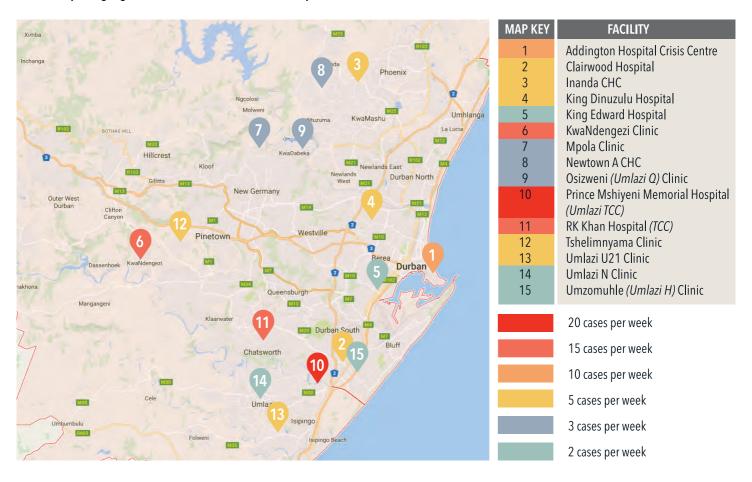
However, these findings must be interpreted cautiously for two reasons. Firstly, most facilities reported that the number of cases of sexual assault vary from week to week. One week they could get no cases and the following week they could get four. Secondly, interviewees did not consult any records when answering this question but spoke from memory. It was not clear from the interviews that PHCs consistently record the victims that report at the clinic and it was therefore a problem for them to report the true number of cases.



'The SIMS [Site Improvement Through Monitoring Systems] tool has one page on GBV. It is an afterthought to say that you have met the minimum requirements. It doesn't allow us to identify if a site is doing well or if a nurse is responsive to a patient.' NGO key informant



### Facilities reporting highest number of sexual assault cases per week



It is worth noting that although KwaNdengezi clinic reportedly receives as a high number of cases of sexual assault per week, it is not able to provide the full package of post-violence care, nor provide medical forensic examinations.

One of the key informants (from DSD) also made the point that data on sexual assault are not consolidated across different sources, such as the facilities, SAPS, and DSD, which makes it difficult to provide accurate numbers on the incidents of sexual violence that had been reported. Furthermore, the key informant also cautioned that statistics might reflect where people access care not where they live, as people might go to other facilities or areas in case they meet people they know and so reveal their assault.

### Vulnerability to sexual assault and incidence of violence

When asked whether there has been an increase in sexual violence reported at the facility in the last 5 years, most interviewees at facility-level reported that they did not think that there had been an increase as they do not receive any victims at their facility. Interviewees reported that victims know where to access services and usually go to the police station first. One respondent indicated that some patients are found to be victims of violence during HIV testing or in consultation, and are then referred to post-violence care. Some reported that although the number of cases they receive in the facility has not increased, they do think that sexual violence has become more prevalent in their community. The interviewees that reported that sexual violence had increased in the last 5 years explained that they hear reports from other facilities who have a large number of victims reporting to them. When asked about the ages of most of the victims, children seemed more commonly affected than adults. Most interviewees at facilities reported that victims are most likely to report in the morning as soon as the facility opens. Other interviewees mentioned the holidays, festive seasons and weekends as high-risk times.

Key informants spoke of the various socio-economic factors in eThekwini that increase the vulnerability of women to sexual violence. Examples included poverty and economic dependency, the proximity to the harbour which also enables/facilitates prostitution, the normalisation of violence in the community, and insufficient access to female condoms.

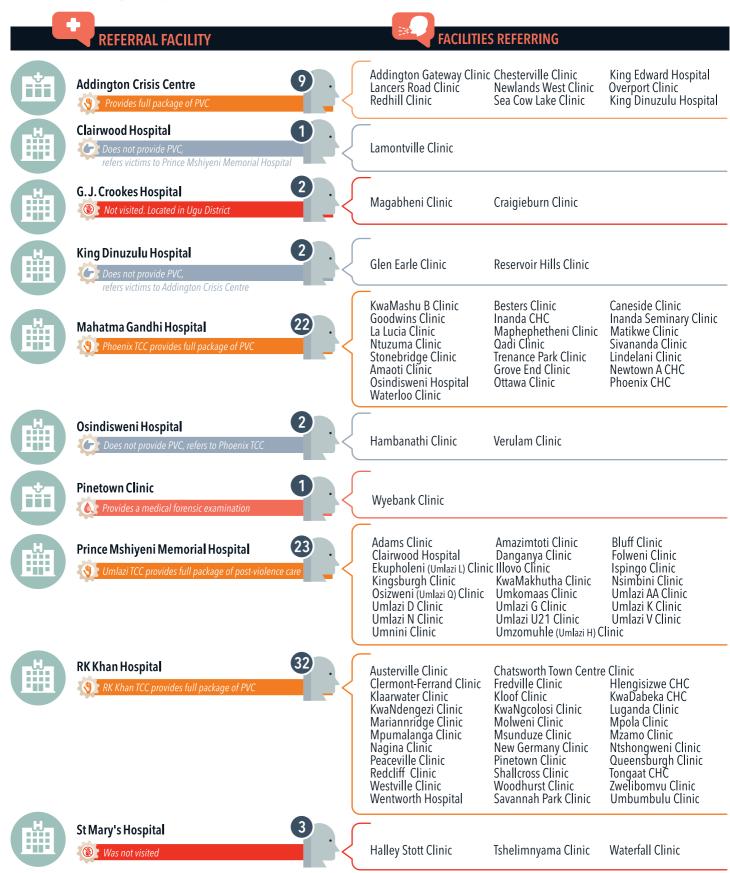




### 2.2 PVC referral pathways

There are 10 healthcare facilities that receive referrals for post-violence care services.

### eThekwini referral pathways

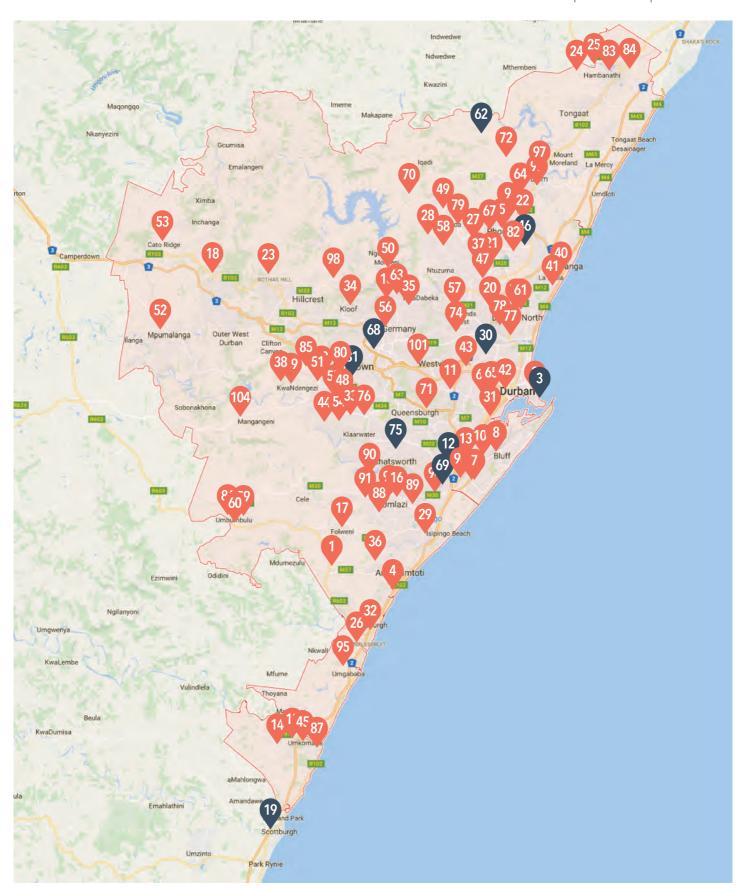


MAP KEY	FACILITY
1	Adams Clinic
2	Addington Gateway Clinic
3	Addington Hospital Crisis Centre
4	Amazimtoti Clinic
5	Amaoti Clinic
6	Austerville Clinic
7	Besters Clinic
8	Bluff Clinic
9	Caneside Clinic
10	Chatsworth Town Centre Clinic
11	Chesterville Clinic
12	Clairwood Hospital
13	Clermont-Ferrand Clinic
14	Craigieburn Clinic
15	Danganya Clinic
16	Ekupholeni (Umlazi L) Clinic
17	Folweni Clinic
18	Fredville Clinic
19	G.J Crookes Hospital (not visited)
20	Glen Earle Clinic
21	Goodwins Clinic
22	Grove End Clinic
23	Halley Stott Clinic
24	Hambanathi Clinic
25	Hlengisizwe CHC
26	Illovo Clinic
27	Inanda CHC
28	Inanda Cric Inanda Seminary Clinic
29	Ispingo Clinic
30	King Dinuzulu Hospital
31	King Edward Hospital
32	Kingsburgh Clinic
33	Klaarwater Clinic
34	Kloof Clinic
35	KwaDabeka CHC
36	KwaMakhutha Clinic
37	KwaMashu B Clinic
38	KwaNdengezi Clinic
39	KwaNgcolosi Clinic
40	La Lucia Clinic
41	Lamontville Clinic
42	Lancers Road Clinic
43	Lindelani Clinic
44	Luganda Clinic
45	Magabheni Clinic
46	Mahatma Ghandi Hospital ( <i>Phoenix TCC - not visited</i> )
47	Maphephetheni Clinic
48	Mariannridge Clinic
49	Matikwe Clinic
50	Molweni Clinic
51	Mpola Clinic
52	Mpumalanga Clinic
	p.sauriga omito

MAP KEY	FACILITY
53	Msunduze Clinic
54	Mzamo Clinic
55	Nagina Clinic
56	New Germany Clinic
57	Newlands West Clinic
58	Newtown A CHC
59	Nsimbini Clinic
60	Ntshongweni Clinic
61	Ntuzuma Clinic
62	Osindisweni Hospital
63	Osizweni (Umlazi Q) Clinic
64	Ottawa Clinic
65	Overport Clinic
66	Peaceville Clinic
67	Phoenix CHC
68	Pinetown Clinic
69	Prince Mushiyeni Memorial Hospital (Umlazi TCC)
70	Qadi Clinic
71	Queensburgh Clinic
72	Redcliff Clinic
73	Redhill Clinic
74	Reservoir Hills Clinic
75	RK Khan Hospital (TCC)
76 77	Savannah Park Clinic
77 78	Sea Cow Lake Clinic Shallcross Clinic
76 79	Sivananda Clinic
80	St Anne's Clinic
81	St Mary's Hospital (not visited)
82	Stonebridge Clinic
83	Tongaat CHC
84	Trenance Park Clinic
85	Tshelimnyama Clinic
86	Umbumbulu Clinic
87	Umkomaas Clinic
88	Umlazi AA Clinic
89	Umlazi D Clinic
90	Umlazi G Clinic
91	Umlazi K Clinic
92	Umlazi N Clinic
93	Umlazi U21 Clinic
94	Umlazi V Clinic
95	Umnini Clinic
96	Umzomuhle <i>(Umlazi H)</i> Clinic
97	Verulam Clinic
98	Waterfall Clinic
99	Waterloo Clinic
100	Wentworth Hospital
101	Westville Clinic
102	Woodhurst Clinic
103	Wyebank Clinic
104	Zwelibomvu Clinic

The blue pins indicate facilities that receive referrals for post-violence care.

### Map of referrals for post-violence care



In summary, the majority of referrals are made to Addington Hospital Crisis Centre (eThekwini South), Mahatma Ghandi Hospital (Phoenix TCC) (eThekwini North), Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South), and RK Khan Hospital TCC (eThekwini South). It is very encouraging that many facilities are referring victims to places where they would be able to access the full package of post-violence care.

Key informants from DSD and the NGO sector also had mainly positive views on some of these facilities and knew that patients were being referred there, or were referring them as well.



'Ghandi Hospital (Phoenix TCC) is doing well. They have a number of staff to deal with GBV and the other facilities refer to them. They also have a gender-assistance person which liaises between the clients and doctors. This person is employed by the NPA. They have a special unit to deal with GBV and special units work well for these type of services.'

\*\*DoH kev informant\*\*

'Mahatma Ghandi provides excellent service. Addington also seems to be doing well.' DSD key informant

'At Addington the police comes over to complete the J88 instead of the victim going there. There is a good relationship between the facility and the police.'

NGO key informant

'For health services we refer people to Addington. Although Addington does not generally have a good history of patient care, they have been revamping it and it seems to be improving. The biggest challenge is frustrations around the amount of time spent at the hospital, the waiting time and queues.'

NGO kev informant



However, other elements of the referral pathways are also worth nothing as these have potential for improvement:

The facility in eThekwini West that receives most referrals for post-violence care (from 4 facilities) is St. Mary's Hospital. However, the hospital is currently under liquidation and fieldworkers were not able to gain access for data collection. St Anne's clinic that is attached to the hospital is reportedly able to perform medical forensic examinations and it is therefore unclear if facilities are in fact referring to St. Anne's Clinic when mentioning St. Mary's. Only one facility (Wyebank Clinic) refers victims to Pinetown clinic, reportedly able to perform medical forensic examinations. No facilities refer to Clermont-Ferrand Clinic who are also able to perform medical forensic examinations. These are therefore potential referral facilities.

Three other facilities that victims are being referred to - King Dinuzulu Hospital, Osindisweni Hospital, and Clairwood Hospital - do not provide the full package of postviolence care, or medical forensic examinations. King Dinuzulu does .not provide the full package of PVC and refers victims to Addington Crisis Centre; Osindisweni Hospital does not provide PVC and refers victims to Mahatma Gandhi Memorial Hostpial (where the Phoenix TCC is based); and similarly Clairwood Hospital does not provide the full package of PVC care and refers victims to Prince Mshiyeni Hospital (where Umlazi TCC is based). This might mean that victims only receive some services there and are again referred, which is not ideal considering the level of trauma already suffered.

Tongaat CHC reported that they are able to provide the full package of post-violence care, however, other facilities reportedly do not refer to them.

Similarly, Clermont-Ferrand clinic, Umlazi V Clinic, and Maphephetheni Clinic are able to provide medical forensic examinations, but none of the other facilities reported referring victims there.

G.J Crookes Hospital also receives referrals for post-violence care, but was not visited for data collection as they are located in Ugu district.

Again the importance of follow up was mentioned by key interviewees as it is unclear whether victims who have reported to facilities and are then referred on have received care.



'There is no follow up after the person has been referred to a crisis centre. A system like this would strengthen care.' NGO key informant

### 2.3 Willingness to provide post-violence care

The majority of respondents felt that post-violence care is a service they should be offering because if a victim reports at their facility they would like to be able to help them rather than just referring them somewhere else. They also reported that it is often difficult for victims to travel to the facility they have been referred to because of a lack of transport and money, so they would like to provide post-violence care to the community they serve.

Respondents who reported that they should be equipped to provide post-violence care also described the significant need to be fully equipped with the correct equipment and enough trained staff to provide a high quality service to victims.

The majority of facilities wanted to be able to provide a full package of post violence care so that they would not have to refer victims anywhere. They would also like to be able to provide this service 24 hours a day as sexual violence often happens after normal working hours. Some clinics did report that they would not like to provide a full package of post-violence care, but only the basics such as counselling and HIV testing, and then refer victims.

Some key informants commented on some of the reasons why facilities are referring victims of sexual assault, despite their general willingness to provide these services. Reasons include standard operating procedures that state that victims should be referred, the sheer volume of patients seen at facilities, the pressures added by other illnesses that are treated at facilities, and fear of doing something wrong.



'The public health system is overwhelmed especially because noncommunicable diseases such as high blood pressure and diabetes are on the increase. GBV needs to be integrated into other care provided at the facilities, but a challenge is that number of clients that nurses have to see at facilities and that clients need more time with nurses if something like GBV is reported as it takes time for people to open up, trust and have a discussion about this.' NGO key informant

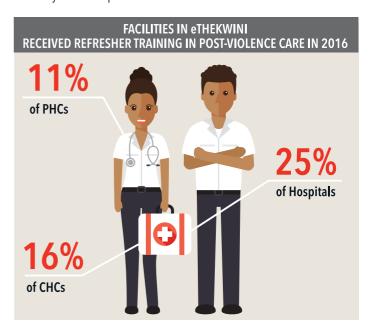


'The reasons behind PHCs referring GBV cases... PHCs see a high numbers of people. There is an issue around the capacity of staff and not having proper infrastructure. There is a policy that says that they are required to refer. There is no follow up to see if people have been treated. PHCs do not feel comfortable to manage rape. This has to do with skills, resources, a clinical governance piece that stipulates that these cases need to be referred, the fear that they might do something wrong and that they are under scrutiny. The real fear of being called to court to be a witness. It is important to remember that many nurses live in the community which might make them reluctant to get involved and people reluctant to report. Nurses sometimes know the victim and perpetrator. There is a lot of fear around reporting, both from the clinical side and the victim's side.' NGO key informant

### 2.4 Training on providing post-violence care

Only 13 facilities (12.75%) reported that their healthcare staff had received refresher training in managing and treating victims of sexual assault. Only 2% of facilities reported that the non-healthcare staff had received training in managing and responding to victims of sexual assault, and no facilities reported that auxiliary staff, such as cleaners and security guards, had received training.

Eleven percent of PHCs, 16% of CHCs and 25% of hospitals reported that their healthcare staff had received refresher training. The two TCCs reported that their healthcare and non-healthcare staff had received refresher training in post-violence care in 2016 from the National Prosecuting Authority and the Department of Health.



The refresher training was provided by the following organisations:













FPD

**National Prosecuting Authority** 

Department of Health

MatCH Systems

**HST** 

**Netcare Education** 

There was widespread acknowledgement among those interviewed at facilities and the key informants that refresher training would be appreciated in order to ensure a more uniform skills set and sensitisation among staff.



'Facilities differ and staff sensitisation is needed. I would not trust the skills of all staff to deal with this [incidents of sexual violence]...Larger facilities have an algorithm on their walls to deal with this which is helpful.' DoH key informant

> 'Nurses can do anything if you train them.' DoH key informant

'Dealing with anything is dependent on having sharp nurses.' NGO key informant

'Staff retention is problem. There is no cascading. On the one had there might be a need for a champion, although this has proved to be a disadvantage in the past because then this person gets tasked with the topic or programme and when it is all linked to them which is then a problem when they are not there. An alternative has been suggested which is to train two professional nurses instead of one so that there is always someone there who is linked to the topic area.'

NGO key informant

### 2.5 Client/victim friendliness

The majority of interviewees at the facilities were of the opinion that their facility is client-friendly because all patients are treated equally, all patients are treated with dignity and respect, there is a complaint/suggestion box, and there are youth-friendly areas and services. Those that thought their facility was not client-friendly reported that their staff needed training on client-friendliness, especially those who have first contact with patients, the environment was not confidential or private due to a lack of space, and some staff have negative attitudes towards victims of sexual violence.

During the key informant interviews respondents also spoke about the extent to which they perceive facilities to be client friendly, including theattitudes staff might have towards victims of violence. Both DoH and DSD spoke about how perceptions towards victims of violence might have been negative in the past, but that this has changed. Many facilities now have youth friendly services, and both the Patients' Rights Charter and the Constitution projects patients against discrimination. However, the perception of prejudice might still exist, although this is not necessarily grounded in the experience of patients.



'All this stems from a time where nurses were portrayed as rude to young people. They used to be old and demand respect. In case of GBV they would say 'what did you do' instead of listening to a person's story. In the case of contraception, if it was a girl, they would talk to them strongly before giving them protection...Staff still need training and sensitisation, but they have changed, although prejudice might still be there at the back of people's minds.' DoH key informant

'Might be a perception that the community has or is it the experience that nurses will tell on them? There is a confidentiality issue, but it's unclear whether this is the perception or people's actual experience. It was the same with HIV and ARVs - there is still the perception that people will tell. That the nurses will tell others and will tell the patents' families. This hasn't happened, although the perception has an impact.' DSD key informant

Key informants from NGOs, specifically those working with sex workers and persons who have been trafficked, had a slightly different view on the client friendliness of facilities.



'We do refer [sex workers] to public facilities and see that people do understand the clinic processes. But the ladies do not seem to see their health as a priority. And a challenge is that they do not have a place where they can leave their children either when they go to a clinic or if they need to be admitted to hospital. Their family structures is not such that they can leave their children anywhere for that long a period of time. Another challenge is the long queues and waiting times at facilities and that puts people off and is also time lost in which to earn an income.'

NGO key informant



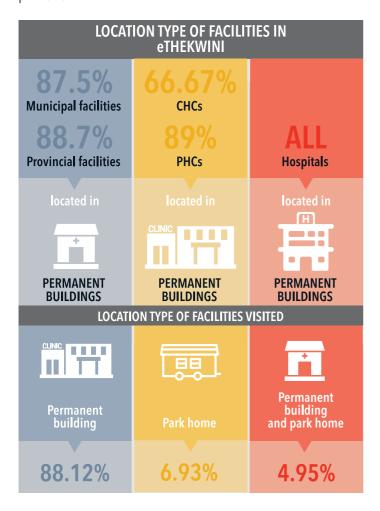
Talking specifically about shelters for abuse women 'Survivors [of trafficking] see shelters as a trap – they cannot leave, it reminds them of the trafficking situation. Also, the idea of being bombarded with questions wherever they go for help, as well as the issue of shame still exists.'

NGO key informant

# 3 Facilities and sites

### 3.1. Location type

Across all facilities, 88.12% were located in a permanent building, rather than a parkhome. Similarly, 87.5% of municipal and 88.7% of provincial facilities are located in a permanent building. All of the hospitals are located in a permanent building, 66.67% of CHCs are in a permanent building, and 89% of PHCs are in a permanent building. Umlazi TCC is located within the Prince Mshiyeni hospital building and RK Khan TCC is located in a parkhome.

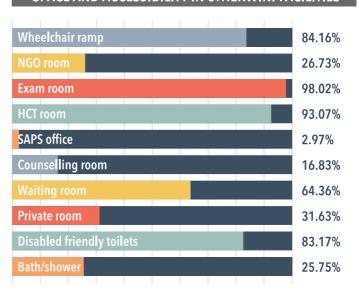


### 3.2. Space and accessability

The majority of facilities have disabled-friendly toilets (83.17%) and a wheelchair ramp (84.16%), examination rooms (98.02%) and HCT rooms (93.07%). Almost 75% of facilities do not have a private ablution area with a bath or shower; 36% do not have a waiting room and 83% do not have a roomfor counselling.



### SPACE AND ACCESSIBILITY IN eTHEKWINI FACILITIES



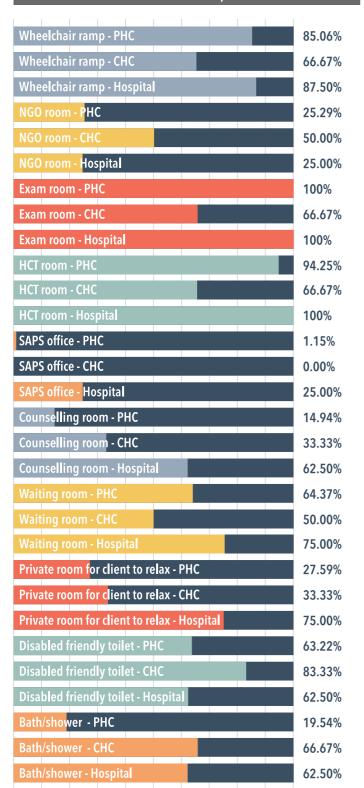
Only 19% of PHCs; 67% of CHCs and 62.5% of hospitals have private ablutions with a bath or shower. Furthermore, 63% of PHCs and 83% of CHCs, and 62.5% of the hospitals have disabled-friendly ablutions. All PHCs and hospitals (which includes the TCCs) have examination rooms, but only 66% of CHCs have examination rooms available. The two TCCs have all of the facilities available except an NGO room.



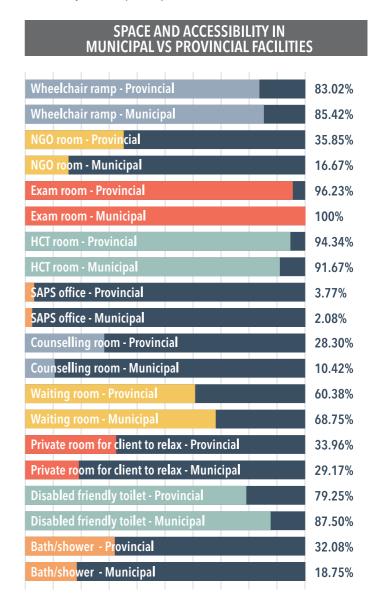
'I am worried about space. There are CHCs that have four professional nurses in one big consulting room. This does not lend itself to privacy in consulting and care.'

DoH key informant

### SPACE AND ACCESSIBILITY IN PHCs, CHCs AND HOSPITALS



Overall, there were no significant differences between space and accessibility in municipal and provincial facilities.



### 3.3. Equipment and supplies

### 3.3.1 General equipment

The majority of facilities have computers (97.03%), telephones (95.05%), a printer (80.20%), access to the internet (61.39%), air conditioners (81.19%), fire extinguishers (99.01%) and IEC material (69.31%). The equipment and items most needed are refreshments, comfort packs, clean clothes for victims, toys for children and anatomical dolls, and cameras.

# GENERAL EQUIPMENT AVAILABLE ACROSS FACILITIES IN eTHEKWINI (NORTH, SOUTH AND WEST)

69.31%

IEC material

Anatomically correct dolls

4.95%

Comfort packs

Clean clothes

4.95%

Refreshments

Lockable cabinet

85.15%

99.01%

Fire extinguisher

Microwave

95.05%

Fridges

31.68%

Heaters

81.19%

Aircon

Fans

5.94%

Cameras for evidence

Email/Internet



Printer



Photocopier



Fax machine





Telephone

Computer

There are not many significant differences between PHCs, CHCs and hospitals or municipal and provincial facilities. CHCs and hospitals are more likely to have toys for children than PHCs do, while hospitals are more likely than CHCs and PHCs to have anatomically correct dolls.

# GENERAL EQUIPMENT AVAILABLE PHCs, CHCs AND HOSPITALS

65.52% - PHC 83.3370 - Cr. 100% - Hospital

IEC material

4.60% - PHC **50.00%** - CHC **50.00%** - Hospital

Toys

**6.90%** - PHC 733.33% - CHC 25.00% - Hospital

Clean clothes

**86.21%** - PHC 66.67% - CHC **87.50%** - Hospital

Lockable cabinet

78.16% - PHC 83.33% - CHC 50.00% - Hospital

Microwave

32.18% - PHC 33.33% - CHC 25.00% - Hospital

Heaters

**73.56%** - PHC 66.67% - CHC 25.00% - Hospital

Fans

**57.47%** - PHC 83.33% - CHC 87.50% - Hospital

Email/Internet

**60.92%** - PHC 83.33% - CHC 75.00% - Hospital

Photocopier

97.70% - PHC 83.33% - CHC 75.00% - Hospital

Telephone

1.15% - PHC 50.00% - CHC **12.50%** - Hospital

Anatomically correct dolls

4.60% - PHC 16.67% - CHC 0.00% - Hospital

Comfort packs

3.45% - PHC 16.67% - CHC 12.50% - Hospital

Refreshments

**100%** - PHC 83.33% - CHC 100% - Hospital

Fire extinguisher

**96.55%** - PHC 83.33% - CHC **87.50%** - Hospital

Fridges

**80.46%** - PHC 83.33% - CHC 87.50% - Hospital

Aircon

0.00% - PHC **66.67%** - CHC 25.00% - Hospital

Cameras for evidence

80.46% - PHC **83.33%** - CHC 75.00% - Hospital

Printer

49.43% - PHC 83.33% - CHC **50.00%** - Hospital

Fax machine

97.70% - PHC 83.33% - CHC 100% - Hospital

Computer

## GENERAL EQUIPMENT AVAILABLE IN PROVINCIAL VS MUNICIPAL FACILITIES

**69.81%** - Provincial **68.75%** - Municipal

IEC material

7.55% - Provincial 2.08% - Municipal

Anatomically correct dolls

15.09% - Provincial 6.25% - Municipal

Toys

7.55% - Provincial 2.08% - Municipal

Comfort packs

15.09% - Provincial 4.17% - Municipal

Clean clothes

5.66% - Provincial 4.17% - Municipal

Refreshments

**84.91%** - Provincial **85.42%** - Municipal

Lockable cabinet

98.11% - Provincial 100% - Municipal

Fire extinguisher

81.13% - Provincial 70.83% - Municipal

Microwave

92.45% - Provincial 97.92% - Municipal

Fridges

39.62% - Provincial 22.92% - Municipal

Heaters

84.91% - Provincial 77.08% - Municipal

Aircon

Printer

69.81% - Provincial 68.75% - Municipal

Fans

11.32% - Provincial 0.00% - Municipal

Cameras for evidence

43.40% - Provincial 81.25% - Municipal

Email/Internet

92.45% - Provincial 66.67% - Municipal

**84.91%** - Provincial **39.58%** - Municipal

Photocopier

71.70% - Provincial 29.17% - Municipal Fax machine

92.45% - Provincial 97.92% - Municipal

ıl al **96.23%** - Provincial **97.92%** - Municipal

Telephone

Computer

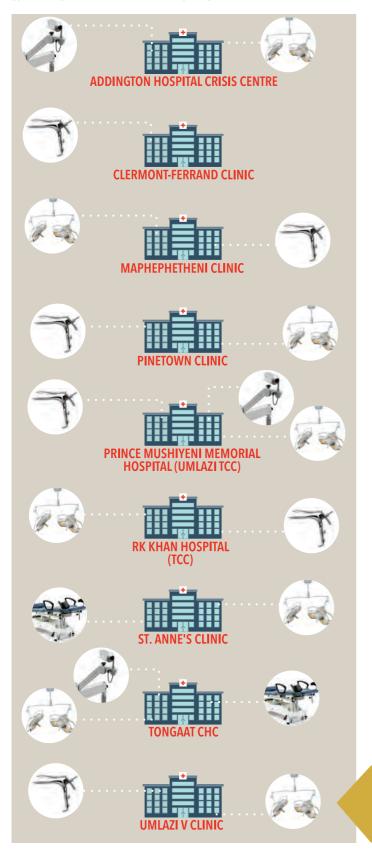
### 3.3.2 Medical equipment

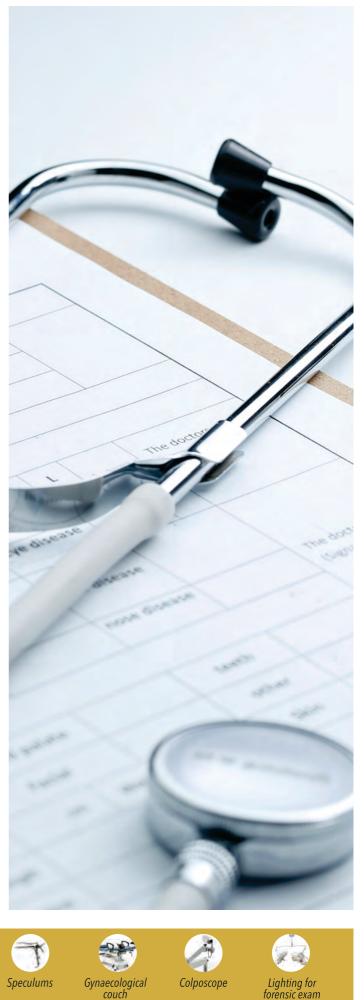
While the majority of facilities have the general medical equipment required of a healthcare facility, the majority did not have the medical equipment needed for post-violence care. The greatest need is for colposcopes – 93.14% of facilities do not have these. Only two-thirds of facilities have speculums, (35.29% do not), and just over half of facilities (55.45%) do not have a gynaecological couch.

### MEDICAL EQUIPMENT AVAILABLE ACROSS FACILITIES



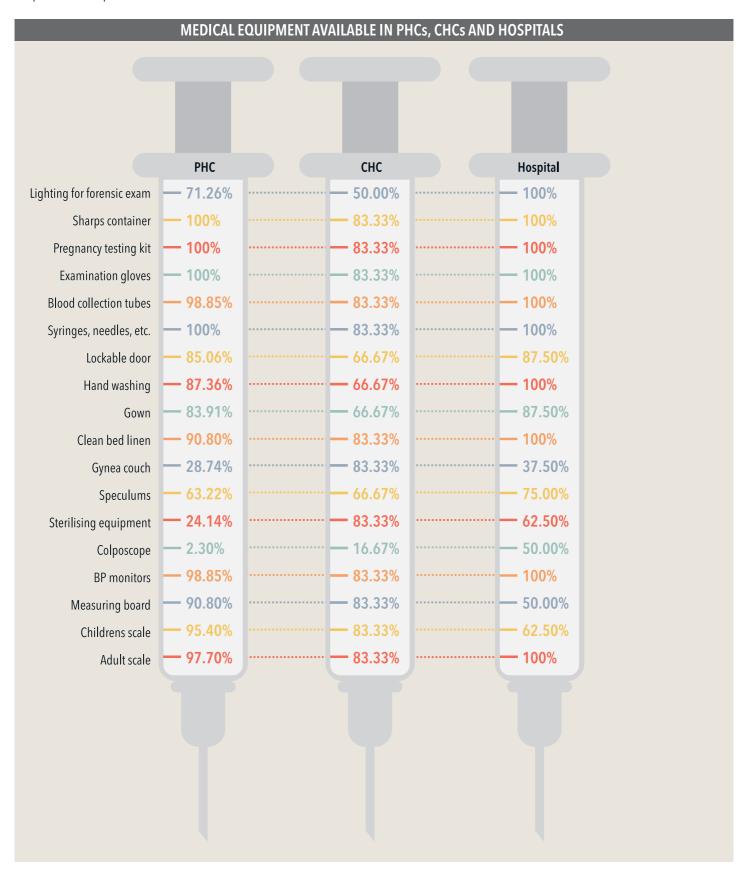
Of the nine facilities that reported that they provide the medical forensic examination, 30% had a colposcope, 55% had speculums, 22% had a gynaecological couch, and 88% had lighting for forensic examinations.

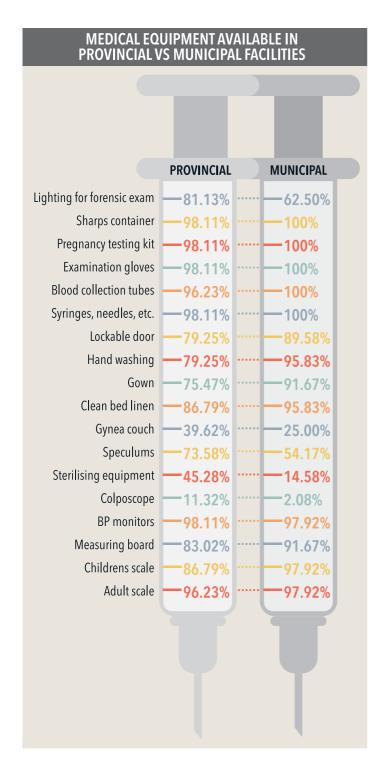






There are not many significant differences between PHCs, CHCs and Hospitals or Municipal and Provincial facilities.







### 4.1. Days and hours of service

Overall, 39 facilities (38.24%) are open 7 days a week. Of the facilities not open 7 days a week, 51% are open from Monday to Friday and 10% are open Monday to Saturday.

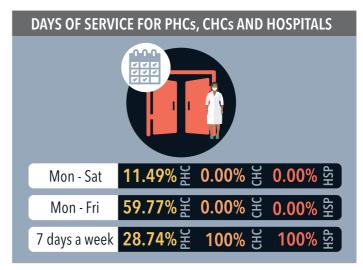




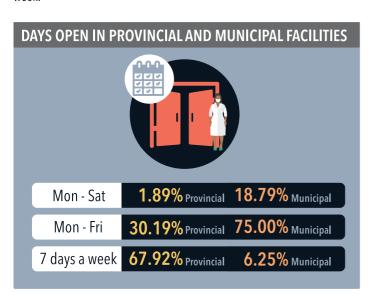
With regards to PHCs, only 28% are open 7 days a week, and most (60%) are open Monday to Friday.



All of the CHCs and all of the Hospitals are open 7 days a week.



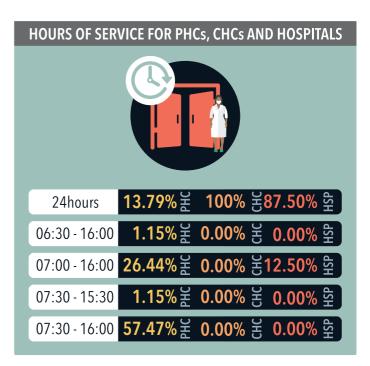
The majority of provincial facilities (67.92%) provide services 7 days a week, while the minority of municipal facilities (6.25%) provide services 7 days a week.



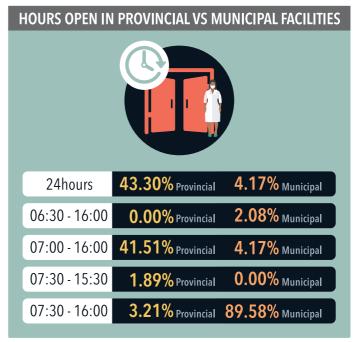
Overall, 25 facilities (24.75%) deliver a 24 hour service. Just less than 1% of facilities are open from 6:30 to 16:00 and 7:30 to 15:30.25% are open from 7:00 to 16:00 and half (50%) are open from 7:30 to 16:00.



The majority (87.5%) of hospitals are open 24 hours a day, one is open from 7:00 to 16:00. All the CHCs are open 24 hours a day. The majority of PHCs are open from 7:30 to 16:00. The two TCCs are open 24 hours a day, 7 days a week.

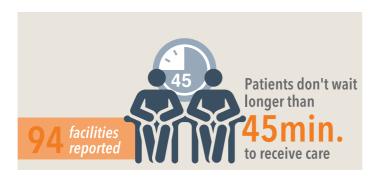


Just under half of the provincial facilities are open 24 hours a day (43.4%), 41% are open from 7:00 to 16:00 and 13% from 7:30 to 16:00. The majority (90%) of municipal facilities are open from 7:30 to 16:00.



### 4.2. Waiting time

Ninety-four facilities (92.16%) reported that they have a waiting time of 45 minutes or less. The remaining facilities reported that patients wait longer than 45 minutes.





The majority of hospitals (100%), CHCs (83%) and PHCs (92%) have an average waiting time of less than 45 minutes. The two TCCs have a waiting time of 45 minutes or less.

Similarly, most provincial (94.34%) and municipal (89.58%) facilities have an average waiting time of less than  $45\,$ minutes.

It was often reported that if patients are identified as victims of violence they are immediately taken to emergency or fast tracked to see a healthcare professional.

5 Human resources

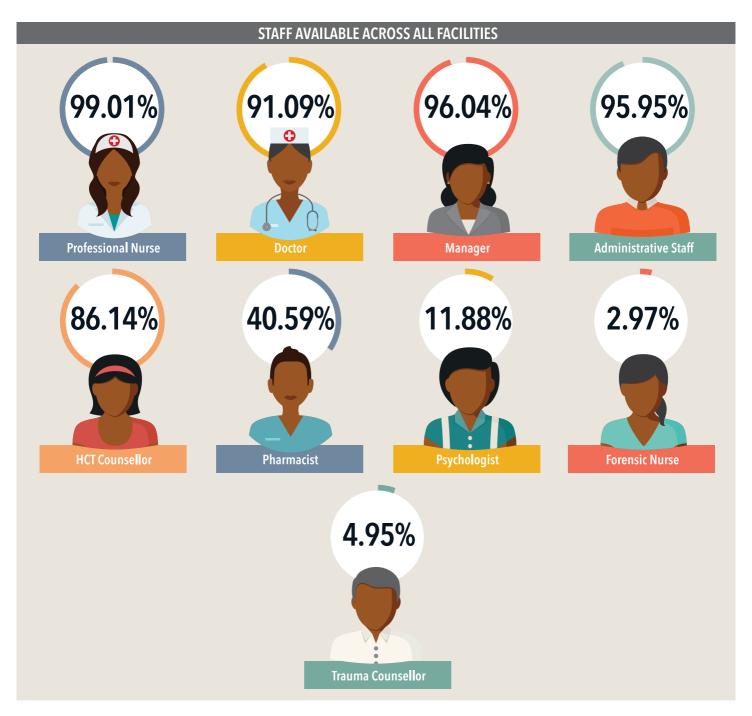
5.1. Staffing

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

The only three facilities that have forensic nurses are King Dinuzulu Hospital (1), Prince Mshiyeni Hospital (UmlaziTCC) (1) and RK Khan Hospital TCC (2). Ninety-one percent of facilities have either a full time or part time doctor.



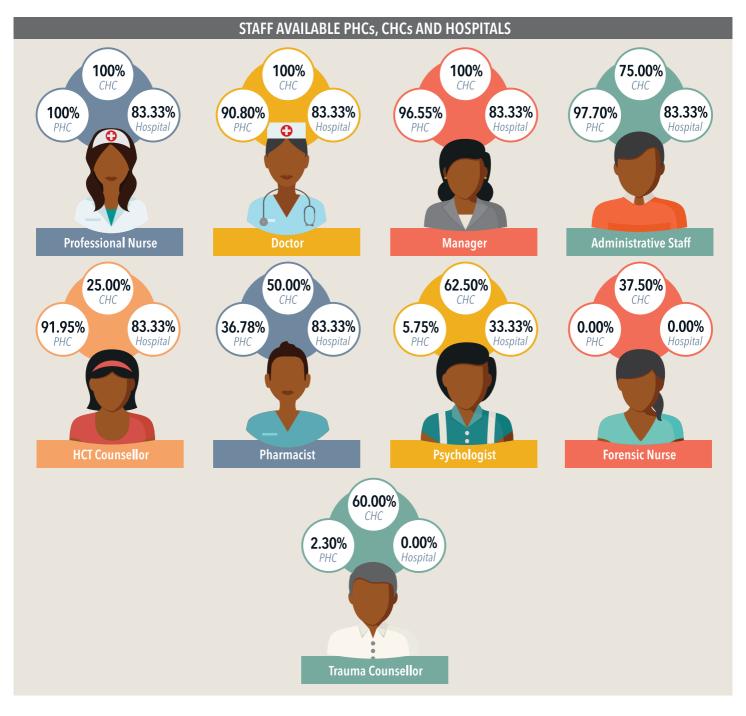




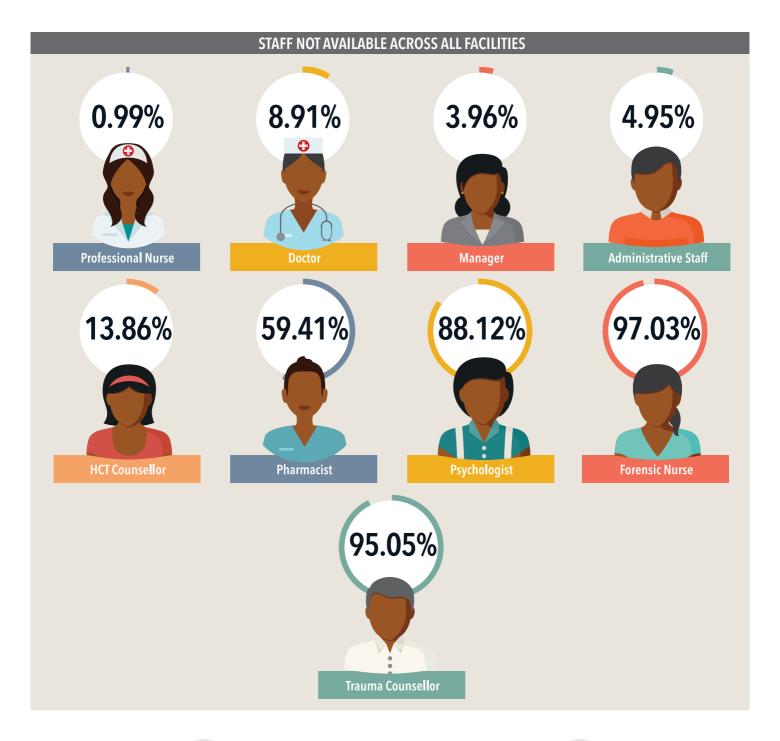


Only 4% of facilities have no manager, 1% have no professional nurse, and 5% have no administrative staff. 97% have no forensic nurse, 95% have no trauma counsellor, 88% have no psychologist and 59% have no pharmacist or pharmacy assistant.

The following graphic shows the staff available in PHCs, CHCs and Hospitals. The positions most often vacant were forensic nurses, trauma counsellors and psychologists.









'The lack of diverse staff means that inter-sectoral or multidisciplinary care is missing.'

DoH kev informant

'A gap is that there are no social workers at the facilities.'

NGO kev informant



'It is necessary to create a pool of experts to refer to. A multidimensional range of solutions necessary. The client thinks one thing and then realises other options might be more effective.' NGO key informant

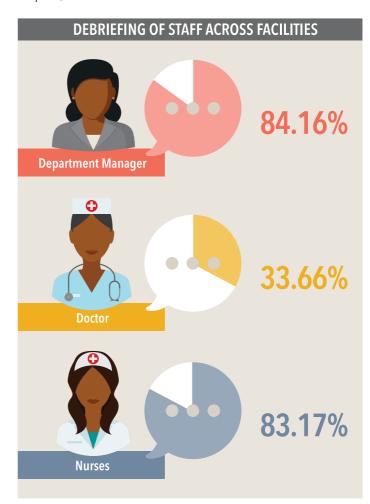
### 5.1.2 Staff supervision

It was reported that 99% of department managers are supervised, 54% of doctors are supervised and 69% of nurses are supervised. There was very little difference between supervision in hospitals, CHCs and PHCs.

# SUPERVISION OF STAFF ACROSS FACILITIES 99.01% Department Manager 54.46% Nurses 69.31%

### 5.1.3 Staff debriefing

It was reported in 84% of facilities that the managers receive debriefing, in 33.66% that doctors receive debriefing and in 83% that nurses receive debriefing. There was very little difference between the debriefing of staff in hospitals, CHCs and PHCs.





# **6.** Recommendations for improvements at facilities

When interviewees at facility-level were asked about recommendations improving the functioning of the facilities the three most frequent recommendations were additional staff, relevant training and enough equipment and space. Other recommendations included maintaining and repairing the physical structure of facilities, making services available 24 hours a day and 7 days a week, and more support from the Department of Health in terms of more leave and time to be debriefed.

A shortage of staff, insufficient space and insufficient resources were reported by almost all interviewees at the facilities as major challenges they are facing. Other challenges reported often include a lack of infrastructure maintenance, repairs taking a long time to be attended to and shortages and stock-outs of medicine. Some respondents mentioned challenging relationships between staff members, not having access to the internet, being overworked and experiencing burn-out.

When asked about recommendations for additional services that the facility could provide Mother, Women and Child Health (MWCH) was most often recommended as additional services. Other services recommended include post-violence care, ART initiation, social services, counselling, mental health, treatment of minor ailments, and chronic care.

# NGOs as • service providers

### 7.1. The role of NGOs in the provision of care

Key informants acknowledged the important role that NGOs play in supporting or supplementing the services that government provides and in serving the community.



'Because of apartheid and our history services were supposed to be there, but facilities have been disadvantaged in being able to provide every type of care. NGOs are supplementing what government is providing. Their presence is good. Under DREAMS young girls are now specifically catered for, which they weren't before. Some nurses have complained that NGOs are bringing extra work to facilities, which is not a good thing. This indicates that the NGO and facility did not sit and discuss what is needed beforehand in the facility and how they can work together.'



'NPOs are in the community, they are accessible and are more accessible than government. They are focused on dealing with specific things and therefore are able to provide quality. They are specialised and will have more knowledge. They are also exposed to training. The challenges are that they sometimes provide the same services but do not know each other.'

DSD key informant

It is clear from the key informant interviews and the section on NGOs that provide services within facilities in eThekwini (see below) that NGOs operate according to different models. Some work outside facilities to support victims of violence by being approachable to those in need of care, by assessing the needs of clients, providing face-to-face counselling, referrals to other service providers, shelter, and legal aid. Sometimes there is crisis intervention and at other times longer-term support is provided where trust is built between providers of care and victims of sexual violence. In each case an individual care plan is developed as cases are often complex and the needs of victims differ. Many of these NGOs also run prevention campaigns to make communities aware of the existence of GBV and where to seek help. In many instances funding for their work remains a challenge as they are reliant on external support and receive limited or no support from government. Some receive funding from churches, while others are too small to apply for big grant funding. There was also a sense that funding for supporting victims of violence is difficult to come by because funders are wary of funding new and smaller initiatives and that there are other areas of work that donors are happier to fund. Funding constraints impact on the sustainability of the work of NGOs and their continued ability to provide services to those who need them.

In order for the referral pathways for victims of violence to be strengthened it is necessary for NGOs to understand where best to refer victims to in order to receive medical care, as well as for facilities to understand the wider network of NGOs they can draw on.

### 7.2. NGOs supporting specific facilities

Seventy-eight facilities (77.23%) have an NGO providing services within the facility. The question in the survey related to NGOs supporting facilities was initially intended to only record support in the provision of post-violence care services. However, in the process of identifying NGOs that provide support in relation to the provision of post-violence care, the services NGOs provide more generally, such as HIV Counselling and Testing was also captured. Seventy-five percent of hospitals have an NGO providing support, as do 66% of CHCs and 78% of PHCs. It was found that NGOs mostly assist facilities in the provision of services such as HIV programmes, OVC support, social workers and related services, supporting abused women and other psychosocial services.

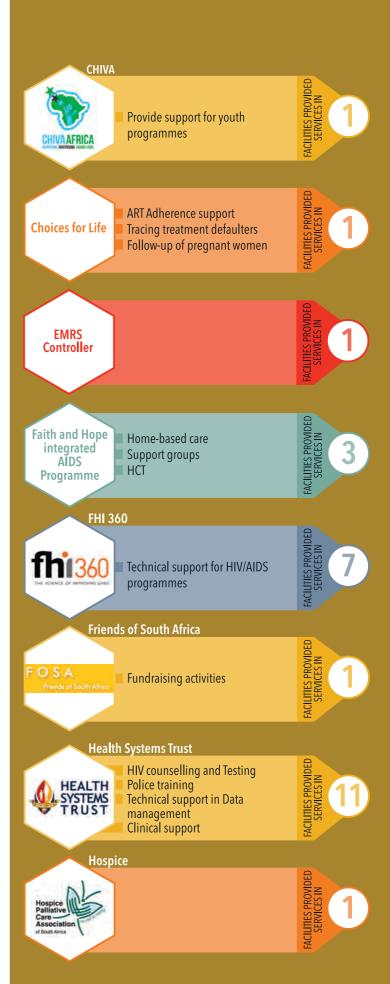
Of the five facilities able to provide all of the post-violence care services, four had an NGO working in them. Three of these were providing services related to counselling – Lifeline and Childline (Prince Mshiyeni and RK Khan Hospital) and SRC (Addington Hospital Crisis Centre). Tongaat CHC is supported by MatCH and StAnne's does not have an NGO.

Of the additional four facilities able to provide medical forensic examination, MatCH was reported by Umlazi V clinic and Maphephetheni Clinic; Open Door Crisis Centre was reported by Pinetown clinic; Key Population was reported by Umlazi V clinic and Clermont-Ferrand clinic doesn't have an NGO. Open Door Crisis Centre assist abused women and Key Population assist sex workers and the LGBTI community.

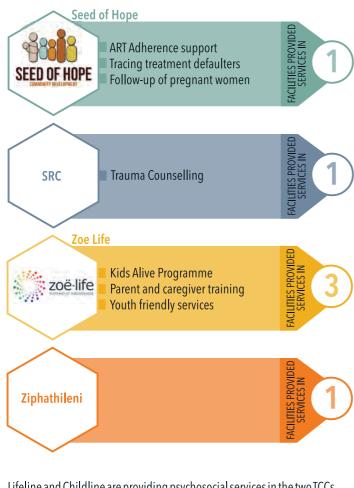
From this we conclude that NGOs support facilities in the provision of services such as counselling, but not necessarily in providing medical forensic examinations.

A list of the 32 NGOs and the services they provide.









Lifeline and Childline are providing psychosocial services in the two TCCs.

### Facilities without an NGO





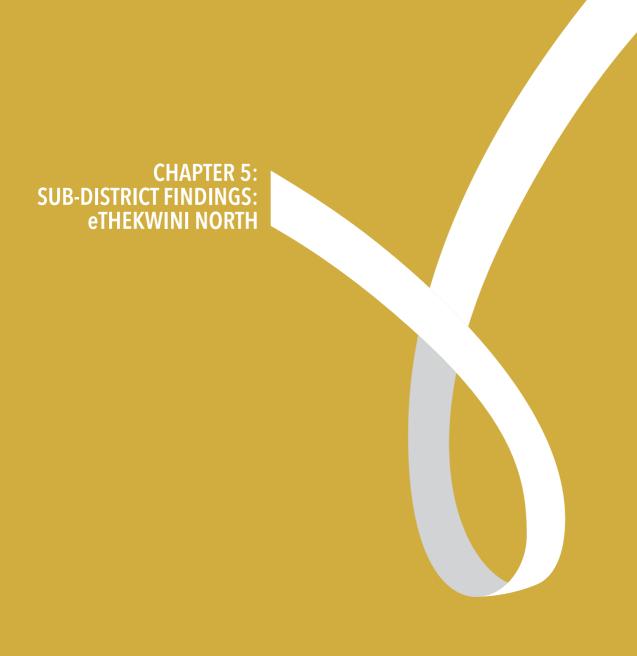


**Clermont-Ferrand Clinic Mariannridge Clinic** St Anne's Clinic

eThekwini North **Besters Clinic Caneside Clinic Goodwins Clinic Inanda Seminary Clinic** KwaMashu B Clinic La Lucia Clinic Lindelani Clinic **Matikwe Clinic Newlands West Clinic Ntuzuma Clinic Qadi Clinic Sea Cow Lake Clinic** Sivananda Clinic

eThekwini South **Lancers Road Clinic Overport Clinic** 





### CHAPTER 5: SUB-DISTRICT FINDINGS: eTHEKWINI NORTH

### Data were collected from 29 facilities in eThekwini North; 1 hospital, 4 CHCs and 24 PHCs.

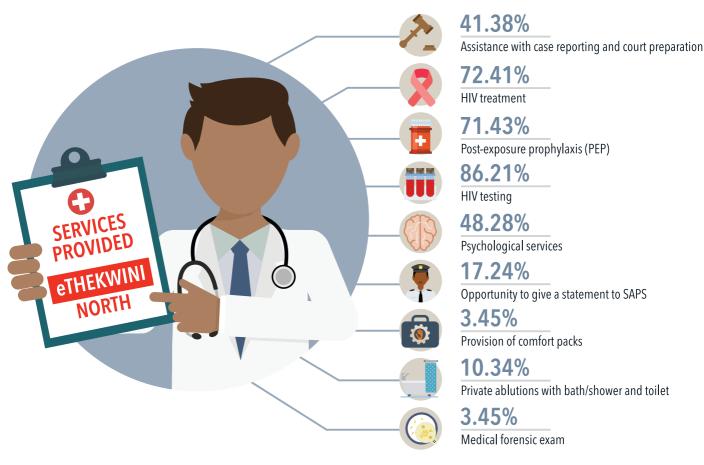
# Findings • related to PVC

Only one facility (Tongaat CHC) in eThekwini North provides the full package of post-violence care services, including medical forensic examinations. According to the Compliance Audit and Gap Analysis conducted by FPD in 2016, Phoenix TCC at Mahatma Gandhi Hospital (eThekwini North), provides the full package of post-violence care. We were not able to visit the facility due to concerns about approvals.

Eighty-six percent provide HIV testing, 71% provide PEP, and 72% provide HIV treatment.

### Post-violence care services provided in eThekwini North facilities





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

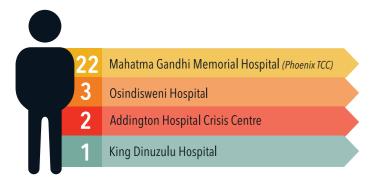
The average number of sexual assaults per week reported in eThekwini North facilities is 0.67. This is lower than in eThekwini South facilities (2.05). The facility receiving the highest number of cases was Inanda CHC, reporting five cases per week. Following them is Newtown A CHC, reporting three cases per week.



### 1.2. PVC referral pathways

Facilities in eThekwini North reported to refer victims of sexual violence to the following facilities:

### Facilities victims of sexual violence are referred to



Although Tongaat CHC reported that they do provide the full package of post-violence care, none of the facilities refer victims there.

Mahatma Gandhi Memorial Hospital (Phoenix TCC) provides the full package of post-violence care services (FPD, 2016) and is located in eThekwini North. The majority of facilities in eThekwini North refer victims there.

Osindisweni Hospital is also located in eThekwini North, but reported that they do not provide medical forensic examinations and refer victims to Mahatma Gandhi Memorial Hospital (Phoenix TCC). This means that victims that are referred to Osindisweni Hospital by facilities are referred again for medical forensic examinations. Recommended changes to this referral pathway could be that this hospital be upscaled to provide the full package of post-violence care, or that victims are referred to other facilities that provide the full package, provided they have the means to travel to these facilities.

Addington Hospital Crisis Centre also provides the full package of post-violence care, but is located in eThekwini South. Similarly, King Dinuzulu Hospital is also located in eThekwini South and the facility reported that they don't provide medical forensic examinations and refer to Addington Hospital Crisis Centre.

post-violence care, none of the facilities refer victims there.	riospitai Crisis Ceritie.
Hambana	MAP KEY FACILITY
Kwazini <sup>8</sup> 29	1 Addington Hospital
	2 Amaoti Clinic
Tanana Tanana	3 Besters Clinic
kapane Tongaat	4 Caneside Clinic
	5 Glen Earle Clinic
	Tongaat B 6 Goodwins Clinic
Mount M65	Desainage 7 Grove End Clinic
Inadi 44 31 Assaland 4 4 4	8 Hambanathi Clinic
32	9 Inanda CHC
23 21 erui, h	10 Inanda Seminary Clinic
16 MZS 4	ti 11 King Dinuzulu Hospital
MZS	12 KwaMashu B Clinic
10 10 27 22 2 7	13 La Lucia Clinic
	14 Lindelani Clinic
18 Phoet 28 15	15 Mahatma Gandhi Memorial Hospital (Phoenix TCC)
12 6	16 Matikwe Clinic
Vgcolosi Molweni	17 Newlands West Clinic
Ni Juma 13 nianga	18 Newtown A CHC
La L cia	19 Ntuzuma Clinic
KwaDabaka 17 5 25 M12	Osindisweni Hospital
KwaDabeka 17 19 2	21 Ottawa Clinic 22 Phoenix CHC
Newlands 26 ban North	23 Qadi Clinic
ew Germany West	24 Redcliff Clinic
	25 Redhill Clinic
M19 M12	26 Sea Cow Lake Clinic
2	27 Sivananda Clinic
Westville	28 Stonebridge Clinic
	29 Tongaat CHC
Durban eThekwini Nor	
	31 Verulam Clinic
The blue pins indicate facilities that receive referrals for post-violence care	32 Waterloo Clinic

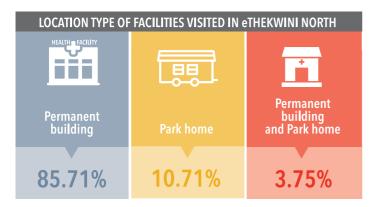
### 1.3. Training on providing post-violence care

Only one facility (Newtown CHC) reported that their healthcare and non-healthcare staff received refresher training in post-violence care from FPD in 2016.

# **2** Facilities and sites

### 2.1. Type of buildings

The large majority (85.7%) of facilities are located in a permanent building.



### 2.2. Space and accessibility

Private room for victim to rest in

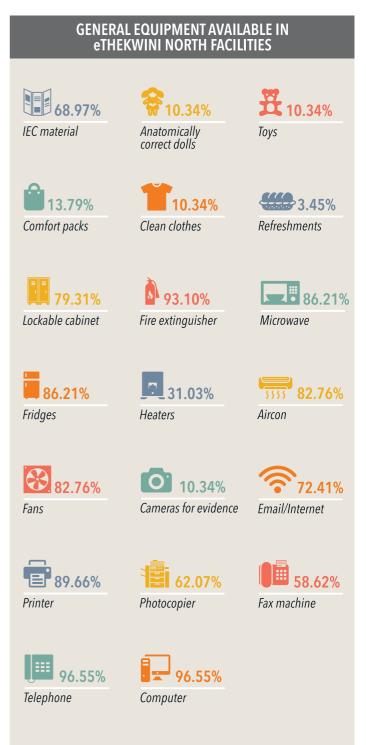
Disabled friendly toilets

The majority of facilities in eThekwini North have a wheelchair ramp (93%) and disabled-friendly toilets (82.7%). Eighty-six percent have a waiting room with seating, 82.7% have an HCT room and 96.5% have at least one examination room.

# SPACE AND ACCESSIBILITY IN eTHEKWINI NORTH FACILITIES Wheelchair ramp 93.10% NGO room 20.69% Exam room 96.55% HCT room 82.76% SAPS office 3.45% Counselling room 10.34% Waiting room with seating 86.21%

### 2.3. Equipment and supplies

The majority of facilities in eThekwini North have sufficient general equipment such as computers and telephones (96.5%), printers (89.66%), access to the internet (72.41%), fire extinguishers (93.10%) and IEC material (68.97%). Few have toys for children (10.34%), refreshments for victims (3.45%), clean clothes for victims (10.34%), and cameras for evidence collection (10.34%).



24.14%

82.76%

31.03%

The majority of facilities in eThekwini North have all the medical equipment necessary for their functioning as a health facility. Few have the equipment necessary for post-violence care, namely a colposcope (6.9%), speculums (68.97%), gynaecological couch (37.93%) and sufficient lighting for forensic examinations (44.83%). Tongaat CHC, who reported they do provide post-violence care, have a gynaecological couch, a colposcope and lighting for forensic exams.

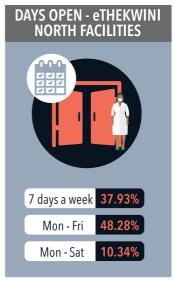
### MEDICAL EQUIPMENT AVAILABLE IN **eTHEKWINI NORTH FACILITIES** Lighting for forensic exam 44.83%-Sharps container 96.55%-96.55%— Pregnancy testing kit **Examination gloves** 96.55%= Blood collection tubes 96.55%-96.55%-Syringes, needles, etc. Examination room with lockable door 75.86%= 96.55%= Hand washing facility in examination room Gown 93.10%-89.66%-Clean bed linen 37.93%-Gynea couch Speculums Sterilising equipment 24.14% Colposcope 6.90% 96.55%-BP monitors 89.66%= Measuring board Childrens scale 89.66%= 96.55% Adult scale

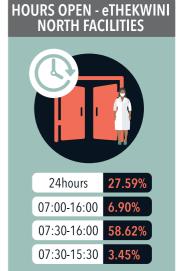
3 Services delivered

### 3.1. Days and hours of service

Just under half of the facilities in eThekwini North are open from Monday to Friday (48.28%), and 37% are open 7 days a week. The majority (58%) of facilities are open from 7:30 to 16:00, and 27.6% are open 24 hours a day.

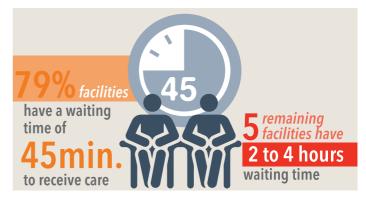






### 3.2. Waiting time

79% of facilities have a waiting time of 45 minutes or less, and the five remaining facilities have waiting times ranging from 2 to 4 hours.



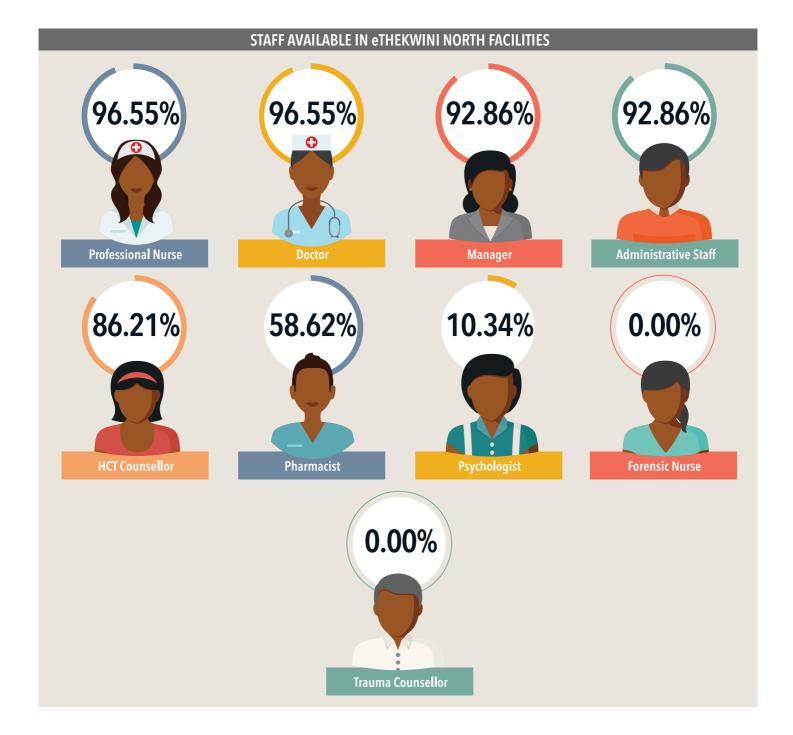
Human resources

4.1.

### Staffing

The majority of facilities have a facility or department manager and administrative staff (92.86%), at least one professional nurse and doctor (96.55%), HCT counsellors (86.21%) and a pharmacist (58.62%). Only three (10.34%) have a psychologist, none have a forensic nurse or trauma counsellor.





Tongaat CHC, who reported that they do provide post-violence care, have eight full time doctors, 94 professional nurses and nine HCT counsellors. They do not have any psychologists, trauma counsellors or forensic nurses.

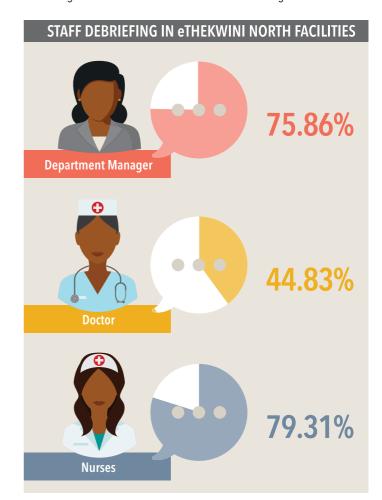
### 4.2. Supervision

The majority (96.55%) of facilities in eThekwini North reported that the facility manager is supervised, 82.76% that the doctors are supervised and 72.41% that the nurses are supervised.

# STAFF SUPERVISION IN eTHEKWINI NORTH FACILITIES 96.55% Department Manager 82.76% Nurses 72.41%

### 4.3. Debriefing

Similarly, the majority (75.86%) of facilities in eThekwini North reported that the manager receives debriefing, 44.83% that the doctor receives debriefing and 79.31% that the nurses receive debriefing.





# **5.** NGOs as service providers

Forty-six percent of facilities have an NGO in them.

### NGOs in eThekwini North







### CHAPTER 6: SUB-DISTRICT FINDINGS: eTHEKWINI WEST

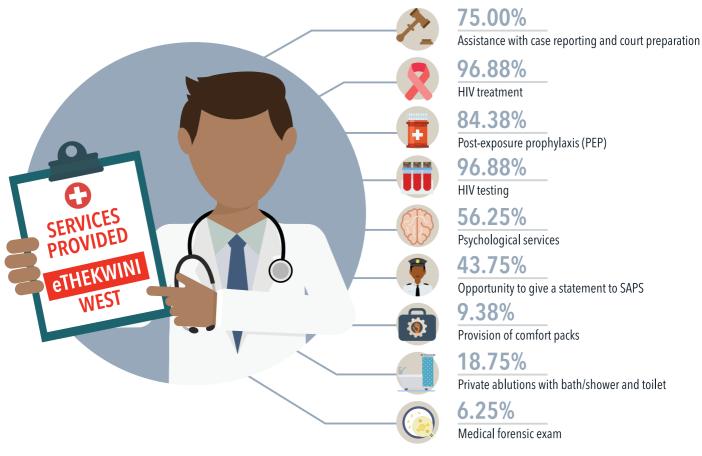
### Data were collected from 31 facilities in eThekwini West; 2 CHCs and 30 PHCs.

# Findings • related to PVC

Three facilities (Pinetown Clinic, Clermont-Ferrand Clinic and St Anne's Clinic) provide medical forensic examinations in eThekwini West. St Anne's Clinic provides the full package of post-violence care services.

The majority of facilities in eThekwini West provide HIV testing (96.88%), PEP (84.38%) and HIV Treatment (96.88%).

### Services provided by facilities in eThekwini West





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

The average number of cases of sexual assault per week in eThekwini West is 1.06. (South = 2.05; North = 0.67).

The facility that receives the highest number of sexual assault cases is KwaNdengezi Clinic, reporting 15 cases per week. Following them is Tshelimnyama Clinic and Mpola Clinic reporting five and three cases per week respectively.

# 1.06 cases of SEXUAL ASSAULT per week

### 1.2. PVC referral pathways

Below lists where facilities refer victims of post-violence care.

### Facilities victims of sexual violence are referred to

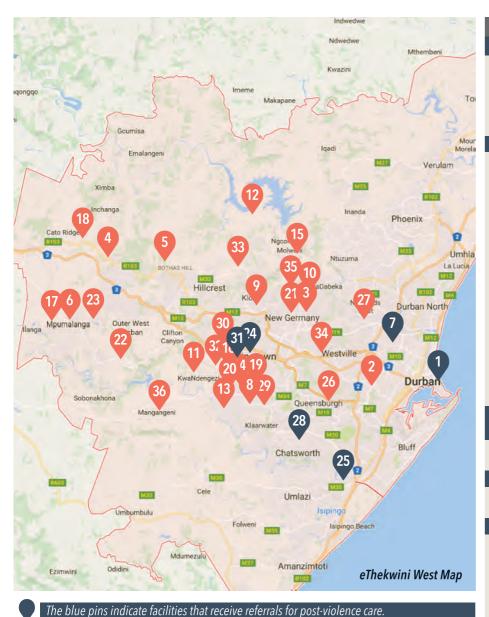
_			
1	Addington Hospital Crisis Centre	South	•
1	King Dinuzulu Hospital	South	
1	Pinetown Clinic	West	
1	Prince Mshiyeni Hospital (Umlazi TCC)	South	•
21	RK Khan Hospital (RK Khan TCC)	South	
4	St Mary's Hospital	West	•

Addington Hospital Crisis Centre provides the full package of post-violence care, but is located in eThekwini South. King Dinuzulu Hospital is located in eThekwini South and the facility reported that they do not provide medical forensic examinations and refer to Addington Hospital Crisis Centre. Pinetown Clinic is located in eThekwini West, and they do provide medical forensic examinations. Prince Mshiyeni (Umlazi TCC) and RK Khan Hospital (RK Khan TCC) are located in eThekwini South and provide the full package of post-violence care.

St Mary's Hospital is located in eThekwini West. Unfortunately we could not collect data from this facility as they are currently in liquidation. Depending on the future of this hospital, facilities referring here might need to be made aware that a different referral pathway for victims of sexual violence should be followed.

Although Clermont-Ferrand Clinic and St Anne's Clinic both provide medical forensic examinations, none of the facilities reported referring victims to either.





MAP KEY	FACILITY	
1	Addington Hospital Crisis Centre	
2	Chesterville Clinic	
3	Clermont-Ferrand Clinic	
4	Fredville Clinic	
5	Halley Stott Clinic	
6	Hlengisizwe CHC	
7	King Dinuzulu Hospital	
8	Klaarwater Clinic	
9	Kloof Clinic	
10	KwaDabeka CHC	
11	KwaNdengezi Clinic	
12	KwaNgcolosi Clinic	
13	Luganda Clinic	
14	Mariannridge Clinic	
15	Molweni Clinic	
16	Mpola Clinic	
17	Mpumalanga Clinic	
18	Msunduze Clinic	
19	Mzamo Clinic	
20	Nagina Clinic	
21	New Germany Clinic	
22	Ntshongweni Clinic	
23	Peaceville Clinic	
24	Pinetown Clinic	
25	Prince Mshiyeni Hospital (Umlazi TCC)	
26	Queensburgh Clinic	
27 28	Reservoir Hills Clinic	
	RK Khan Hospital (RK Khan TCC) Savannah Park Clinic	
29 30	St Anne's Clinic	
31	St Mary's Hospital	
32	Tshelimnyama Clinic	
33	Waterfall Clinic	
33 34	Westville Clinic	
35	Wyebank Clinic	
36	Zwelibomyu Clinic	
30	ZWEIIDOITIVU CIIIIIC	

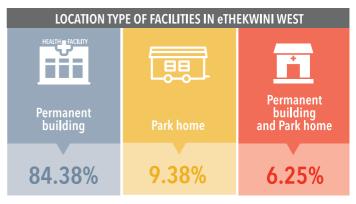
Training on providing post-violence care

Seven facilities (21.88%) reported that the healthcare staff had received refresher training, three (9.38%) that the non-healthcare staff have received refresher training and one (3.13%) that the auxiliary staff have had refresher training. Training was provided by FPD, MatCH, University of KZN or Netcare Education.



### 2.1. Type of buildings

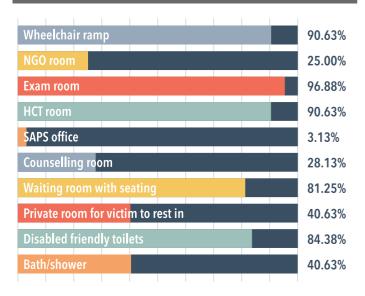
The majority (84.38%) of facilities are located in a permanent building.



### 2.2. Space and accessibility

The majority of facilities have disabled friendly toilets (84.38%), a wheelchair ramp (90.63%), a waiting room (81.25%), an HCT room (90.63%) and an examination room (96.88%).

## SPACE AND ACCESSIBILITY IN eTHEKWINI WEST FACILITIES





### 2.3. **Equipment and supplies**

The majority of facilities in eThekwini West have the general equipment necessary such as computers (96.88%), telephones (93.75%), fire extinguishers (100%) and IEC material (62.50%).

### **GENERAL EQUIPMENT AVAILABLE** eTHEKWINI WEST FACILITIES

























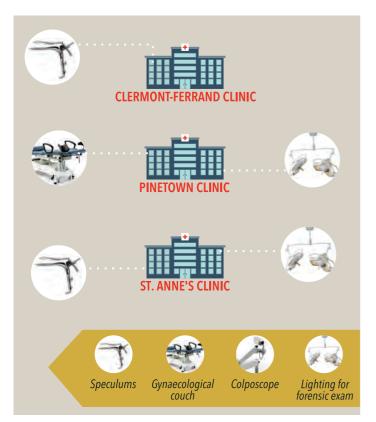


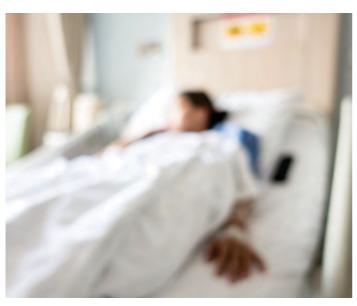


93.75%



All of the facilities in eThekwini West have adult scales, children's measuring board, syringes, needles, sterile swabs, examination gloves, pregnancy testing kits and sharps containers. The majority of facilities have a children's scale (96.88%), BP monitors (96.88%), speculums (71.78%), a gown for victims (81.25%), hand washing facilities (84.38%) and lighting for forensic examinations (65.63%). None of the facilities in eThekwini West have a colposcope and 28.13% have a gynaecological couch. The one facility providing comprehensive post-violence care (St Anne's clinic) and the two facilities providing medical forensic examinations have the following medical equipment specific to post-violence care available.







## 3. Services delivered

### 3.1. Days and hours of service

Half of facilities in eThekwini West are open from Monday to Friday (50.00%), and from 7:30 to 16:00.







3.2. Waiting time

Most (except one facility) have a waiting time of 45 minutes or less.





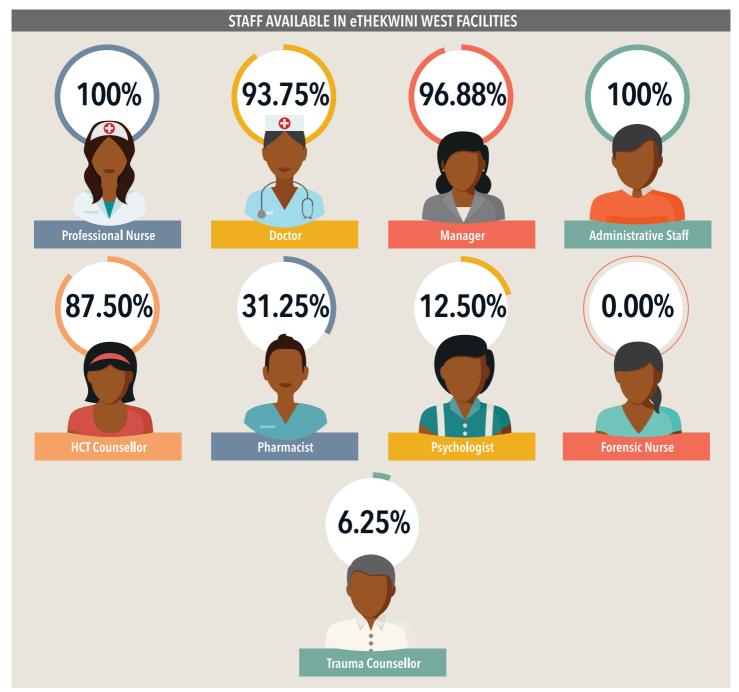
Human resources

4.1.

Staffing

The majority of facilities in eThekwini West have at least one professional nurse (100%), a doctor (93.75%), a facility or department manager (96.88%), administrative staff (100%), and an HCT counsellor (87.50%). None have a forensic nurse.





Clermont-Ferrand Clinic, who reported that they do provide medical forensic examinations, do not have forensic nurses, but have two part time doctors. St Anne's Clinic has a full time and part time doctor, but no forensic nurse. Pinetown Clinic has two part time doctors but no forensic nurse.

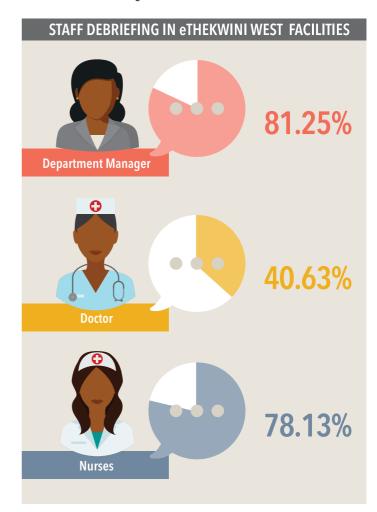
### 4.2. Supervision

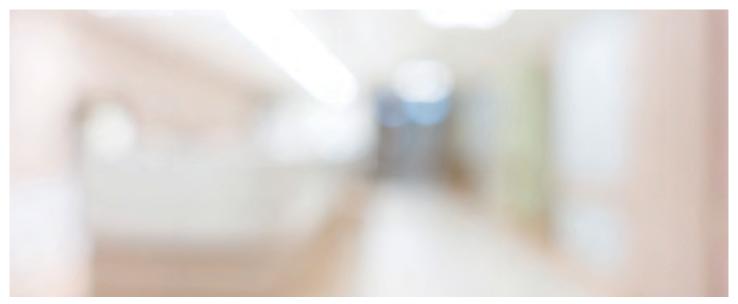
It was reported by all facilities that the managers are supervised, 59.38% that the doctors are supervised and 34.38% that the nurses are supervised.

# STAFF SUPERVISION IN eTHEKWINI WEST FACILITIES 100% Department Manager 59.38% Nurses 34.38%

### 4.3. Debriefing

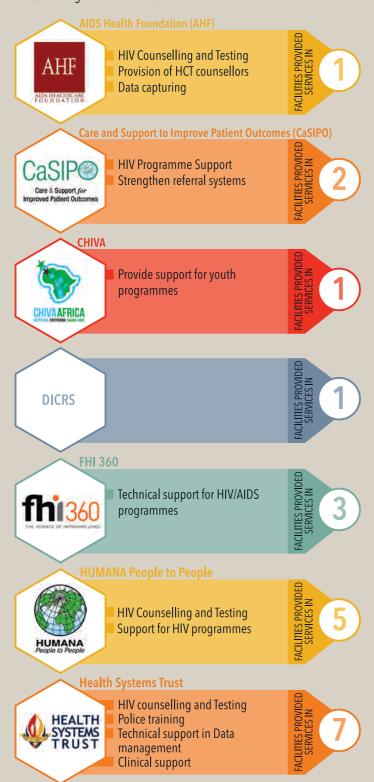
It was reported by the majority of the facilities that the manager (81.25%) and nurses (78.13%) receive debriefing. Only 40.63% reported that the doctors receive debriefing.

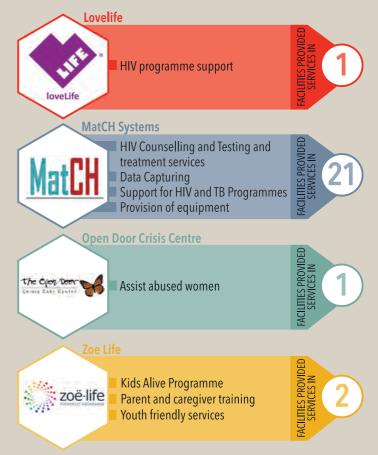


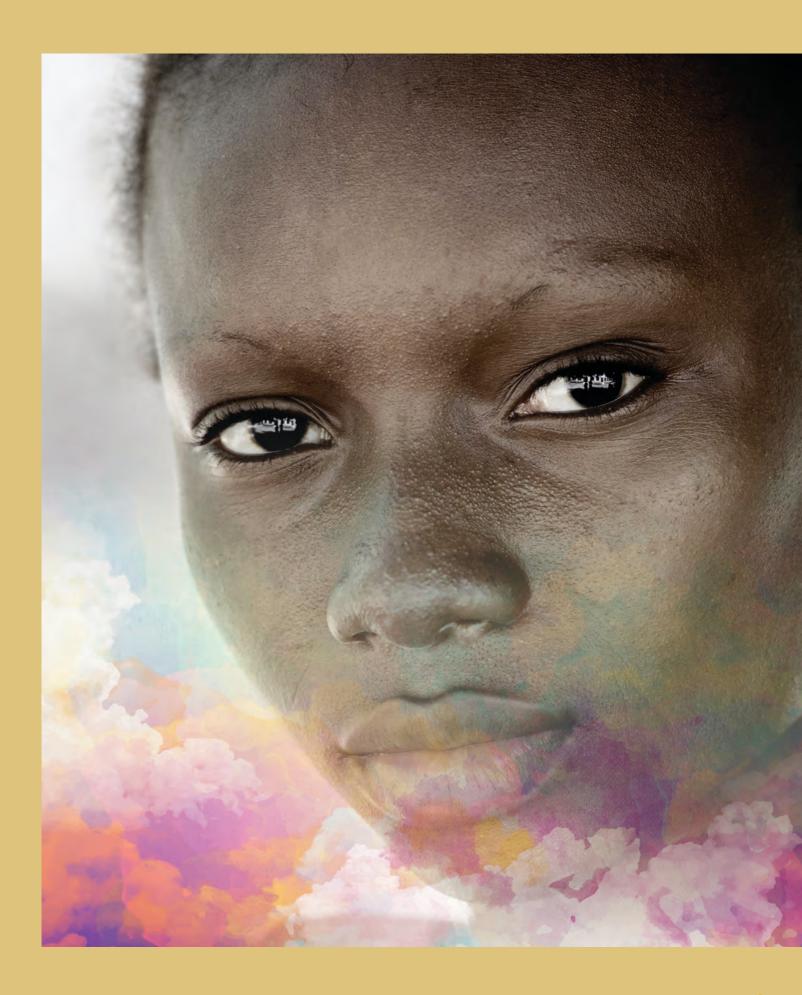


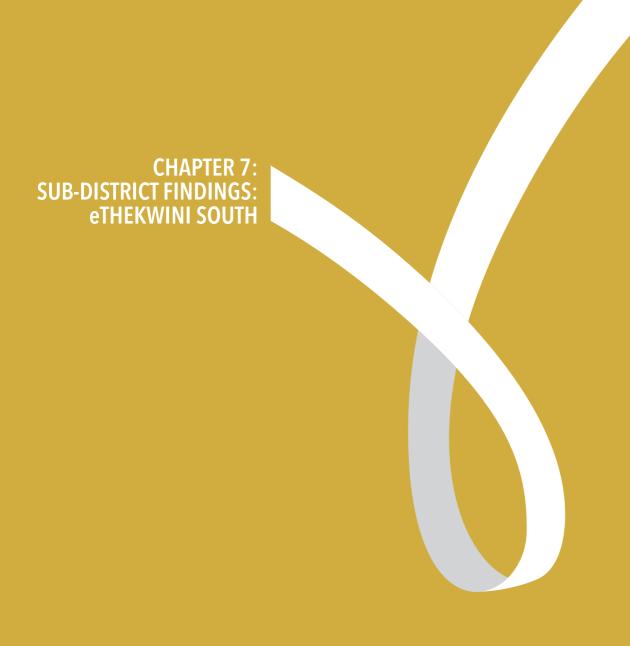
# **5.** NGOs as service providers

Eighty percent of facilities have an NGO working with them. Below lists the NGOs working in eThekwini West.









### CHAPTER 7: SUB-DISTRICT FINDINGS: eTHEKWINI SOUTH

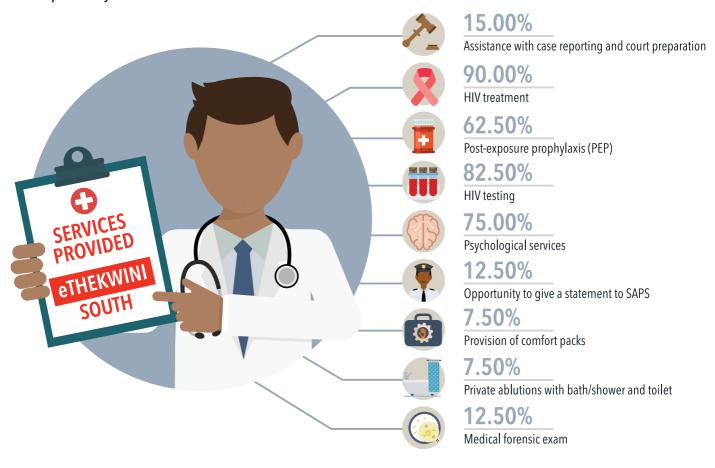
Data were collected from 40 facilities in eThekwini South; 7 hospitals and 33 PHCs.

# Findings • related to PVC

Three facilities provide the full package of post-violence care services – Addington Hospital Crisis Centre, Prince Mshiyeni Hospital (Umlazi TCC) and RK Khan Hospital (RK Khan TCC).

Five facilities provide medical forensic examinations, the three listed above, as well as, Maphephetheni Clinic and Umlazi V clinic. The majority of facilities in eThekwini South are able to provide HIV testing (82.50%), PEP (62.50%) and HIV treatment (90.00%).

### Services provided by facilities in eThekwini South



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

The average number of sexual assault cases per week reported in eThekwini South facilities is 2.07. The facilities receiving the highest number of sexual assault cases are Prince Mshiyeni Memorial Hospital (Umlazi TCC) who reported seeing 20 cases on average per week, followed by RK Khan Hospital (RK Khan TCC) reporting 15 cases per week, and Addington Hospital Crisis Centre who reported 10 cases per week on average.



### 1.2. PVC referral pathways

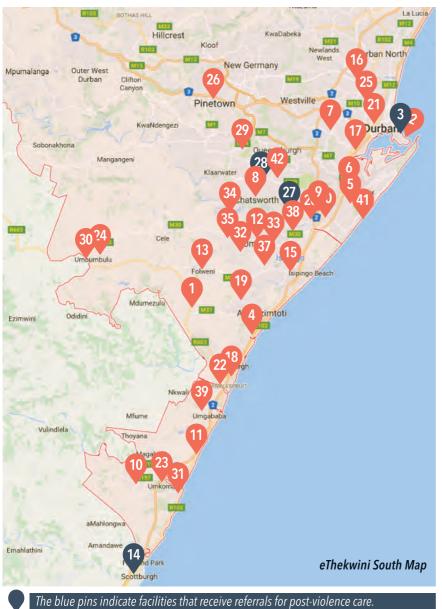
It was found that facilities in eThekwini South refer victims of sexual violence to Addington Crisis Centre, Prince Mshiyeni Hospital (Umlazi TCC), G.J Crookes Hospital, or RK Khan Hospital (RK Khan TCC).

Facilities victims of sexual violence are referred to

1 Addington Hospital Crisis Centre South
22 Prince Mshiyeni Hospital (Umlazi TCC) South
5 RK Khan Hospital (RK Khan TCC) West
2 G.J Crookes Hospital Ugu District

Addington Hospital Crisis Centre, Prince Mshiyeni Memorial Hospital (Umlazi TCC) and RK Khan Hospital (RK Khan TCC) provide the full package of post violence care and are located in eThekwini South.

G.J Crookes Hospital was not part of the sample as it is located in Ugu District, south of eThekwini.



MAP KEY	FACILITY
1	Adams Clinic
	Addington Gateway Clinic
3	Addington Hospital Crisis Centre
4	Amazimtoti Clinic
5	Austerville Clinic
6	Bluff Clinic
7	Cato Manor CHC
8	Chatsworth Town Centre Clinic
9	Clairwood Hospital
10	Craigieburn Clinic
11	Danganya Clinic
12	Ekupholeni (Umlazi L) Clinic
13	Folweni Clinic
14	G.J Crookes Hospital
15	Ispingo Clinic
16	King Dinuzulu Hospital
17	King Edward Hospital
18	Kingsburgh Clinic
19	KwaMakhutha Clinic
20	Lamontville Clinic
21	Lancers Road Clinic
22	Lovo clinic
23	Magabheni Clinic
24	Nsimbini Clinic
25	Overport Clinic
26	Pinetown Clinic
27	Prince Mshiyeni Memorial Hospital (Umlazi TCC)
28	RK Khan Hospital (TCC)
29	Shallcross Clinic
30	Umbumbulu Clinic
31	Umkomaas Clinic
32	Umlazi AA Clinic
33	Umlazi D Clinic Umlazi G Clinic
34	Umlazi K Clinic
35	Umlazi N Clinic
36	Umlazi U21 Clinic
37	Umlazi V Clinic
38 39	Umnini Clinic
39 40	Umzomuhle ( <i>Umlazi H</i> ) Clinic
40 41	Wentworth Hospital
41	Woodhurst Clinic

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

Four facilities reported that their healthcare staff received refresher training in post-violence care (Prince Mshiyeni Hospital, RK Khan Hospital, Folweni Clinic and Maphephetheni Clinic). Three facilities reported that their non-healthcare staff had received refresher training in post-violence care (Prince Mshiyeni Hospital, RK Khan Hospital and Maphephetheni Clinic. This training was either provided by the National Prosecuting Authority, the Department of Health or MatCH.

None of the facilities' auxiliary staff had received refresher or sensitisation training in post-violence care.

2. Facilities and sites

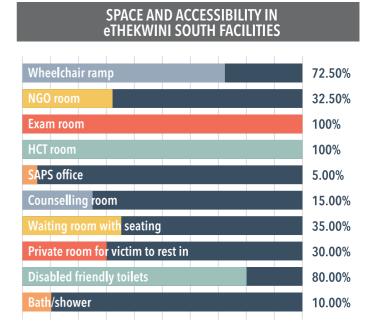
2.1 Type of buildings

All except three facilities (92.50%) are located in permanent buildings.



### 2.2. Space and accessibility

All of the facilities in eThekwini South have an examination room and an HCT room. The majority of facilities have a wheelchair ramp (72.50%) and disabled-friendly toilets (80.00%).





### 2.3. Equipment and supplies

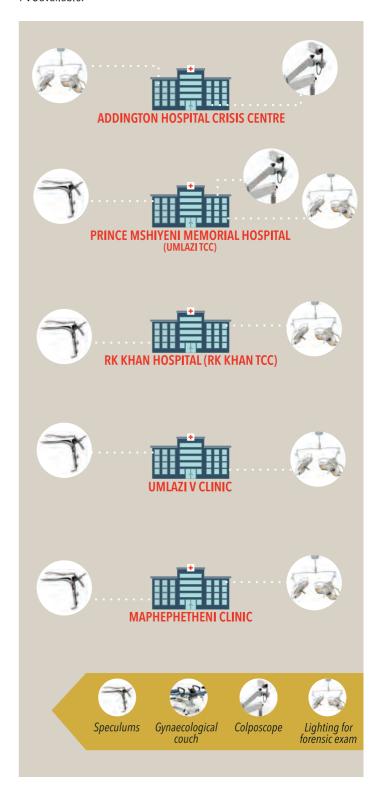
The majority of facilities in eThekwini South have the necessary equipment for a healthcare facility, but none have the general equipment necessary for post-violence care such as comfort packs and anatomical dolls. Prince Mshiyeni Hospital (Umlazi TCC) does not have refreshments for victims, clean clothes, comfort packs or anatomical dolls, but they do have toys for children to play with. RK Khan Hospital (RK Khan TCC) has refreshments for victims, clean clothes and toys for children to play with, but they do not have comfort packs or anatomically correct dolls.

GENERAL EQUIPMENT AVAILABLE eTHEKWINI SOUTH FACILITIES 75.00% IEC material Anatomically 0.00% 2.50% Comfort packs Clean clothes Refreshments 100% 85.00% 65.00% Lockable cabinet Fire extinguisher Microwave 97.50% 82.50% Fridges Heaters Aircon 2.50% 52.50% Cameras for evidence Email/Internet Fans 75.00% Printer Photocopier Fax machine

Computer

Telephone

Similar to above, facilities in eThekwini South have the medical equipment necessary to function as healthcare facilities. Few have the equipment necessary to provide post-violence care, such as a colposcope (12.50%), speculums (57.50%) and gynaecological couches (32.50%). The three facilities providing post-violence care, plus the only two providing medical forensic examinations, have the following medical equipment specific to PVC available.



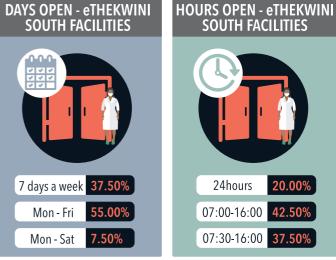
### MEDICAL EQUIPMENT AVAILABLE IN **eTHEKWINI SOUTH FACILITIES** Lighting for forensic exam 97.50%-100%-Sharps container Pregnancy testing kit 100%-**Examination gloves** 100%-100%— Blood collection tubes Syringes, needles, etc. 100%-82.50%-Examination room with lockable door Hand washing facility in examination room 85.00%-Gown 77.50% Clean bed linen 87.50%-Gynea couch 32.50%-57.50% Speculums 27.50%-Sterilising equipment 12.50% Colposcope BP monitors 100%-Measuring board 75.00%-Childrens scale 90.00%-Adult scale 95.00%

3. Services delivered

### 3.1. Days and hours of service

The majority of facilities are open from Monday to Friday (55.00%), and from 7:30 to 16:00 (37.50%).





3.2. Waiting time

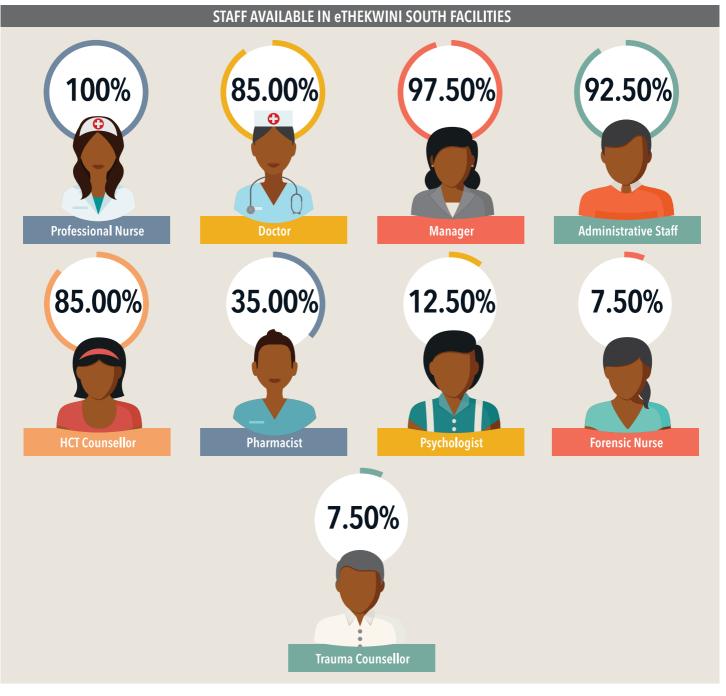
Only two facilities have a waiting time longer than 45 minutes.



4 Human resources

4.1. Staffing

All of the facilities have at least one professional nurse. Forty facilities (97.50%) have a facility or department manager and thirty-five (85.00%) have a doctor. Only three facilities (7.50%) have a forensic nurse, these are King Dinuzulu Hospital (reported that they do not provide PVC, Prince Mshiyeni Hospital (Umlazi TCC) and RK Khan Hospital TCC. Addington Hospital Crisis Centre have two full-time doctors. Maphephetheni and Umlazi V Clinics only have a part time doctor each and no forensic nurses.





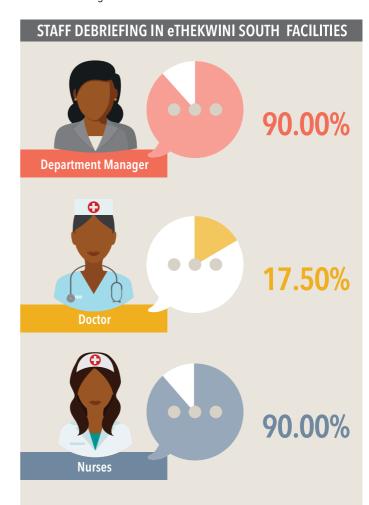
### 4.2. Supervision

Thirty-nine facilities (97.50%) reported that the manager and nurses are supervised. Twelve (30%) reported that the doctors are supervised.

# STAFF SUPERVISION IN eTHEKWINI SOUTH FACILITIES 97.50% Department Manager 30.00% Nurses 97.50%

### 4.3. Debriefing

Thirty-six facilities (90%) reported that the manager and nurses receive debriefing, and only seven facilities (17.50%) reported that the doctors receive debriefing.

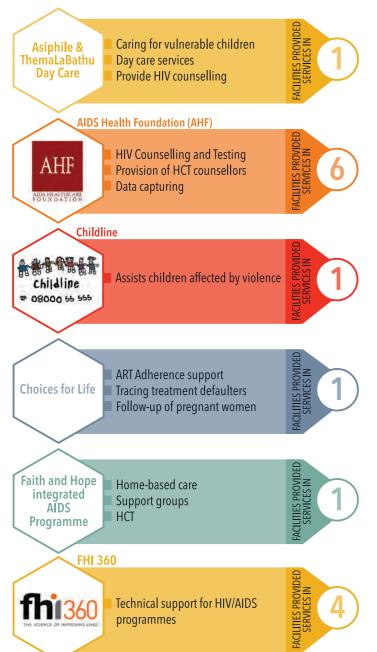


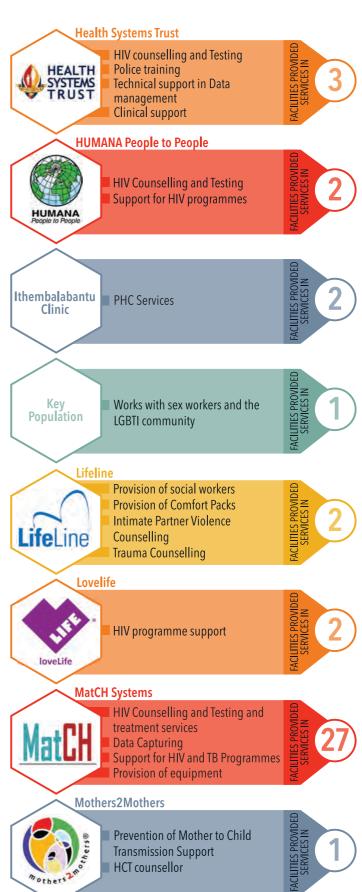


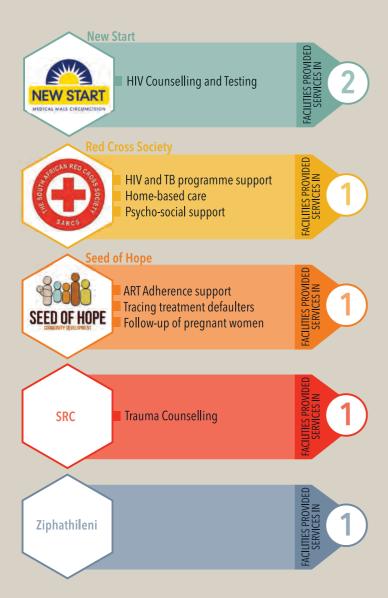
**5.** NGOs as service providers

Thirty-six facilities (90.24%) reported that they have an NGO providing services in their facility.

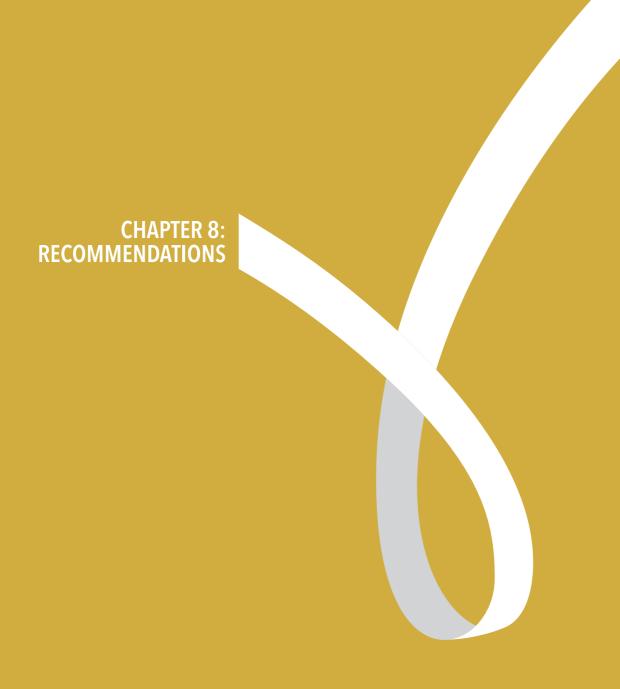
All of the five facilities providing either the full package of care or medical forensic examinations, had an NGO. Addington Hospital Crisis Centre is supported by the SRC who provide counselling services. Prince Mshiyeni (Umlazi TCC) and RK Khan TCC are supported by Lifeline who provide counselling. Maphephetheni clinic is supported by MatCH and Umlazi V clinic is supported by MatCH and Key Population, who support sex workers and the LGBTI community.











# CHAPTER 8: RECOMMENDATIONS

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

Recommendations
on post-violence care services

### 1.1. General



There are many facilities that already provide the full package of post-violence care to victims. These are: Addington Hospital Crisis Centre, Prince Mshiyeni Memorial Hospital (Umlazi TCC), RK Khan Hospital (RK Khan TCC), Tongaat CHC, and St. Anne's clinic.

In addition, four more facilities are able to provide medical forensic examinations. These are Clermont-Ferrand clinic, Umlazi V clinic, Pinetown clinic, and Maphephetheni clinic.





These facilities should be commended for their good work. The services they provide can be strengthened in relation to staffing and equipment.



A general finding across facilities is that staff 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.



This would include refresher training for staff as the data indicated that only 13 facilities (12.75%) reported that their healthcare staff had received refresher training in managing and treating victims of sexual assault.

12.75% of facilities' healthcare staff received REFRESHER TRAINING



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 postviolence care services as they are closer to the communities they serve.

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





Considering the widespread provision of HIV testing, treatment and PEP, nearly all facilities have the potential to provide these services to victims of sexual violence.

Many facilities are already open 24/7, but are not equipped to provide post-violence care. These could be considered for up-scaling so that uninterrupted services are available to victims.



Interviewees recalled from memory the average number of cases of sexual violence reporting to facilities. Although these numbers are therefore not verified, it is important to match areas where higher numbers of sexual assault occurs to facilities that are able to provide appropriate care to victims.

An example of this is KwaNdengezi clinic in eThekwini West that reportedly received an average of 15 cases of sexual assault per week, but is not able to provide the full package of post-violence care or medical forensic examinations.



There was a big gap with regards to forensic nursing.

It is recommended that the DoH considers how existing nurses could be equipped with these skills.



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



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



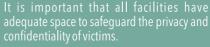
In addition, it could be explored how NGOs supporting facilities could assist in providing this service to victims.



### 1.3. Space and equipment



In addition, many facilities did not have medical equipment specific to post-violence care. The greatest need is for colposcopes which are not available in 93.14% of facilities. Nearly two-thirds of facilities have speculums, (35.29% do not), and just over half of facilities (55.45%) do not have a gynaecological couch. Where facilities do have this equipment but are not currently providing post-violence care, upscaling could be considered.



It is preferred that there is a private, separate examination room, as well as a counselling room that is used exclusively for sexual assault victims.





Other equipment that are also much needed include refreshments for victims, comfort packs, toys for children and anatomically correct dolls, cameras, and clean clothes for victims.

Facilities could explore how NGOs might be able to provide or source some of these items.



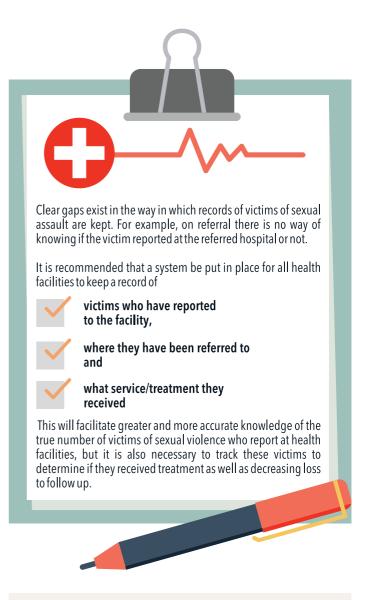




### 1.4. Community interventions

In addition to equipping facilities and staff, a barrier to accessing care that was mentioned repeatedly by interviewees is the hidden nature of GBV in the community. This relates to a lack of awareness of what constitutes GBV, the stigma attached to it, and poverty and related economic dependence - all resulting in victims not reporting cases. Although some of these challenges are structural and therefore harder to address, such as women being financially dependent on abusive partners, it is recommended that more awareness raising is done around GBV. **HIDDEN NATURE OF GENDER-BASED VIOLENCE** IN THE COMMUNITY LACK OF AWARENESS **STIGMA ECONOMIC DEPENDENCE** IT IS RECOMMENDED THAT MORE THAT MORE
THAT MORE
AWARENESS RAISING
IS DONE AROUND
IS DONE AROUND
GENDER BASED WOLENCE

# Recommendations on referral pathways





The majority of referrals for post-violence care are made to Addington Hospital Crisis Centre (eThekwini South), Mahatma Ghandi Hospital (Phoenix TCC) (eThekwini North), Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South), and RK Khan Hospital TCC (eThekwini South).

**RECEPTION** 

It is very encouraging that many facilities are referring victims to places where they would be able to access the full package of post-violence care. However, other elements of the referral pathways are also worth nothing as it they could potentially be improved:

One of the facilities in eThekwini West that other facilities refer victims of sexual violence to is St. Mary's Hospital. However, St. Mary's is currently under liquidation and depending on the future state of the hospital an alternative place of referral might be needed. The fieldworkers were not able to gain access to this hospital for data collection and it is therefore unclear whether they provide post-violence care. Alternative facilities to refer to in eThekwini West are Pinetown clinic, Clermont-Ferrand clinic and St. Anne's clinic that are all reportedly able to perform medical forensic examinations, although the latter do not currently receive any referrals.

Four other facilities that victims are being referred to – G.J Crookes Hospital, King Dinuzulu Hospital, Osindisweni Hospital, and Clairwood Hospital – do not reportedly provide the full package of post-violence care, or medical forensic examinations. This might mean that victims only receive some services there and are again referred, which is not ideal considering the level of trauma already suffered.

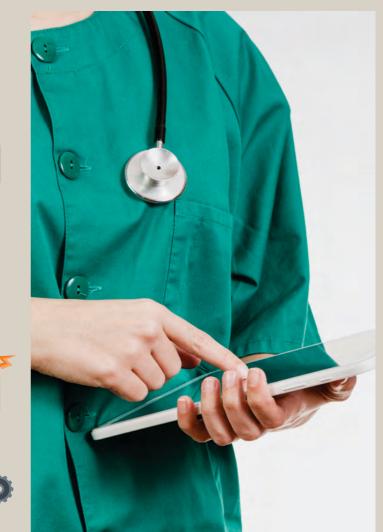
Two facilities (Tongaat CHC and St. Anne's clinic) reportedly are able to provide the full package of post-violence care, however, other facilities reportedly do not refer victims to them.

Similarly, Clermont-Ferrand clinic, Umlazi V clinic, and Maphephetheni clinic are able to provide medical forensic examinations, but none of the other facilities reported referring victims there.

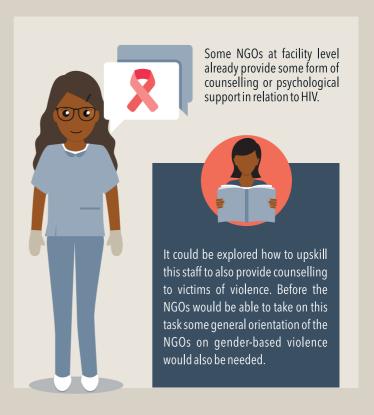
It is important for all facilities to understand where the best place is to refer victims to, both in terms of accessibility for victims, but also in terms of the care that they would be able to receive.

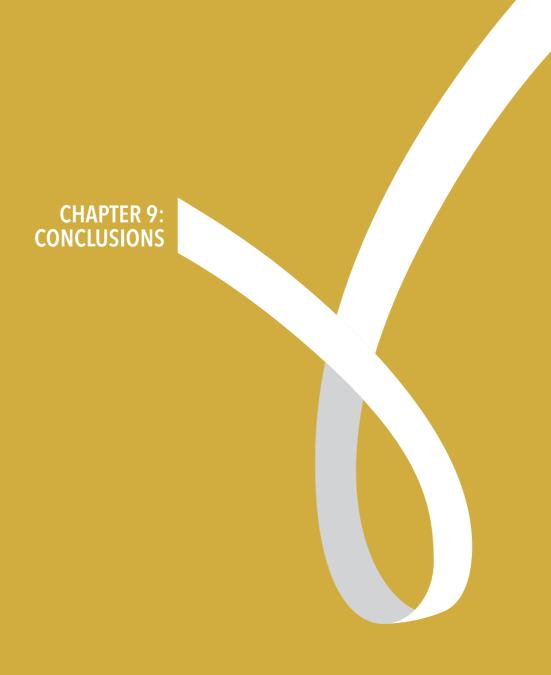
It is recommended that a directory of post-violence care service providers is put together for all stakeholders, including SAPS, to prevent people being referred to facilities that cannot help them. The results of this rapid assessment and gap analysis can guide the development of such a referral directory.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





Recommendations on NGOs



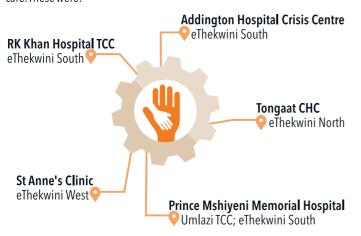


# CHAPTER 9: CONCLUSIONS

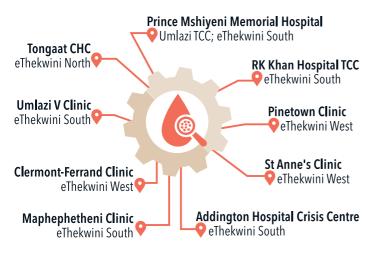
The rapid assessment and gap analyses assessed the provision of post-violence care at 101 public health facilities in eThekwini (North, South and West). The study was conducted in three phases. Phase one involved conducting a desk review to inform a situational analysis, the second phase was field work and data collection, and the third phase is reporting. The rapid assessment and gap analysis used a mixed methods approach consisting of a check-list administered at facilities as well as key informant interviews. The study was conducted between September 2016 and February 2017.

The researchers noticed that facilities had different assessments or definitions of what post-violence care entails and who they should be providing these services to. Some facilities were providing some elements of post-violence care to victims, such as testing for HIV, but not medical forensic examinations, for example. Additionally all of the facilities are able to provide some services, such as HIV testing, but they do not always provide this service to victims of sexual violence because their understanding is that they should refer victims in order not to interfere with the collection of evidence.

Only five facilities (4.9%) provided all of the services related to post-violence care. These were:

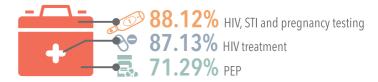


Nine facilities (8.91%) are able to provide a medical forensic examination:



The services most often provided across facilities were HIV, STI and pregnancy testing (88.12%), HIV treatment (87.13%) and PEP (71.29%), which means that these services are potentially available to victims sexual violence at most facilities irrespective of their ability to provide the full package of care.

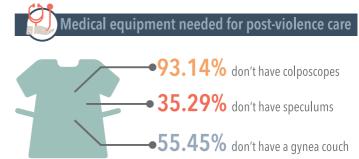




The services least often provided include the medical forensic examination (8.91%) and the provision of comfort packs (6.93%).



While the majority of facilities have the general medical equipment required of a healthcare facility, the majority did not have the medical equipment needed for post-violence care. Colposcopes are not available in 93.14% of facilities. Nearly two-thirds of facilities have speculums, (35.29% do not), and just over half of facilities (55.45%) don't have a gynaecological couch.



Overall, 25 facilities (24.75%) deliver a 24 hour service and 39 facilities (38.24%) are open 7 days a week which shows potential for upscale as post-violence care should ideally be available to victims 24/7. The majority of facilities reported that they have very limited space inside their facilities. For example, 75% of facilities do not have private ablutions with a bath or shower, 36% don't have waiting rooms, and 83% don't have a room for counselling.



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

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

The majority of referrals for post-violence care are made to Addington Hospital Crisis Centre (eThekwini South), Mahatma Ghandi Hospital (Phoenix TCC) (eThekwini North), Prince Mshiyeni Memorial Hospital (Umlazi TCC) (eThekwini South), and RK Khan Hospital TCC (eThekwini South). It is very encouraging that many facilities are referring victims to places where they would be able to access the full package of post-violence care. However, there are other facilities that are reportedly equipped to provide the full package of post-violence care or medical forensic examinations that none of the other facilities are referring to.

Seventy-eight facilities (77.23%) have an NGO providing services within the facility. However, none of these relate directly to the provision of post-violence care. It is important to note that the NGOs are contributing to the continuum of care for victims of sexual assault and it should therefore be explored how these NGOs can also support facilities in the provision of post-violence care.



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



### General

Strengthen facilities that are already doing good work in providing post-violence care.

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

Equip and allow all PHCs and CHCs to provide post-violence care as distance to hospitals and TCCs is a barrier to care.

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

Considering the widespread provision of HIV testing, treatment and PEP, nearly all facilities have the potential to provide these services to victims of sexual violence.

Many facilities are already open 24/7, but are not equipped to provide post-violence care. These could be considered for upscaling so that uninterrupted services are available to victims.



### Staffing

Staffing gaps identified are specifically for forensic nurses, trauma counsellors and psychologists.

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



### Space and equipment

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

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



### **Community interventions**

There should be awareness-raising in the community on gender-based violence.



### **Referral pathways**

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

The existing referral pathways should be maximised. Victims should be referred to facilities where they are able to receive comprehensive care, and referrals should be made to all facilities that are equipped to provide such care.

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

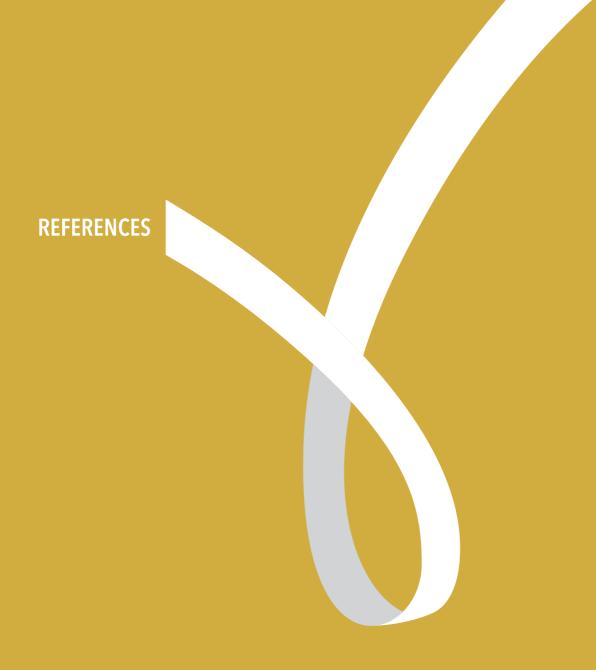


### **NGOs**

Some NGOs at facility level already provide some form of counselling or psychological support in relation to HIV and they should be provided with further training, if needed, so they can support facilities by providing victims of sexual assault with psychological support.

There are existing facilities in eThekwini (North, South and West) that are already providing comprehensive services to victims of sexual assault. These facilities should be commended for their work and further strengthened to sustain these services. In addition, post-violence care services need to be upscaled in order to provide services closer to the community. It is clear that some facilities have the potential for upscaling. The team believes that if the recommendations are adhered to all post-violence care services in eThekwini (North, South and West) will be strengthened.





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