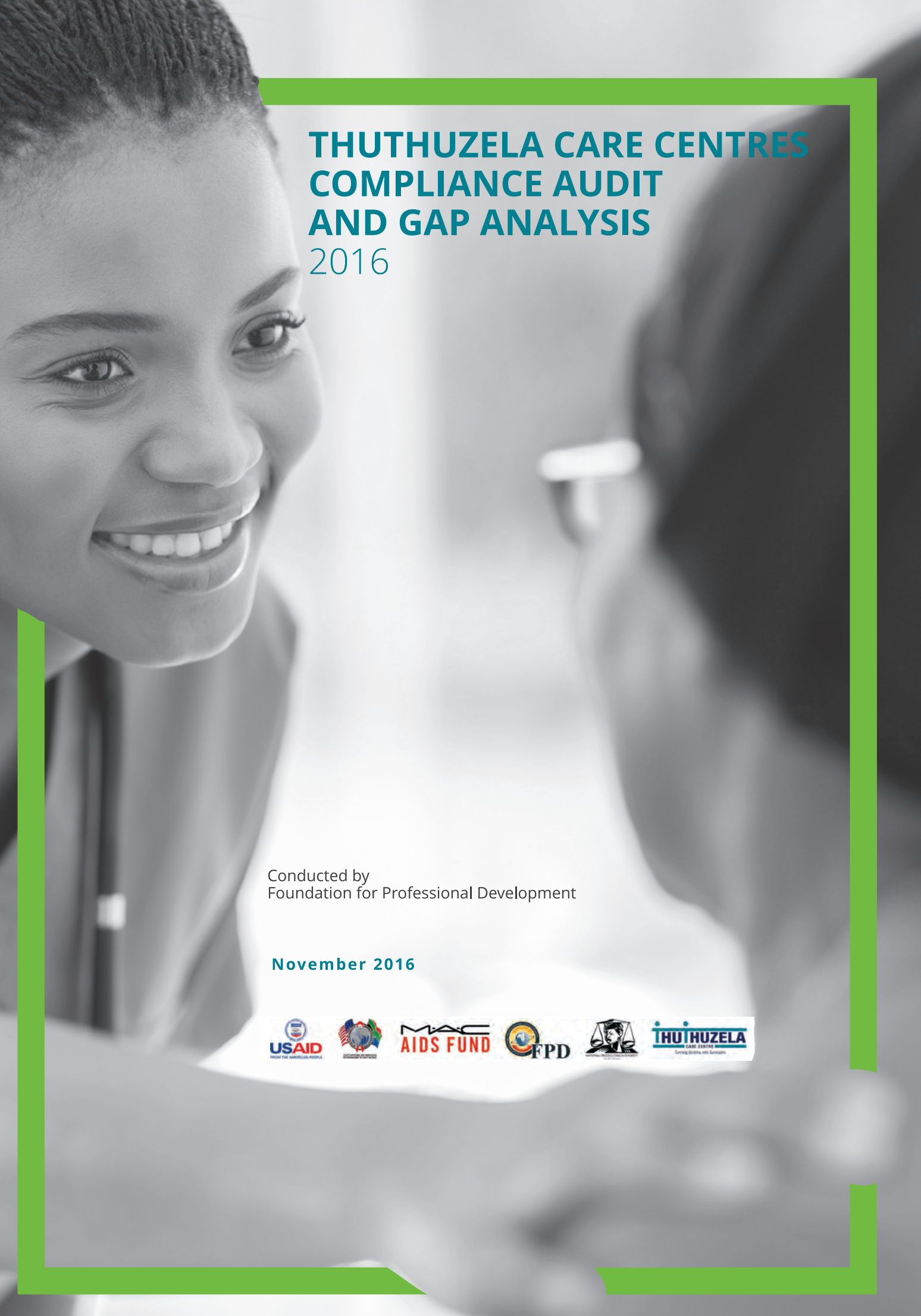

THUTHUZELA CARE CENTRES COMPLIANCE AUDIT AND GAP ANALYSIS 2016

Conducted by
Foundation for Professional Development

November 2016

ACKNOWLEDGEMENTS

The team wishes to express their gratitude to all the key informants (NPA personnel, NPA TCC Regional Managers, GBV experts), site coordinators, VAOs, case managers and managers from NGOs who were willing to spare their time and share their experiences and insights with us. We believe that this TCC compliance audit and gap analysis will go a long way in contributing to the work that the TCCs are doing.

Prepared by

The Foundation for Professional Development
Struland Office Park
173 Mary Road
Pretoria

The evaluation team consisted of Sunet Jordaan, Frances Slaven, Cornelius Louwrens, Pumla Sodo, Lizette van den Broek, Jonathan Klapwijk, Brandon Booth, and Harold Ncongwane.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community based organisation
CDC	Centers for Disease Control
CPD	Continuing professional development
CSO	Civil society organisation
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DoH	Department of Health
DoJ	Department of Justice and Constitutional Development
DSD	Department of Social Development
EMS	Emergency medical services
EU	European Union
FBO	Faith based organisation
FCS	Family Violence, Child Protection and Sexual Offences Investigation Unit
FHI360	Family Health International 360
FPD	Foundation for Professional Development
GBV	Gender based violence
HCP	Healthcare practitioner
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
IDMT	Interdepartmental management team
IEC	Information and education communication
IMC	Inter-ministerial committee
ISS	Institute for Security Studies
ISSSASA	Increasing services for survivors of sexual assault
MRC	Medical Research Council
MSF	Médicins Sans Frontièrs/Doctors without Borders
NACOSA	Networking HIV & AIDS Community in South Africa
NGO	Non-governmental organisation
NPA	National Prosecuting Authority
PEP	Post-exposure prophylaxis
PEPFAR	Presidents Fund for Emergency AIDS Relief
PFA	Psychological first aid
PHC	Primary healthcare facility
POA: VAWC	Programme of action to address violence against women
RTI	Research Triangle Institute

SAECK	Sexual assault evidence crime kit
SAPS	South African Police Service
SC	Site coordinator
SOA	Sexual Offences and Related Matters Amendment Act
SOC	Sexual offences court
SOCA	Sexual offences and community affairs
STI	Sexually transmitted infection
TCC	Thuthuzela Care Centre
TIMS	Thuthuzela Information Management System
TOP	Termination of pregnancy
VAO	Victim assistance officer
VAWC	Violence against women and children
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organisation

EXECUTIVE SUMMARY

Background

The Foundation for Professional Development (FPD) was contracted by the United States Agency for International Development (USAID) to conduct a compliance audit and gap analysis of 55 Thuthuzela Care Centres (TCCs) in South Africa. In addition, the President's Fund for Emergency AIDS Relief (PEPFAR) programme in South Africa is currently carrying out a gender analysis of all its programming. The information gathered from the TCC review will feed into the gender analysis conducted for PEPFAR. In 2015, USAID conducted an impact evaluation titled the 'Increasing Services for Survivors of Sexual Assault in South Africa programme'. The baseline report draft also recommends that the TCCs be audited for compliance with the TCC Blueprint.

Purpose

The purpose of this compliance audit and gap analysis was to assess all 55 TCCs. The analysis focused on all components related to the functioning of TCCs. It assessed the quality of services provided, the equipment available in facilities, the staffing of the TCCs as well as the relationship between the TCC and any non-governmental organisations (NGOs) working within the TCCs. The aim is to increase compliance with the TCC Blueprint. The compliance audit and gap analysis results will contribute to the improvement of the services delivered by TCCs. It will also contribute to better informed decision-making about the functioning of TCCs, foster an environment of excellent service delivery and promote greater accountability for performance of facilities. It will also provide information regarding the working relationships between the various government departments, as well as NGOs who are involved in the functioning of TCCs.

Methodology

55 TCCs part of study

The compliance audit and gap analysis was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two, field work and data collection, and phase three, reporting. The data collection team used a concurrent triangulation mixed methods design. Quantitative and qualitative data of equal weight were collected simultaneously and integrated during the interpretation of the findings. Sampling was not necessary, as all 55 TCCs were part of the study. Khayelitsha TCC was not included in the study as the site coordinator was unavailable due to illness and there is no victim assistance officer (VAO).

There were two populations in this compliance audit and gap analysis, the NPA staff and the NGO staff. The exact number of NPA staff across all facilities was unknown. However, 54 of the 55 facilities had either a site co-ordinator, VAO or case manager overseeing the facility. These individuals were the key National Prosecuting Authority (NPA) informants who had to be interviewed and were therefore selected using purposeful sampling. The team also interviewed key NPA personnel, regional TCC managers appointed by the NPA, NGOs working in the field of gender based violence as well as South African experts in gender based violence (GBV). The NGO informants were conveniently sampled based on who was available at the time of data collection.

The team conducted a situational analysis using a literature review. The team used international and local reports, articles and standards to develop the situational analysis.

The TCC model was studied and a questionnaire was developed based on the model. An application (ODK App) and survey tool was developed in collaboration with 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 database into Excel™, where it was cleaned and coded. It was then imported into the Statistical Package for Social Sciences. Descriptive analyses were conducted and the data analysis output was displayed in graphs, tables and cross-tables. No inferential analyses were conducted.

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

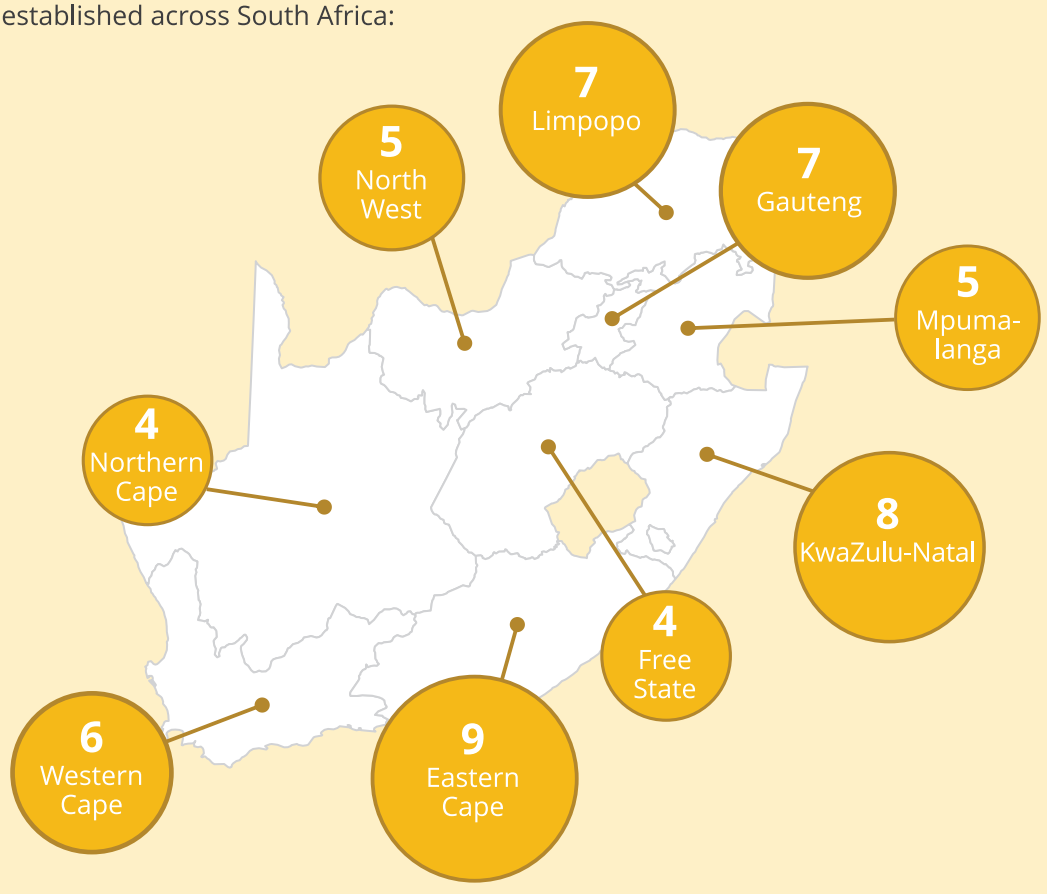
Major findings

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

One of the greatest strengths of the TCC model is the multisectoral approach that bring all services under one umbrella, and bring all the stakeholders together (i.e. NPA, DoH, DSD, SAPS and various NGOs). This is also the model's greatest weakness, as not all stakeholders are equally involved and there is no way to ensure accountability. This varies across and within provinces.

The findings show that the governance of the TCCs is too centralised and this is influencing human resource (HR) relationships within TCCs negatively. There are serious disciplinary and accountability issues that need to be addressed. Many regional managers are not based in the provinces in which they are responsible for the functioning of the TCCs and this compromises their work. They also have other responsibilities that compromise their focus on the TCCs. There is insufficient accountability from all stakeholders, and while relationships are generally good at national and provincial level, there is a need to improve relationships and accountability at district and facility level.

There are 55 TCCs established across South Africa:



19% in buildings outside the hospital

31% within the hospital

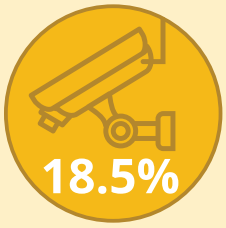
50% in parkhomes

83% sign showing that there is a TCC at a specific hospital

At some sites there have been issues with security of after-hours staff, which is of greater concern when the TCC is based in a park home or outside the hospital. Some TCCs (7%) have now contracted a private security company, and have panic buttons available. Others have security guards (20%) and CCTV cameras (18.5%).

contracted a private security company & have panic buttons

security guards



CCTV cameras

Victim friendliness in TCCs is still a major problem. There is still much secondary victimisation because sites are not victim friendly, there are insensitive emergency medical services (EMS) and police (SAPS) staff, and there are inadequate counselling rooms and privacy within the TCCs. Only 52% of TCCs have a separate entrance for perpetrators. Not all TCCs are child friendly, in spite of the fact that almost 60% of cases are children. Although 80% of all TCCs provide comfort packs there's an additional need to ensure that TCCs have basic groceries to provide food and beverages to victims.

75.9%
provided statement-taking services

88.9%
had cleaning services

66%
wheelchair ramp

72.2%
had a private room for children to play or wait

The majority, but not all, services are delivered according to the TCC Blueprint. All the TCCs provided reception services, HIV counselling and testing (HCT) and HIV treatment referral services. Ninety-eight percent of the TCCs provided case reporting services, 92.6% provided court preparation services and 75.9% provided statement-taking services. Seventy percent were linked to a sexual offences court (SOC). Ninety-eight percent provided forensic examinations, 83.3% provided comfort packs, 96.3% had shower and/or bath services, 83.3% provided clean clothes and 88.9% had cleaning services. 90% offered short term psychological support and 98.1% provided a referral for long term psychological support. Half of the TCCs offered other services not previously mentioned, such as age estimation, suspect DNA testing and shelter services. It is important to note that although all these services are offered, they are not always offered within the TCC. Some are provided within the hospital or at the local police station.

There's a serious gap with regard to facilities that are not structured according to the Blueprint. Many key informants highlighted the lack of adequate, private counselling space. The majority of TCCs (96.3%) had private ablution facilities of which 53.7% were disabled-friendly. More than half had a private room for clients to rest and 72.2% had a private room for children to play or wait. Ninety-two percent have a waiting room with seating for their clients. Eighty-seven percent had at least one counselling office, 75.9% had a SAPS and VAO room, 61.1% had a HCT room, 98.1% had at least one examination room, and 74.4% had an NGO office. 66% had a wheelchair ramp.

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

Human resources

Almost 95% of TCCs have a site co-ordinator, and 70% a VAO, but only 46% have a case manager. A major problem with the TCCs is the lack of adequate and continuous debriefing in a very stressful and emotionally demanding work environment.

Accessibility

Seventy percent of all TCCs provide a 24/7 service. However, most health services are not available within the TCC after hours. Victims are either referred to the casualty department of hospitals or have to wait for a forensic nurse or doctor to come to the TCC from casualty. Ninety percent of security guards are aware of the location of the TCC.

Health services

Just over 50% of TCCs have at least one DoH staff member dedicated to them, but mainly during the day. The TCC is dependent on casualty staff after hours and during weekends. EMS personnel are not adequately sensitised to work with victims of GBV and do not prioritise victims. Post-exposure prophylaxis (PEP) is provided, but victims usually receive only a starter pack and need to return to the TCC for the remainder of the medication.

Psychosocial support

There are serious concerns about the ability of TCCs to provide long-term psychosocial support. The Department of Social Development (DSD) is not providing adequate social workers and psychologists to the TCCs and some key informants highlighted the language barriers between the victims and the DSD staff.

Equipment and supplies

Most TCCs have the equipment to ensure that they are operational. Almost 89% of TCCs have telephone lines, but most can only receive calls and cannot call out of the hospital. The NGOs working within the TCCs do not have access to these telephones and rely on their own cell phones and air time provided either by the NGO, or sometimes by the counsellors themselves. There is serious concern about the medical equipment at the TCCs. Although 82% have speculums, only 61% have colposcopes and 37% have either a gynae couch or lithotomy table. This is influencing the health services that can be delivered within the TCC.

Transport

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

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

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

RECOMMENDATIONS

The evaluation team made many recommendations to improve the service delivery and functioning of the TCCs, which can be summarised as follows:

Governance and operational recommendations

There is a need to legalise the TCCs to ensure that all stakeholders take responsibility and be held accountable for their roles and responsibilities within the model.

Operational management of the TCCs, including the reporting of VAOs and site coordinators, should be decentralised to provincial level.

NPA regional managers should be based in the province they are responsible for.

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

Stakeholder relationships

There needs to be better engagement between stakeholders to ensure commitment from all the relevant stakeholders. It is recommended that the stakeholders meet bi-annually to discuss strategic operations as well as challenges within the TCC model.

NGOs

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

Improvement of service delivery recommendations

All vacant positions should be filled and staff should receive regular, face-to-face debriefing. In TCCs where it is not possible to deliver a 24/7 service there is a need to develop protocols that involve all stakeholders to ensure access to services after hours.

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

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

All TCCs must have the required medical equipment to deliver medical services. In addition to this the NPA needs to ensure that TCCs have access to basic groceries to provide victims with refreshments. It must be investigated if the associated hospital can provide food.

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

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

Other

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

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

It is recommended that a toll free GBV helpline is established that will link the victim directly with the local family violence child protection and sexual offences investigation unit (FSC).

Information and Education Communication (IEC) materials must be available in the main language in each areas and be upgraded.

The NPA interdepartmental training materials should be revisited and presented by an accredited institution that can link it to continuing professional development (CPD) points.

The TCCs are experiencing research fatigue. All research done on the model should be better coordinated.

CHAPTER 1: INTRODUCTION AND OBJECTIVES

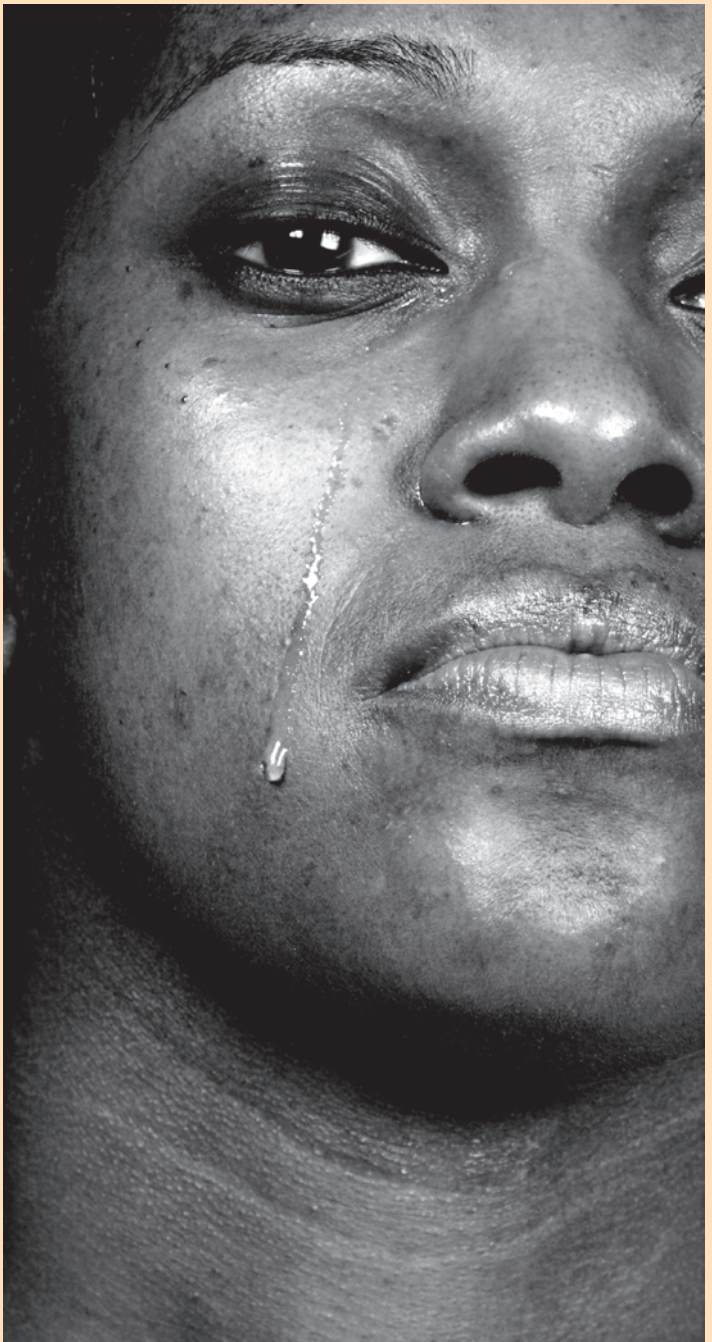
1. Contextual background and context for the compliance audit and gap analysis

The Foundation for Professional Development (FPD) was contracted by USAID to conduct a compliance audit and gap analysis of 55 Thuthuzela Care Centres (TCCs) in South Africa. This was based on a recommendation made at the mid-term ISSSASA check-in. In addition to this, the PEPFAR programme in South Africa is currently undertaking a gender analysis of all its programming. In 2015, USAID conducted an impact evaluation titled the *Increasing Services for Survivors of Sexual Assault in South Africa* programme. The baseline report draft also recommends that the TCCs be audited for compliance to the TCC Blueprint.

The purpose of this compliance audit and gap analysis was to assess all 55 TCCs in South Africa. The analysis focused on all the components related to the functioning of TCCs. It assessed the quality of services provided, the equipment in facilities, the staffing of the TCC personnel as well as the relationship between the TCC and any NGOs working within them. The aim was to increase compliance with the TCC Blueprint. The compliance audit and gap analysis results will contribute to the improvement of the services delivered by TCCs. It will also contribute to better informed decision-making about the functioning of TCCs, foster an environment of excellent service delivery and promote greater accountability for performance of facilities. It will also provide information regarding the working relationships between the various government departments, as well as NGOs who are involved in the functioning of TCCs.

2. Contextual background for the creation of the TCCs

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



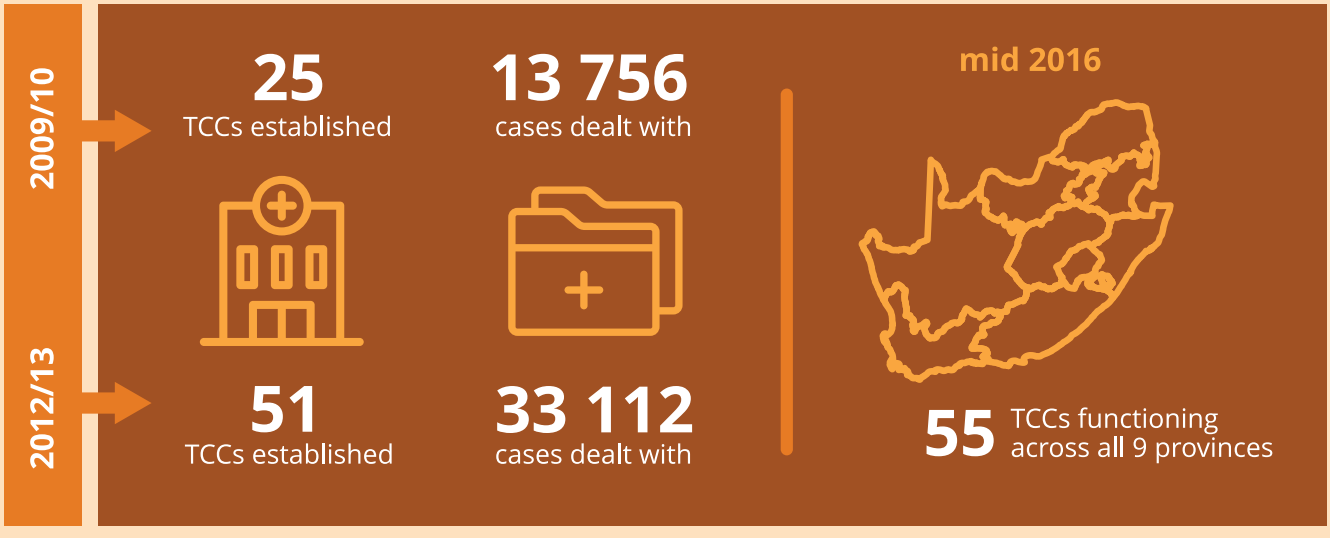
3. Government response

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

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

The word Thuthuzela is derived from the isiXhosa word for 'comfort' and the TCCs function in two arenas. Immediate services are delivered in a care centre that is located within a public healthcare facility. The legal component is ideally dealt with at a sexual offences court.

At some TCCs the victim can also give the required police statement. The required staff component for a TCC is prescribed by the TCC Blueprint. This includes a case manager, a victim assistance officer (VAO), a site coordinator, counsellors, trained detectives and personnel to transport victims home or to a place of safety (Vetten, 2015).



4. Purpose of the compliance audit and gap analysis

The purpose of this compliance audit and gap analysis was to assess all 55 TCCs. The analysis focused on all the components related to the functioning of TCCs. It assessed the quality of services provided, the equipment available in facilities, the staffing of the TCC personnel as well as the relationship between the TCC and any NGOs working within the TCCs. The aim is to increase compliance with the TCC Blueprint.

The compliance audit and gap analysis results will contribute to improving the services delivered by TCCs. It will contribute to better informed decision-making about the functioning of TCCs, foster an environment of excellent service delivery and promote greater accountability for performance of facilities. It will also provide information regarding the working relationships between the various government departments, as well as NGOs who are involved in the functioning of TCCs.

The compliance audit and gap analysis will inform the PEPFAR gender analysis that is currently underway. This will also guide the NPA in promoting more efficient and effective service delivery by the TCCs.

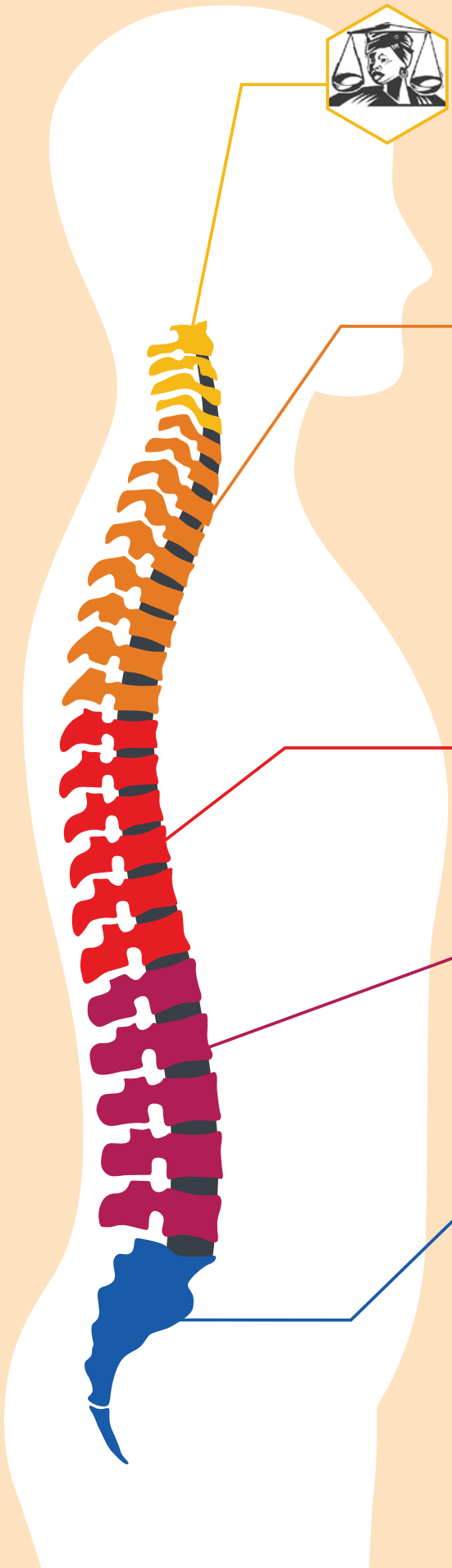
5. Objectives of the compliance audit and gap analysis

The compliance audit and gap analysis had the following major objectives:

1. To assess if all TCCs deliver the minimum services as defined by the TCC Blueprint.
2. To assess TCCs care against a comprehensive package of post-violence care services.
3. To assess if all TCCs are adequately staffed according to the TCC Blueprint.
4. To review the working relationship between the staff of the TCCs, staff of the relevant government departments and the NGOs who deliver services within the TCCs.
5. Identify lessons learned and make recommendations on areas of improvement for the functioning of the TCCs.

The compliance audit and gap analysis was conducted between April 2016 and October 2016 and included a survey of 54 of the 55 TCCs in South Africa.

6. Intended users of the compliance audit and gap analysis



National Prosecuting Authority
SOCA Unit

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

Department of Justice and Constitutional Development

Improved oversight and increased conviction rates

Department of Health

Promote accountability and transparency
Improved management of TCCs in health facilities

Department of Social Development

Improved services and long-term support for victims of GBV and sexual assault

Department of Basic Education

Improved support to children who are victims of sexual assault

Treasury

Decisions on future funding of TCCs

South African Police Services

Improved oversight and increased conviction rates

Funder: USAID

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

Non-governmental organisations working with TCCs

Improved engagement between NGOs and the NPA, as well as with TCCs

Non-governmental organisations working within TCCs

Improved engagement between NGOs and the NPA, as well as with TCCs

CHAPTER 2: DESK REVIEW AND SITUATIONAL ANALYSIS

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

1. Key terms in GBV

1.1. Gender based violence (GBV)

Gender based violence refers to harm that is committed against a person's will because of their gender. This can have a negative impact on the person's physical or psychological health, development and identity. This is usually linked to inequality in power relations between men and women (Mpani and Nsibande, 2015). GBV is defined as 'violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life' (Khan, 2011).

1.2. Sexual violence

Sexual violence, specifically, is defined as any sexual act, attempt to commit a sexual act, unwanted sexual comments and advances, coercion, threats and physical force to obtain a sexual act (WHO, 2003). This can be conducted by any person, regardless of their relationship with the victim and can happen in any setting (including home and work). Rape is defined as forced sexual intercourse or a sexual act perpetrated against a person without consent. Survivors of sexual assault are at an increased risk of acquiring HIV due to possible lacerations and trauma in the vaginal and/or anal area (Herstad, 2009). In many countries, including South Africa, Botswana and Namibia, both men and women are often targeted because of sexual identity (being gay or lesbian), (NACOSA, 2015). This is often called 'corrective rape'.

1.3. Sexual assault

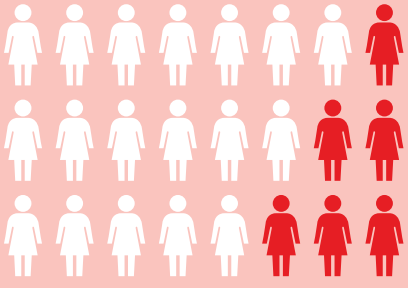
Sexual assault includes all non-consenting sexual activity from fondling to penetration (as well as attempts of penetration) of one person into the anus, mouth or genital organs of another person. This can be with a part of the body, genital organs or any other object (Mpani and Nsibande, 2015).

1.4. Domestic violence

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

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

2. The GBV situation in South Africa



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

APR 2015 - MAR 2016

51 895
sexual offences reported

1 in 13
rape cases are reported

33%
of men report that they have raped a woman during their lifetime

37.4%
of men in South Africa admitted to have perpetrated sexual offences

AUG 2015 - JUL 2016

32 688
rape cases at TCCs

58%
are children below the age of 18 years

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

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

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

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

The criminal justice system is perceived as ineffective and corrupt

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

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

Costs and impacts:

Physical injury and psychological trauma and depression. Rape is often associated with post-traumatic stress disorder (PTSD). This can also result in social withdrawal. Women who have experienced sexual assault are also more likely to attempt or commit suicide.

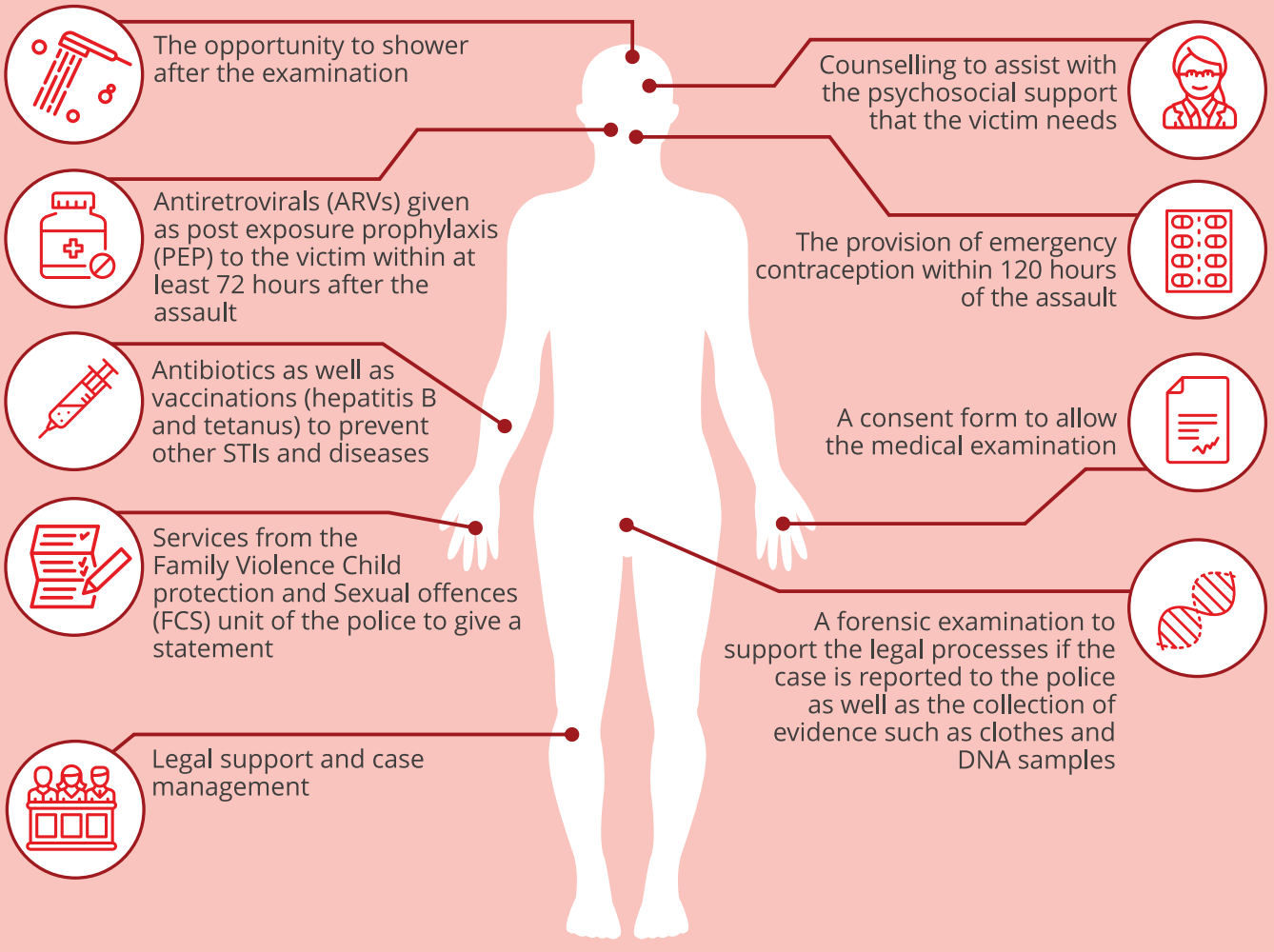
Increased risky behaviour and increased substance abuse. Substance abuse is five times higher in survivors of GBV.

Increased health problems such as HIV, STIs, urinary tract infections and pelvic pain. The physical trauma that is associated with rape increases the risk of HIV and other STI infections.

Unwanted pregnancy as a result of the rape. A Western Cape study shows that girls who had been raped before the age of 14, are more likely to have unprotected sex later, increasing teenage pregnancy rates. (Hwenha, 2014; Kim et al, 2009, NACOSA, 2015).

It is also important to consider the influence/consequences of sexual violence on the rest of the country's economy and development. It influences the social and economic development of the country as it reduces victims' contribution to the economy. KPMG estimated that the direct cost of GBV in South Africa is between R28.4 and R42.4 billion per year (Watson, 2015). There are also other costs to consider. The health costs of direct treatment as well as follow-up psychosocial support is estimated at R105 billion per year (Hwenha, 2014). The costs related to the prosecution and rehabilitation of perpetrators is not included in this amount and relates to the government services from SAPS, the justice system as well as the correctional services system.

Doctors without Borders (2016) and Shukumisa (2016) identified a package of care that is required for the survivors of sexual assault, which includes:



In spite of various services that are currently available to the victims of sexual assault and rape, Doctors without Borders (2016) report that many women don't make use of the services available at clinics, hospitals, TCCs and other facilities. It is also reported that many women who access services arrive after the 72 hour timeframe for PEP and the 120 hour timeframe for emergency contraception. This also inhibits the forensic investigation. There are various reasons provided for the barriers in the uptake of services, including:

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

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

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

3. International standards for managing sexual assault

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

3.1. WHO: Guidelines for medico-legal care for victims of sexual violence

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

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

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

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

- Healthcare providers must be appropriately trained to manage a victim of sexual assault.
- Victims must be treated with respect and sensitivity and at all costs be protected against secondary victimisation.
- Patient confidentiality is essential at all times.
- The victim (or a caregiver if underage) must give informed consent at all stages of examination and treatment.
- The health and welfare of the victim must be the priority of healthcare providers and should take priority over evidence collection.
- Reporting to the police should not be a prerequisite for examination, treatment and support.
- In the case of children, the best interests of the child should always take precedence and healthcare providers and other staff must understand and comply with their legal obligation to report cases of suspected sexual abuse of children.
- Research involving survivors should be limited as far as possible.
- Comprehensive care must be provided to the victim, including the medical, legal and psychosocial needs that should be addressed. This can be provided at a 'one-stop-centre' or facilitated through a referral network between stakeholders.
- Special care should be taken to ensure that the needs of children and adolescents are taken into account and that facilities are child friendly.

Core components of a comprehensive response to sexual violence

Health	Pregnancy testing and emergency contraception HIV testing, counselling and PEP STI prophylaxis Hepatitis B and tetanus vaccination Treatment for injuries Forensic investigation Trauma counselling Referral to police and social services (where applicable)
Police and Justice	Statement taking and documentation Criminal investigation Forensic evidence collection not linked to the forensic examination Witness support and court preparation Referral to health and social services (where applicable)
Social Services	Assessment to determine need for psychosocial support Referral for short-term and long-term psychosocial support Provision of safe accommodation if needed Community awareness and advocacy Referral to health and police and justice services (where applicable)

Adapted from Keesbury and Thompson (2010).

4. South Africa's legislative and policy frameworks as a response to GBV in South Africa

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

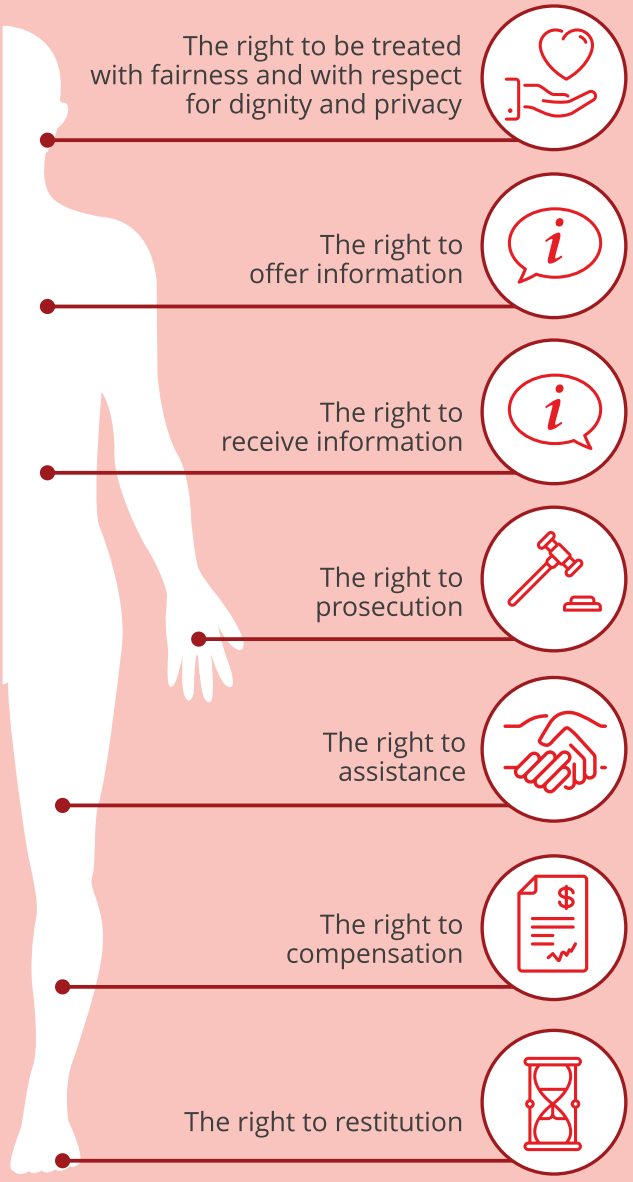
- The Domestic Violence Act (Act No. 116, 1998)
- The Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007)
- Firearms Control Act (Act No. 60, 2000)
- The Children's Act 38 of 2005
- National Policy Guidelines on Victim Empowerment
- National Instructions on Domestic Violence
- National Policy Framework on the Management of Sexual Offences
- National Instructions on Sexual Offences
- National Directives and Instruction on Conducting a Forensic Examination on Survivors of Sexual Offences in terms of the Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007)
- The Victims Charter (2004)
- National Management Guidelines for Sexual Assault 2003
- Court System and Case flow Management
- Family Violence Child Protection and Sexual Offences (FCS) investigation units at the SAPS.

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

4.1. The Victims Charter (2004)

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

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



4.2. The Domestic Violence Act 116 of 1998

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

4.3. The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

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

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

4.4. Sexual Offences Courts

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

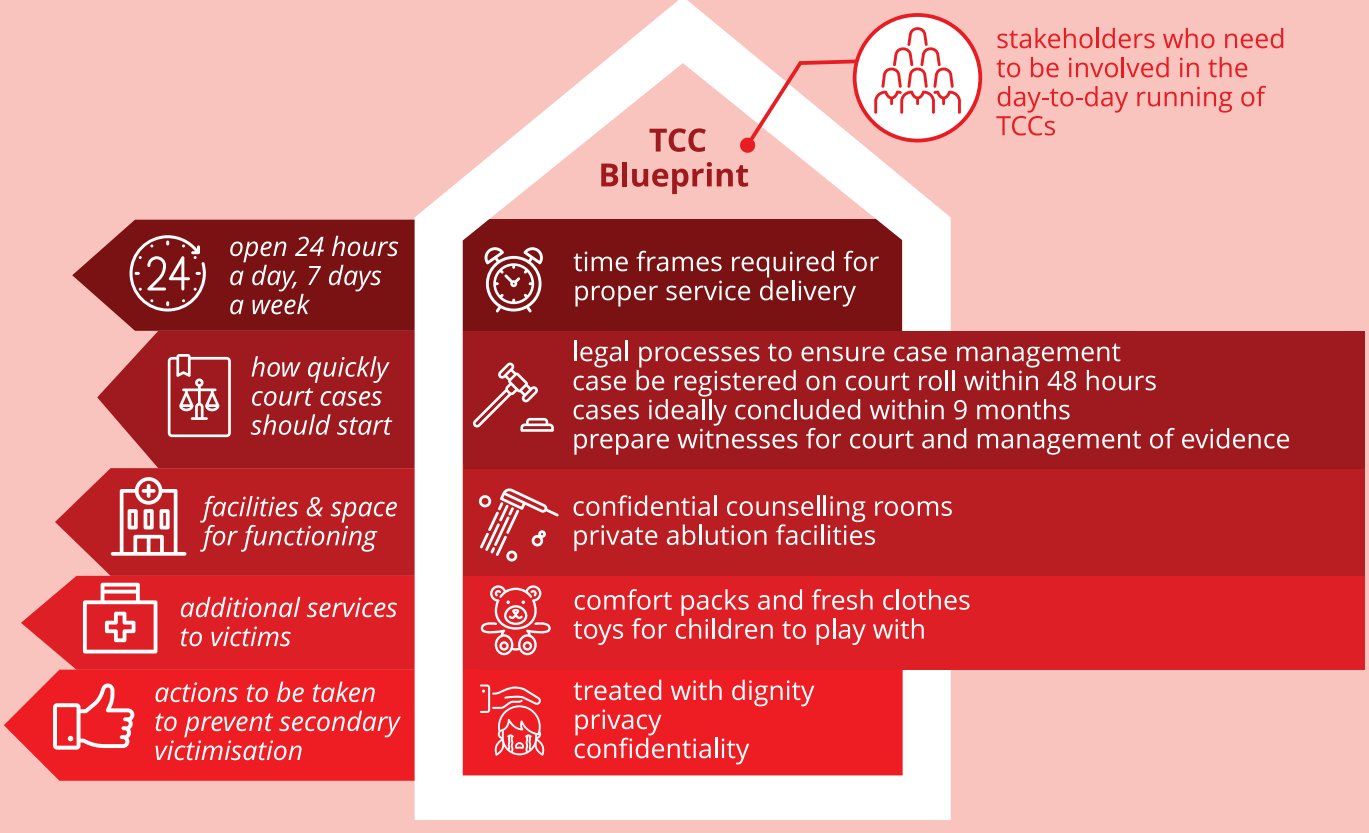
5. South Africa's policy guidelines, norms and standards to address GBV

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

5.1. The TCC Blueprint

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

The TCC Blueprint 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 department and the NGOs who deliver services within the TCCs. This includes staff members from these departments and NGOs who work within the TCCs, (RTI, 2012).



5.2. Department of Health National Norms and Standards, 2003

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

- That TCCs should be monitored by DoH officials monthly to monitor quality of services delivered
- That DoH will complete annual evaluations to identify gaps in service delivery
- That a facility checklist will be frequently conducted to ensure that all required services are delivered and that all equipment is functioning
- That the appropriate cadre of staff (such as a forensic nurse or medical doctor) who is trained on the management of sexual assault conduct the required medico-legal investigation
- That TCC will be victim-friendly and will have age-appropriate educational material
- That TCC personnel will follow the appropriate guidelines for the prescription of PEP as well as other medical services
- That there is a functioning, multidisciplinary committee that includes all government and NGO stakeholders that will guide the functioning of the TCC
- That the correct referral mechanisms are used for victims of sexual assault

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

The Department of Social Development (DSD) developed an integrated Programme of Action to address violence against women (POA: VAWC). This is a comprehensive, multi-sectoral strategic plan for ending violence against women and children. It highlights the responsibility of the different government departments who play a role in this sector. The POA is based on three pillars – prevention and protection, response and care and support (DSD, 2014).

5.4. National Management Guidelines for Sexual Assault, 2003

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

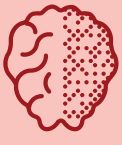
The guidelines provide for the provision of PEP, training of healthcare workers, debriefing of healthcare workers, and the health management of survivors. Others aspects include:

Competency of healthcare workers

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

Medico-legal evidence

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



Psychosocial support for victims

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

Investigations of sexual assault cases

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

Treatment of victims

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

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

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

- Detail the scope and content of services to be provided after sexual assault
- Outline the training needed for first responders
- Ensure consistent, high quality care for survivors of sexual assault
- Help prevent secondary victimisation of victims (NACOSA, 2015).

6. The TCCs in South Africa

The NPA was established in 1998 and is responsible for the start of criminal proceedings on behalf of the state. Within the NPA is the SOCA (Sexual Offences and Community Affairs) unit which is responsible for the management of the TCCs as well as the case management of the criminal cases as a result of sexual assault (Shukumisa, 2016). Owing to the high levels of GBV in South Africa, the NPA's SOCA unit developed the TCC model to respond to this crisis in a comprehensive and multisectoral way.

TCCs have been developed to reach three main goals:

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

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

Reception of the victim, followed by information explaining the services and procedure as well as consent for the process

- Referral, follow-up and emotional support

Emergency medical care

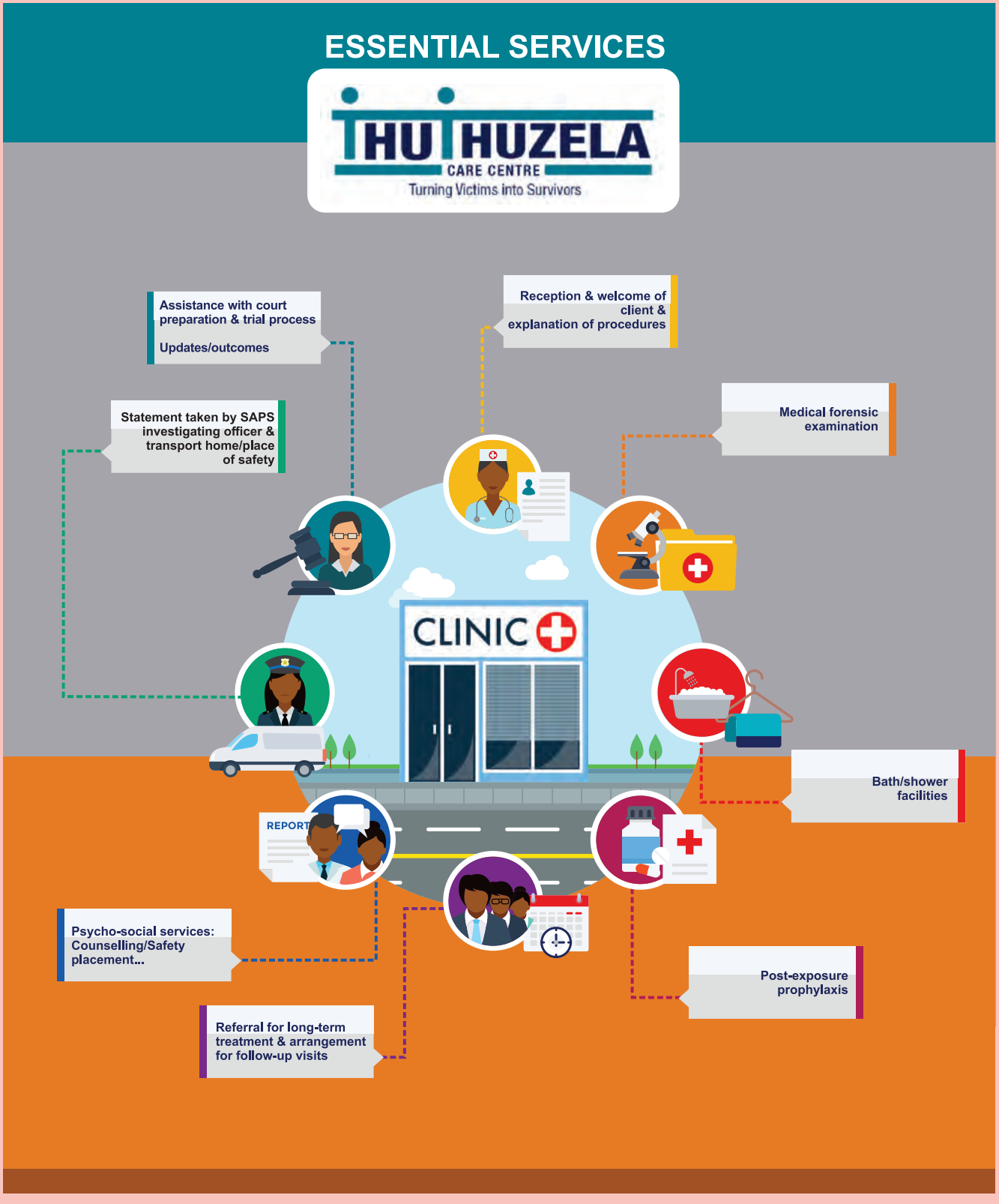
- Provision of prophylaxis for STIs, HIV and against pregnancy
- A medico-legal examination as well as medical history

Immediate psychosocial support

- Assistance with case reporting, statement and court preparation

The opportunity to bath/shower as well as a change of clothing

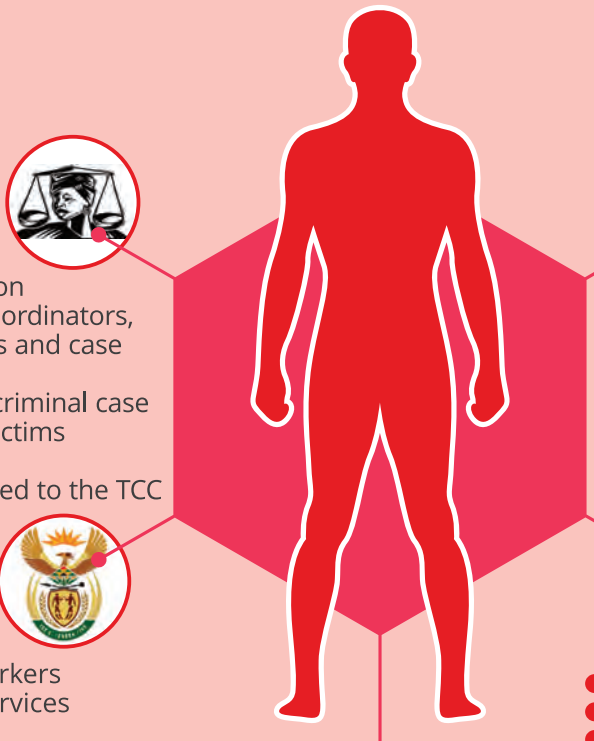
- Transport home or to a place of safety



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

The different government departments have different roles in the TCC model. The graph below is adapted from Shukumisa (2016) and the TCC Blueprint.

Stakeholder roles and responsibilities



National Prosecuting Authority

- Overall TCC coordination
- Appointment of site coordinators, victim assistant officers and case managers
- Case management of criminal case
- Court preparation of victims
- Sexual offences courts
- Operational costs related to the TCC

NGOs

- Counselling
- Comfort kits
- Follow-up psychosocial support
- Assist with 24/7 service delivery

Department of Health

- Provide healthcare workers
- Emergency medical services
- Medical treatment
- Forensic investigation
- Provision of PEP, vaccinations, STI prophylaxis, emergency contraception
- Cleaning services
- Security
- Maintenance

South African Police Services

- Charge office that is victim friendly
- Charge officers who are sensitised
- Take the victim's statement
- Sexual assault evidence collection kits (SAECK)
- Transport

Department of Social Development

- Victim support
- Counselling services
- Emergency shelter services
- Appointment of social workers and counsellors

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

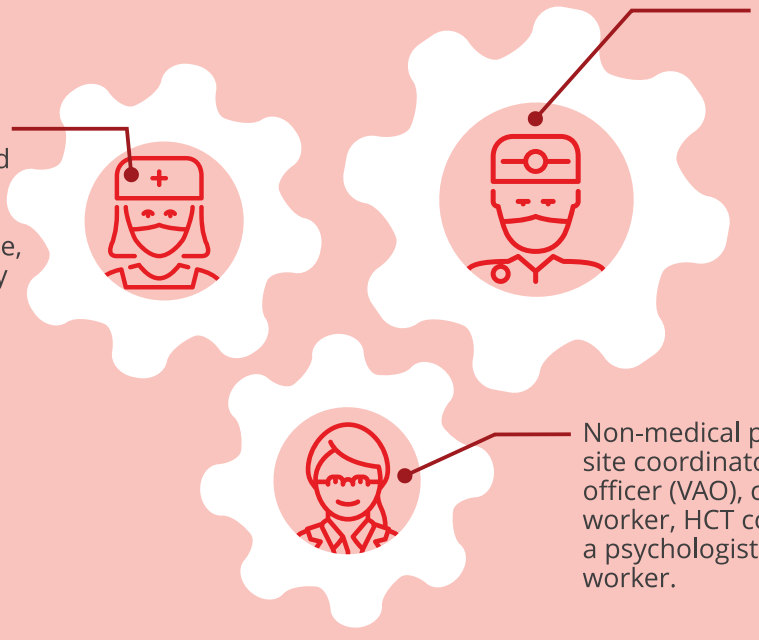
- RTI, 2012. **Final compliance audit of 23 Thuthuzela Centres**. Pretoria: USAID
- Soul City, 2013. **Qualitative formative research on the knowledge, attitudes and behaviours relating to reporting sexual assault and the use of Thuthuzela Care Centres**. Soul City Research Unit
- Vetten, L. 2015. **"It sucks/ It's a wonderful service": Post-rape care and the micro-politics of institutions**. Johannesburg: Shukumisa Campaign and ActionAid South Africa
- Shukumisa, 2016**. Improving after rape care services.** Young urban women programme, Johannesburg.

The findings were as follows:

6.1. Human capacity

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

All TCCs must have the following staff:



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

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

Non-medical personnel, including a site coordinator (SC), victim assistant officer (VAO), case manager, social worker, HCT counsellor and access to a psychologist and forensic social worker.

RTI (2012) found that many TCCs don't have site coordinators and very few have dedicated doctors or forensic nurses. Many TCCs do not have social workers. Gaps in the staffing at TCCs have an impact on the service delivery of TCCs as other staff members provide services in areas where they are not adequately qualified.

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

RTI (2012) also highlights that there is less training provided to non-medical staff than to medical staff. The non-medical staff who were trained received training on:

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

6.2. Health services delivered

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

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

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

National guidelines also make recommendations for various prophylactic treatments that must be available at facilities. TCCs don't have adequate resources and staff to provide short and long term counselling to clients after sexual assault. Very often, this service is provided be referral organisations. However, there isn't an adequate system to track if clients make use of the counselling services.

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

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

6.3. Psychosocial support

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

TCC deliver various counselling services to clients. This includes:

The RTI (2012) study highlighted that psychosocial support services are hindered by a lack of counselling space, which is compromising confidentiality, not enough personnel to deliver the service and personnel who are not trained to deliver the service. Vetten (2015) mentions that in most instances NGOs deliver the counselling services and psychosocial support. Between different TCCs there are different roles allocated to the counsellors, and this makes standardisation of services difficult. One of the main challenges in psychosocial support is follow-up care.

6.4. Stakeholder cooperation

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

Vetten (2015) describes the stakeholder relationships as a 'contested space where power struggles [are] played out between NPA and DoH, DSD and DoH, NGOs and the NPA, NGOs and DoH and NGOs and DSD'. RTI (2012) also highlights that the relationships between the stakeholders are varied across the different TCCs.

6.5. Location and visibility of TCCs

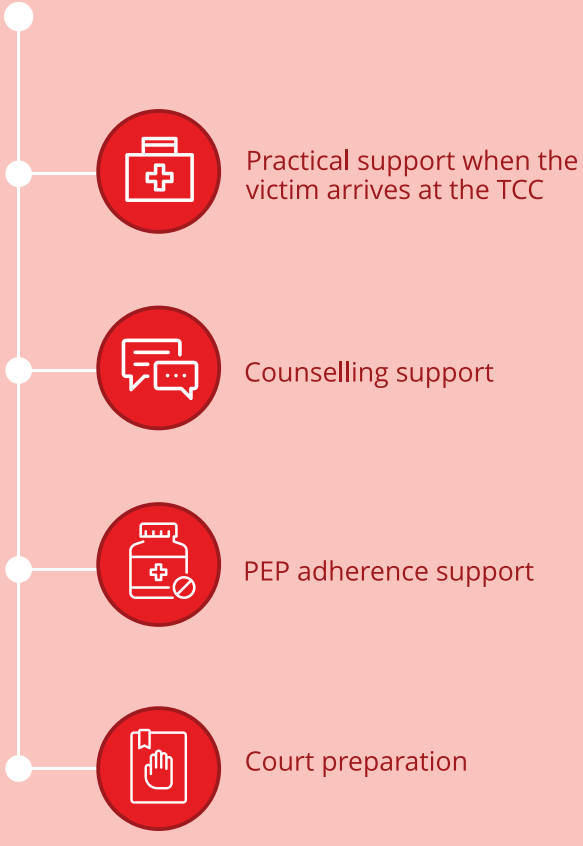
TCCs are located at hospitals, either within the hospital, a building next to the hospital or a park home on hospital grounds. Not all TCCs have signage and this make them difficult to locate (Soul City, 2013).

6.6. Operating hours

The TCCs have different operating hours. Some are open 8 hours a day during the week. Others are able to operate 24 hours a day as well as at weekends. NPA staff only work 8 hours a day, during the week and TCCs who operate 24 hours a day have other stakeholders (mostly NGOs) assisting them (Soul City, 2013). Most TCCs reported that there is a higher demand for TCC services after hours and during weekends (Soul City, 2013).

6.7. Services delivered by NGOs

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



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

6.8. Funding

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

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

7. Other government responses in South Africa

7.1. DSD: Khusuleka One-Stop-Centres

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

- Shelter services for victims of crime and natural disaster
- Trauma counselling and psychosocial support
- Referral to health care facilities
- A close working relationship between SAPS and the court system

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

7.2. DoH: Kgomotso Care Centres

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

- Medical first aid to treat injuries
- A comprehensive medical assessment and forensic examination
- Provision of PEP for HIV and STIs
- Emergency contraception
- Vaccinations to prevent hepatitis B and tetanus
- Counselling and linkage to care

8. Conclusion and still existing gaps

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

- It is not clear what the responsibility and mandate of the Department of Women is in relation to the response to GBV in South Africa.
- There is lack of clarity on departments' financial and human resource responsibilities within the various initiatives.
- There is a lack of public awareness on the various programmes.
- There is a lack of coordinated efforts between departments.
- There is inadequate psychosocial support for victims of GBV.
- There are laws are in place to address GBV, but enforcement is not adequate.
- Too few women access services after experiencing GBV.
- Coverage of care is not adequate (Mpani and Nsibande (2015); Vetten (2015); WHO (2016)).

CHAPTER 3: METHODOLOGY

METHODOLOGY

The compliance audit and gap analysis assessed to what extent the 55 operating TCCs function according to the TCC Blueprint, but was also used to identify the gaps in service delivery, staffing and equipment. It was conducted in three phases. Phase one was a desk review to conduct a situational analysis, phase two was field work and data collection, and phase three, reporting.

1. Approach

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

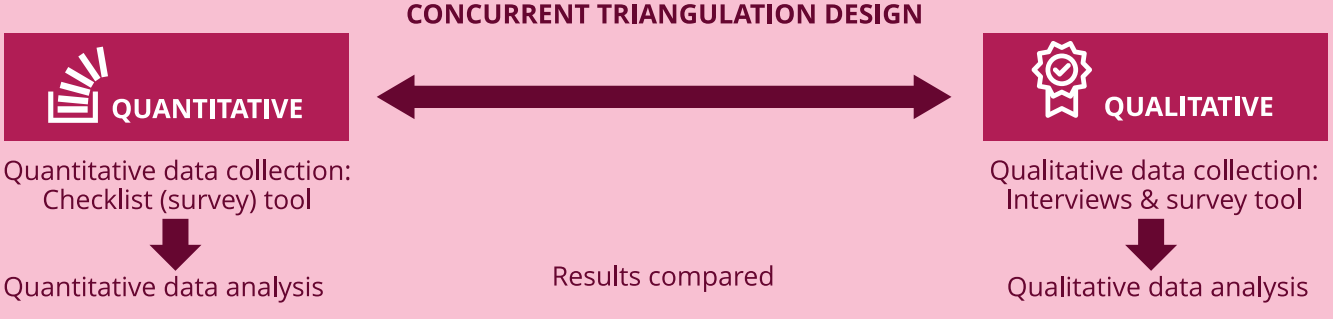
The data collection team used a concurrent triangulation mixed methods design. Quantitative and qualitative data of equal weight were collected at the same time and integrated during the analysis and interpretation of the findings. The following figure was adapted from Creswell (2009, p195) and represents the design of this mixed methods approach.

2. Sample

The data collection team was requested to collect data from each TCC in all nine provinces. Random sampling was therefore not used. There were two populations in this compliance audit and gap analysis, the NPA staff and the NGO staff. The exact number of NPA staff across all facilities was unknown. However, 54 facilities of the 55 facilities had either a site coordinator, victim assistance officer or case manager overseeing the facility. These were the key NPA informants who had to be interviewed and were therefore selected using purposeful sampling. The team also interviewed key NPA personnel, regional TCC managers as appointed by the NPA, NGOs working in the field of GBV, as well as South African experts in GBV. Khayelithsa TCC was not included in the study as the site coordinator at Khayelitsha TCC was unavailable due to illness and there is no VAO or case manager.

The number of NGO staff was also unknown to the data collection team. Each facility manager was informed beforehand of the compliance audit and gap analysis, specifically what it entailed and who needed to be interviewed. They were also asked to inform their facility's NGO of the site visits so that an NGO representative would be available for the interviews (please note that not all TCCs had an NGO assisting them delivering the TCC services). The NGO informants were conveniently sampled based on who was available at the time of data collection.

Figure 1. Approach to the compliance audit



3. Situational analysis and desk review

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

The team also consulted NGOs', administrative and government secondary data for this.

4. Data collection methods, instruments and procedure

A database containing the contact information of the TCCs was used by the data collection team to contact each facility. Some of the TCCs did not have landlines and therefore alternative methods of communication, such as email correspondence, had to be used where possible. Site visits were scheduled with each TCC, except Khayelitsha TCC.

4.1. Quantitative data acquisition

The TCC model was studied and a questionnaire was developed based on the model. An Application (ODK App) and survey tool was developed in collaboration with 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 (Delvy 1.1) was developed and piloted in two TCCs in Gauteng and Limpopo, where some redundant questions where identified. The survey was adapted once more during the first phase data collection, with the final version being Delvy 2.2.

The checklist tool consisted of open- and closed-ended questions. These questions were grouped under different sections, for example, questions regarding the facilities and equipment found at the TCCs were grouped under a section named 'Facilities and Equipment at the TCC'.

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

4.2. Qualitative data acquisition

Semi-structured interview schedules were developed after careful examination of the TCC model and relevant literature. As previously mentioned under the sampling section, four groups of participants were interviewed and therefore four different interview schedules were developed for the facility coordinators, NGOs working within the TCC, key NGOs and GBV experts, and key NPA personnel and regional TCC managers respectively. The majority of the interviews were audio-recorded with permission from the participants. Field notes were made when participants consented to be interviewed but not to be audio-recorded. Each interview lasted approximately 10 to 60 minutes.

5. Data analysis procedure

5.1. Quantitative data analysis

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

5.2. Qualitative data analysis

The audio recordings were transcribed verbatim and analysed through a combination of deductive and inductive thematic coding. Themes were drawn from the semi-structured interview schedules and added to the coding frame. The transcripts were initially read as a whole and notes were made at the end. Codes were developed and grouped as categories under each theme. Two coding frames were developed since two different interview schedules were used. The coding was done in MS Word™ using macros and in the ATLAS.ti® computer programme.

To ensure credibility, the data collection team adopted the correct operational procedures in the collection and analysis of the data. Moreover, the data collection team triangulated different data collection techniques and data sources, used iterative questioning during interviews, ensured that the data collection sessions only involved participants who volunteered to participate, and provided a comprehensive description of the TCCs.

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

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

6. Data verification and quality assurance

Table 1. Data verification

QUANTITATIVE	QUALITATIVE
Used a structured checklist tool to reduce the subjectivity of the evaluator and thus increased the quality.	Used a structured interview guide that decreased subjectivity of the interviewer.
Respondent verification: The data collected through the App was verified by the site coordinator directly after it had been completed to check that it has been filled out correctly and truthfully.	Obtained data from multiple sources, at various levels of implementation.
	Used and compared the data with field notes taken during the interviews.

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

7. Ethics

FPD has an in-house Research Ethics Committee, registered with the National Research Ethics Council of South Africa, who reviewed the proposal and provided approval based on the risk, duration and budget of the audit and gap analysis. The compliance audit 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 audit compliance component did not require ethics clearance.

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

7.1. Respect for persons

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

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

7.2. Beneficence

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

The intention of this compliance audit was to provide all the stakeholders with information on possible gaps in service delivery and to see if there is any incongruence with the TCC model at facility, provincial and national levels. This information could be used in future to improve the quality of services at the facilities. The data collection team ensured that a comprehensive report was developed to achieve this goal.

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

7.3. Justice

The Belmont Report describes the principle of justice as 'that equals ought to be treated equally' (National Commission for the Protection of Human Subjects of Biomedical Behavioural Research and Ryan, 1979:6). The data collection team made sure that all participants were thoroughly informed of the purpose of this evaluation. Additionally, informed consent was obtained from each participant. The data collection team also made sure that the participants were selected fairly without any form of coercion and that the samples were representative of all the TCCs where data were collected. This report is intended to aid in the equal distribution of the benefits of this compliance audit and gap analysis.

7.4. Other aspects

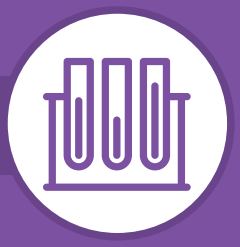
All quantitative data collected via the App were stored electronically. Recorded interviews were stored on Dropbox (in a folder that could only be accessed by the interviewer).

All respondents, key informants and other participants in this audit and gap analysis signed a consent form that was approved by the Research Ethics Committee. The site-coordinator was asked to give consent for the site visit and completion of the checklist tool and the interview respondents were asked to give consent for the interviews.

8. Limitations

Every possible effort was made to conduct the compliance audit and gap analysis with all 55 TCCs in South Africa, and to interview all the NPA regional TCC managers. The following constraints were experienced in the data collection phase:

- The key informants were representative of the 54 TCCs and the NGOs working within the TCCs. The sample was also determined by the availability of personnel on the day of the scheduled interview. The key NPA staff and external NGOs interviewed were selected using convenience sampling. FPD identified the most appropriate key informants, and they were selected for interviews. The NPA regional managers consisted of the full sample of the regional managers within the NPA TCC structure.
- It was not possible to visit Khayelitsha because the only NPA staff member was on sick leave when the study was conducted.
- No clients at TCCs or victims of GBV were interviewed. This is a limitation with regards to the perceptions of the clients on how victim-friendly and appropriate the services of the TCCs are.
- Only NPA staff and NGO staff were interviewed within the TCCs. The focus was not on other government departments who also deliver services within the TCCs, such as the DoH, SAPS, DSD and others. TCC-related aspects such as court proceedings and the judicial system were not part of this compliance audit and gap analysis.
- The focus of the compliance audit and gap analysis was on TCC functionality and not the resulting court processes.
- The findings are based on self-reporting by the TCC personnel, NPA personnel and NGOs. The findings were not triangulated with client files or interviews with clients.
- The focus of the compliance audit and gap analysis was on compliance with the TCC Blueprint as well as the NACOSA 2015 guidelines on the functioning of the TCC. It did not assess the compliance of TCCs with other national policies, procedures and guidelines.



CHAPTER 4: FINDINGS: COMPLIANCE AUDIT AND GAP ANALYSIS

The TCC compliance audit and gap analysis findings are divided into ten sections. Section 1 is a summary of the national, general findings of all TCCs. This is based on the key informant interviews as well as the survey of 54 of the 55 TCCs. Sections 2 to 10 are province specific and provide a general overview of each province.

1. National TCC findings

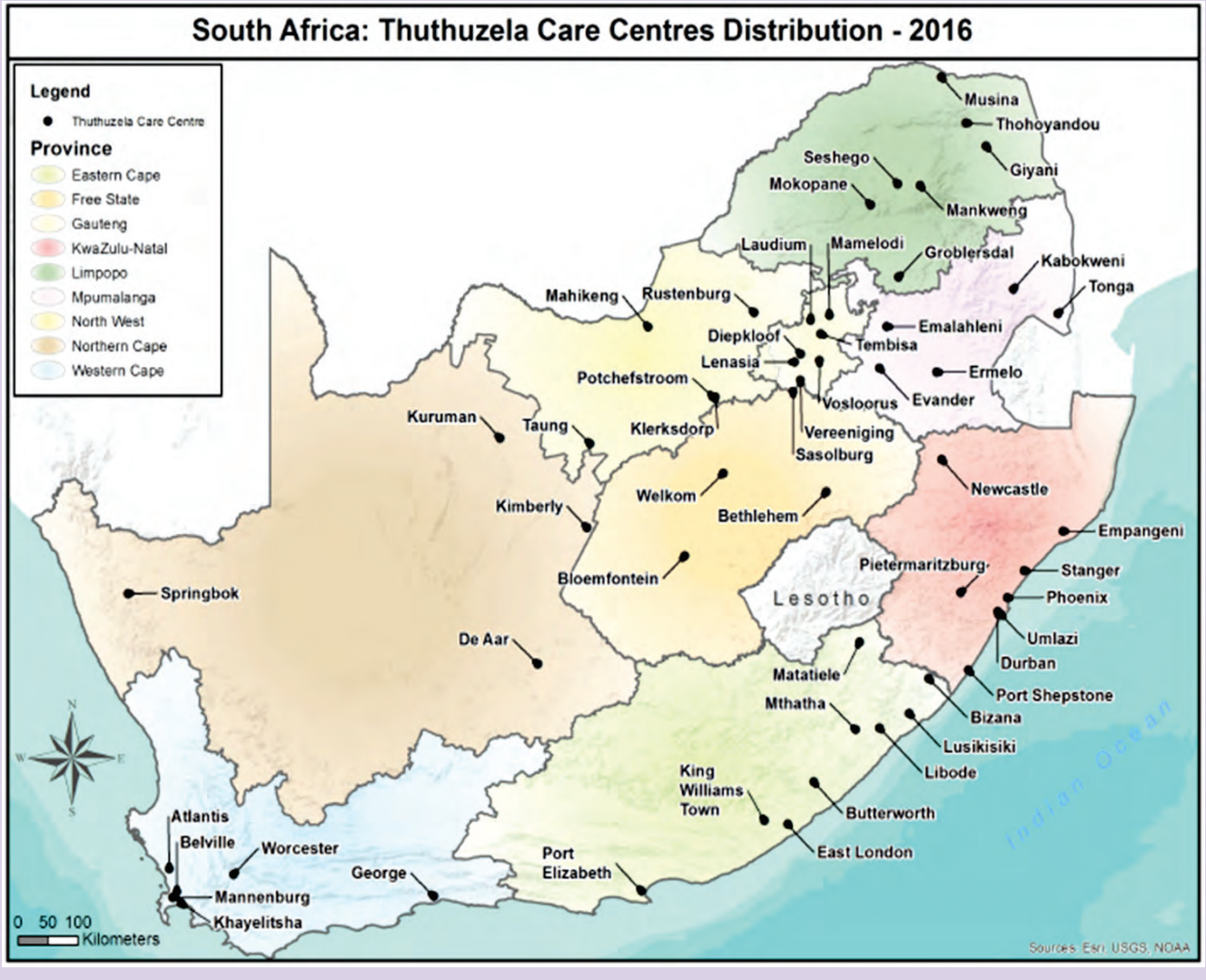


Table 2. TCC location

EASTERN CAPE	FREE STATE	GAUTENG	KWAZULU-NATAL
Port Elizabeth Dora Nginza TCC Dora Nginza Hospital	**Welkom** Bongani TCC Health Complex *(Old Provincial Hospital)*	**Mamelodi** Mamelodi TCC Mamelodi Day Hospital	**Newcastle** Madadeni TCC Madadeni Hospital
Bizana Bizana TCC St Patricks Hospital	**Sasolburg** Metsimaholo TCC Metsimaholo District Hospital	**Diepkloof** Nthabiseng TCC Chris Hani Baragwanith Hospital	**Port Shepstone** Port Shepstone TCC Port Shepstone Regional Hospital
King Williams Town Grey Hospital TCC Grey Hospital	**Bethlehem** Phekolong TCC Phekolong Hospital	**Lenasia** Lenasia TCC Lenasia Hospital	**Umlazi** Umlazi TCC Prince Mshiyeni Memorial Hospital
East London Mdantsane TCC C Makiwane Hospital	**Bloemfontein** Tshepong TCC National District Hospital	**Laudium** Laudium TCC Laudium Hospital & Community Health Centre	**Phoenix** Phoenix TCC M Ghandi Memorial Hospital
Butterworth Butterworth TCC Butterworth Hospital	**NORTHERN CAPE**	**Vosloorus** Thelle Mogoerane TCC Thelle Mogoerane Regional Hospital	**Durban** RK Kahn TCC RK Khan Hospital
Libode Libode TCC St Barnabas Hospital	**Springbok** Springbok TCC Van Niekerk Hospital (Springbok Hospital)	**Vereeniging** Kopanong TCC Kopanong Hospital	**Pietermaritzburg** Edendale TCC Edendale Hospital
Mthatha Mthatha TCC Mthata General Hospital	**Kuruman** Kuruman TCC Kuruman Hospital	**Tembisa** Masakhane TCC Tembisa Hospital	**Stanger** Stanger TCC Stanger Provincial Hospital
Lusikisiki Lusikisiki TCC St Elizabeth Hospital	**Kimberly** Galeshwe TCC Galeshwe Day Hospital	**LIMPOPO**	**Empangeni** Empangeni TCC Ngwelezane Hospital
Matatiele Taylor Bequest TCC Taylor Bequest Hospital	**De Aar** De Aar TCC Central Karoo Hospital	**Groblersdal** Groblersdal TCC Groblersdal Hospital	**WESTERN CAPE**
NORTH WEST	**MPUMALANGA**	**Mokopane** Mokopane TCC Mokopane Hospital	**Worcester** Worcester TCC Worcester Hospital
Rustenburg JS Tabane TCC JS Tabane Hospital	**Kabokweni** Themba TCC Themba Hospital	**Mankweng** Mankweng TCC Mankweng Hospital	**Mannenburg** Mannenburg TCC GF Jooste Hospital
Potchefstroom Potchefstroom TCC Potchefstroom Hospital	**Tonga** Tonga TCC Tonga Hospital	**Seshego** Seshego TCC Seshego Hospital	**Bellville** Karl Bremer TCC Karl Bremmer Hospital
Mahikeng Mahikeng TCC Mahikeng Provincial Hospital	**Ermelo** Ermelo TCC Ermelo Hospital	**Musina** Musina TCC Musina Hospital	**Atlantis** Wesfleur TCC Wesfleur Hospital
Klerksdorp Klerksdorp TCC Klerksdorp Hospital	**Evander** Evander TCC Evander Hospital	**Thohoyandou** Tshilidzini TCC Tshilidzini Hospital	**George** George TCC George Provincial Hospital
Taung Taung TCC Taung District Hospital	**Emalahleni** Emalahleni TCC Witbank Hospital	**Giyani** Nkhensani TCC Nkhensani Hospital	**Khayelitsha** Khayelitsha TCC Khayelitsha Hospital & CHC

There are a number of unique challenges in the functioning of the TCCs across the country, which can be summarised across a number of themes. These includes governance and operation challenges, TCC facilities, victim friendliness, service delivery, factors that influence service delivery, stakeholder cooperation, services delivered by NGOs and challenges in the funding environment.

1.1. Governance and operational challenges

There are a number of governance and operational challenges that inhibit the functioning of the TCCs. It has been reported that the multi-disciplinary approach makes it difficult to implement the model. One of the major challenges reported across provinces is the dual reporting system within the TCCs. The case managers in TCCs report to a provincial regional manager under a legal reporting system. The site coordinators and VAOs report directly to the Director of Administration within the NPA head office in Pretoria, because they are public service appointments (under the Public Services Act) and not legal appointments. As a result, regional managers are held accountable for the functioning of TCCs, but they cannot influence the operational aspects of the TCCs. It has been reported that there is a need for more provincial oversight with the public service appointments.

> 'If we can have maybe a provincial coordinator that can be in the area so that they can be able to coordinate service, because we need to go to the services of the province must align with each other. What I'm doing in Galeshewe, a person who is in De Aar and a person who is in Springbok, must be able to know what is happening in Galeshewe and also what is happening in Springbok, because we are one province. We must be able to learn from each other.'
> *~ NPA key informant*

The centralised operational system, where all resources are ordered from the national office, creates its own challenges. All operational requests and orders (telephone lines, computers, paper, groceries etc.) are ordered through a national system. This delays the delivery of orders and negatively influences the functioning of the TCCs.

Many provincial managers are not based in the province where they manage TCCs. As a result, they cannot visit the TCCs as often as required and cannot take part in other provincial forums (such as human trafficking, victims' charter etc.). There is also a concern regarding the number of TCCs allocated per regional manager. The Limpopo and Gauteng managers are solely responsible for 7 TCCs each, as well as work within the National Office. The 8 TCCs in KwaZulu-Natal are managed by 3 regional managers.

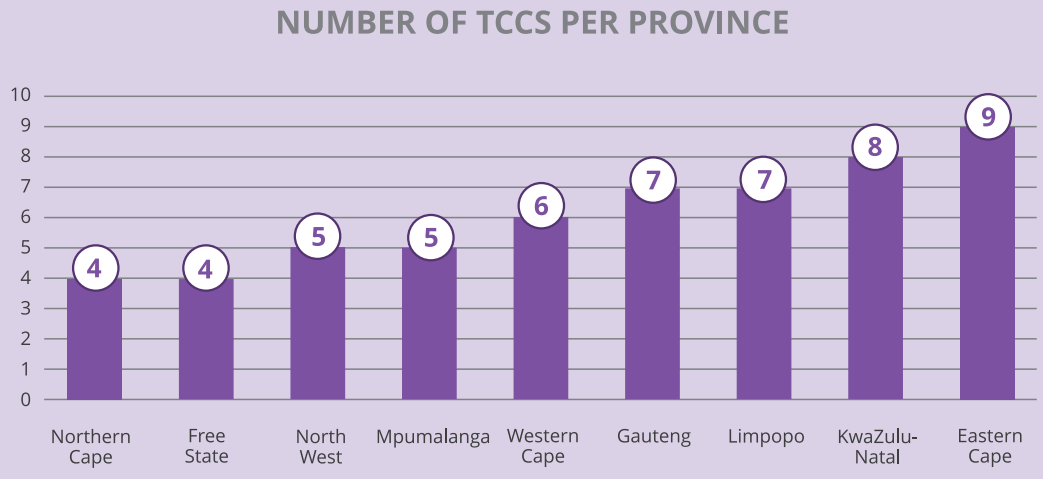
It is important to realise that not all TCCs function in the same way. There are differences in stakeholder management (to be discussed later), caseloads and provincial management. Furthermore, some TCCs have found innovative ways of managing the TCC and the cases they handle. For example one TCC records the court case status of each client they see, and others have developed TCC-specific WhatsApp groups to involve all stakeholders.

1.2. Facilities and sites

Location of TCCs

Not all provinces in the country have the same number of TCCs, and there have been questions asked about the decision on where new TCCs should be established.

Figure 2. Number of TCCs per province

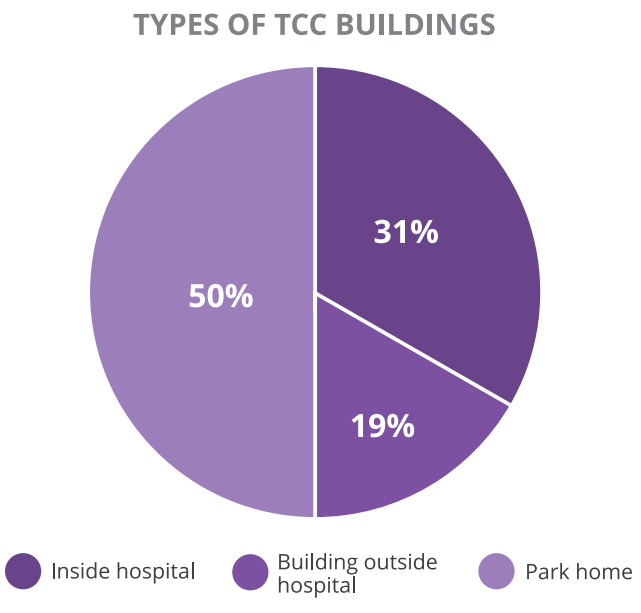


Type of TCC building

31%
of the TCCs were located in **PERMANENT STRUCTURES** inside hospital/clinic facilities

19% were located in permanent structures outside hospital/clinic facilities and 50% were located inside park homes.

Figure 3. Type of TCC building



Safety and security

The safety and security of TCC, DoH and NGO staff, particularly after hours, has been expressed as a concern by many key informants. This is a particular problem when the TCC is based outside the hospital or in a park home. Some of the participants were very concerned about security at the TCCs. One even commented that her personal concern was her own safety. At times perpetrators have to sleep over at the TCCs without any security present to protect the staff members.

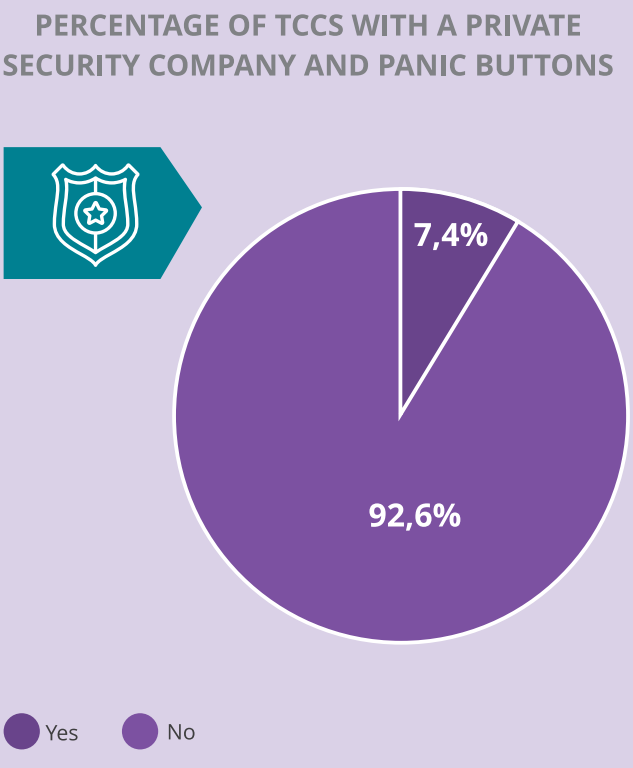
Some TCCs have a private security company assigned to them (7.4%) and also have panic buttons in the facility. These are mainly contracted by the NGOs who are working within the TCCS.

'What our safety is concerned, we are alone here over weekends and at night, and that is quite a risk. This morning one of my colleagues that I relieved, she told me, you know we are in a gang area, don't know if you've heard of it.' ~ *NGO key informant*

'We have been promised that we are going to have panic buttons, we don't, they don't have panic buttons. Because one time there was a break in here, so the safety.' ~ *NPA key informant*

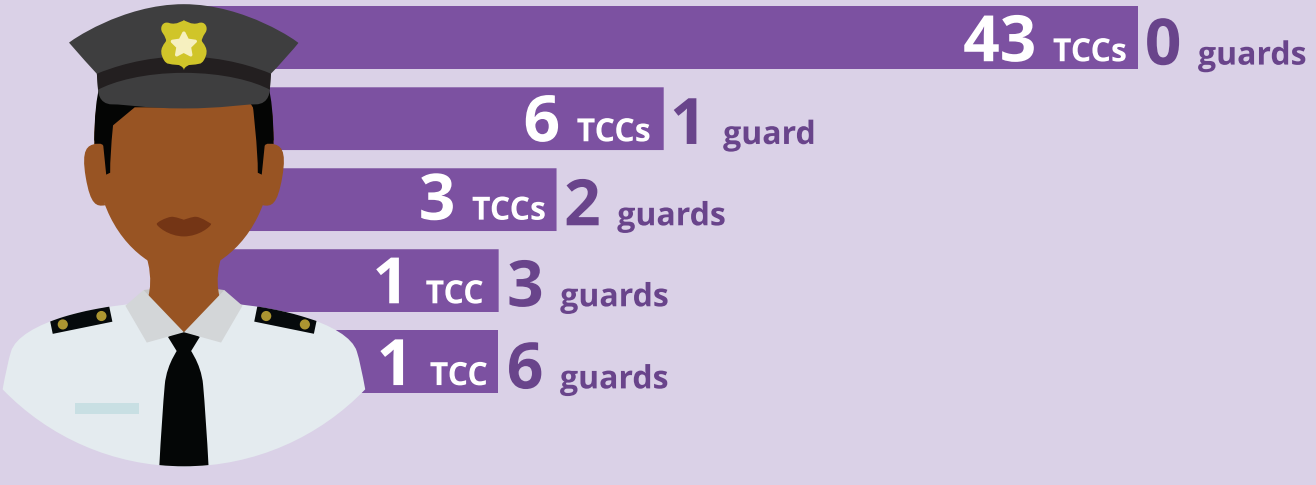
'We are safe, although the hospital is also catering at times for mentally challenged patients like the psych patient having easy access to the park home. So it makes us not safe' ~ *NPA key informant*

Figure 4. Percentage of TCCs with a private security company and panic buttons



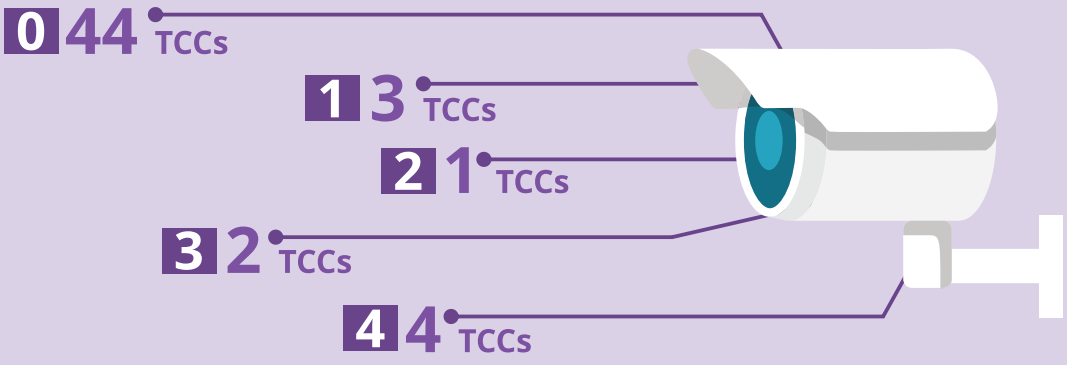
Some TCCs also have a security guard assigned to them to assist with safety and security. Six TCCs had only one security guard assigned to them, three TCCs had two, one had three and one had six guards. The majority of TCCs (43) had no security guards.

Number of TCCs with security guards assigned



In addition to this, selected TCCs have access to CCTV cameras at the TCC. Most TCCs (44) had no CCTV cameras. Three had only one CCTV camera, one had two CCTV cameras, two had three CCTV cameras and four had four CCTV cameras.

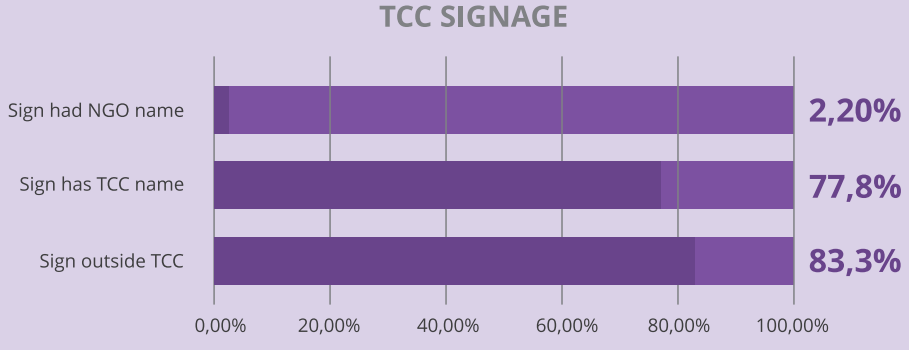
Number of TCCs with CCTV cameras



Signage

More than 80% of the TCCs had a sign outside of the facility. Of those that had signage, 77.8% had the name of the TCC on it. Only 2.2% of the TCCs with signage had the name of an NGO on it. This is a major improvement from previous studies that found that victims struggled to find the TCCs.

Figure 5. TCC signage



Space

Most TCCs mentioned a need for additional space to conduct their work properly. This includes a need for additional counselling rooms, and an area to take statements as well as storage space. Various respondents mentioned that they often have to share space or use rooms for multiple purposes. Others mentioned that they do not have enough space to store equipment.

'We are supposed to have a statement room, where the police are supposed to take the statement for the victim we don't have those the office for that' ~ *NPA key informant*

'The space in the first place is a very big problem, because we can't do anything without space, and even the environment is not ideal for counselling people ... you see. If you came yesterday, you were going to see how full it was' ~ *NGO key informant*

1.3. Victim friendliness

Victim friendliness is a major challenge for TCCs. Most mentioned that victims may experience secondary victimisation as a result of the lack of victim friendliness of the environment. Auxiliary staff lack sensitivity when treating and receiving clients. Other problems include insufficient refreshments and comfort packs, the lack of child friendly facilities and lack of age-appropriate IEC material.

Secondary victimisation

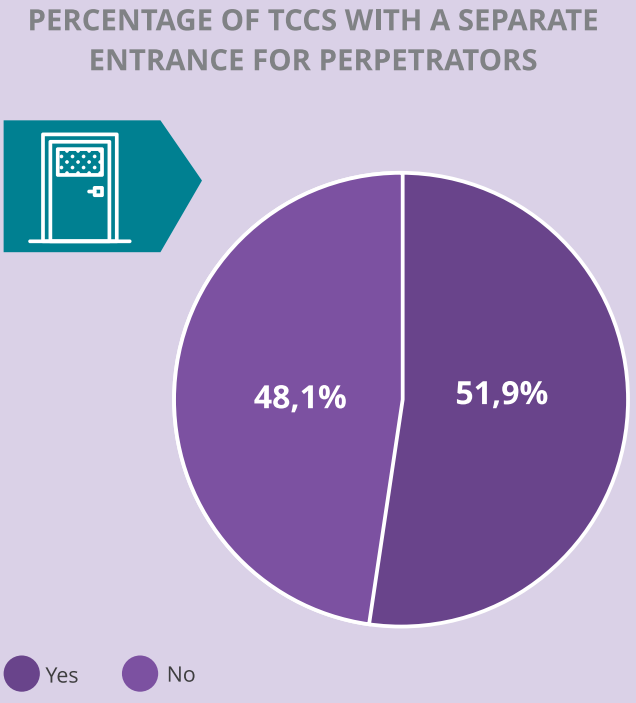
Some of the TCCs mentioned that victims are at a risk of experiencing secondary victimisation as a result of being mishandled as they seek help from various stakeholders. The lack of privacy when assisting victims may also be another factor in secondary victimisation.

'It can be, it can be because you can see let's say for instance if the victim is a walk in and then he is or she is passing the people who are just visiting the hospital for their normal routine of their medication or sicknesses, so those people will see who is coming in and then they might have their own assumption if they see the person coming in and then you know our people they talking about anything that they think of'
~ NPA key informant

'If you start at casualty obviously maybe, you know, because it's not victim friendly, that alone, it exposes you to secondary victimisation, but there, it's out in the open and you are most vulnerable so obviously, I think, to some degree, yes. It does expose them to secondary victimisation'
~ NPA key informant

Another issue is that some TCCs do not have a separate entrance for victims and perpetrators. This opens victims to secondary victimisation, because the perpetrator is examined, DNA taken and HCT completed in the same section of the TCC as the victim.

Figure 6. TCCs with a separate entrance for perpetrators



The interviews revealed that, regardless of the TCCs' best efforts, clients still experienced secondary victimisation due to the actions of other stakeholders. Participants believe that a lot of secondary victimisation comes from the police, despite their training. They believe that the police have become desensitised towards clients and their situations. Mention was made of how victims were transported by the police in the back of vans.

'That's a secondary victimisation, putting a traumatised person at the back of the van'
~ NPA key informant

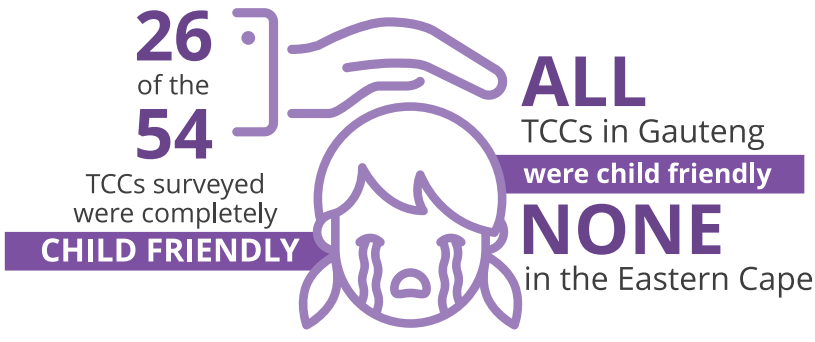
'Because they take these victims and put them at the back of the van that is another thing that we don't like' *~ NPA key informant*

'Once had a lady who was told by a female police official at the police station that she must take off her underwear so that the police official can see if she has been raped.'
~ NPA key informant

Child friendliness

A number of TCCs were not child friendly. Some do not have children's rooms for children to wait and play in, there are not enough toys and not all the walls are painted.

To be completely child friendly, a TCC must have a room for children to wait and play in and sufficient toys. Only 26 of the 54 (48%) TCCs surveyed were completely child friendly. All TCCs in Gauteng were child friendly, but none in the Eastern Cape were.



'It is cold and not childfriendly at all'
~ NPA key informant

'Another challenge is that our kiddies' room is not child friendly. Because this unit doesn't have the painted walls and there are no dolls, there are no toys for the child. You know, there are no crayons and books so that one can do a drawing'
~ NPA key informant

Auxiliary staff sensitivity

Some TCCs reported that they need training in GBV sensitivity because some of the auxiliary staff may not know how to handle clients with sensitivity. This includes training staff such as cleaners, security officers etc. on how to receive and communicate with clients without judgement or discrimination. Some TCCs indicate that they do some training, but it is not adequate.

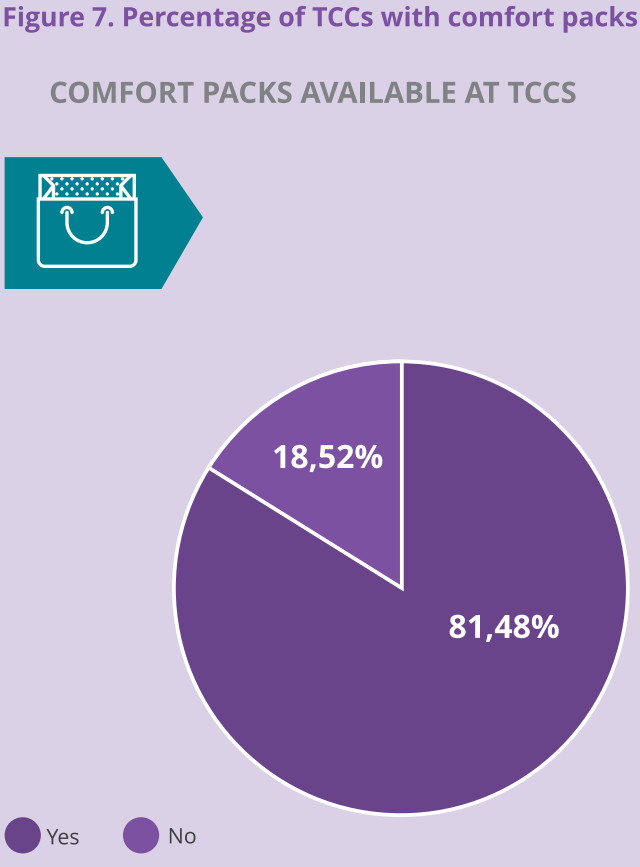
'At some stage, we could speak with them but now they are changing. It will be a new security guard on the other day whom doesn't even know what is happening on that park home. So we are having such, I could say challenge on information' *~ NPA key informant*

'We didn't like the way she was talking to the clients, so we also made arrangements. She is still working at the hospital, but not here, I believe she is at casualty or something'
~ NPA key informant

Refreshments and comfort packs

According to key informants, the TCCs do not always have comfort packs and refreshments for victims. The respondents felt that offering food and comfort packs is one way to reach out to clients and make them feel comfortable and relaxed. They also mentioned that NGOs may sometimes provide them with supplies for victims. Eighty-one percent of TCCs do have comfort packs available, which is significantly higher than expected.

Figure 7. Percentage of TCCs with comfort packs



It is also reported that victims spend a lot of time, sometimes hours, at the TCC during the forensic and medical examination and counselling, and also receive PEP, so need refreshments.

'Because sometimes, some of them, we don't have food in here' ~ *NPA key informant*

1.4. Facilities and services delivered according to the TCC Blueprint

One of the main questions for the compliance audit and gap analysis is to determine to what extent the TCCs are equipped and delivering services according to the TCC Blueprint.

Table 3. Services provided at TCCs

Service provided	Yes		No	
	Number	Percentage	Number	Percentage
Reception service	54	100.00%	0	0.00%
Forensic examination service	53	98.15%	1	1.85%
Shower and/or bath service	52	96.30%	2	3.70%
Comfort packs	45	83.33%	9	16.67%
Clean clothes	45	83.33%	9	16.67%
Statement taking	41	75.93%	13	24.07%
Short term psychological support	49	90.74%	5	9.26%
Long term psychological support	53	98.15%	1	1.85%
HCT service	54	100.00%	0	0.00%
HIV treatment referral	54	100.00%	0	0.00%
Case reporting	53	98.15%	1	1.85%
Court preparation	50	92.59%	4	7.41%
Cleaning service	48	88.89%	6	11.11%
Linked to sexual offences court	38	70.37%	16	29.63%
Other services offered	27	50.00%	27	50.00%

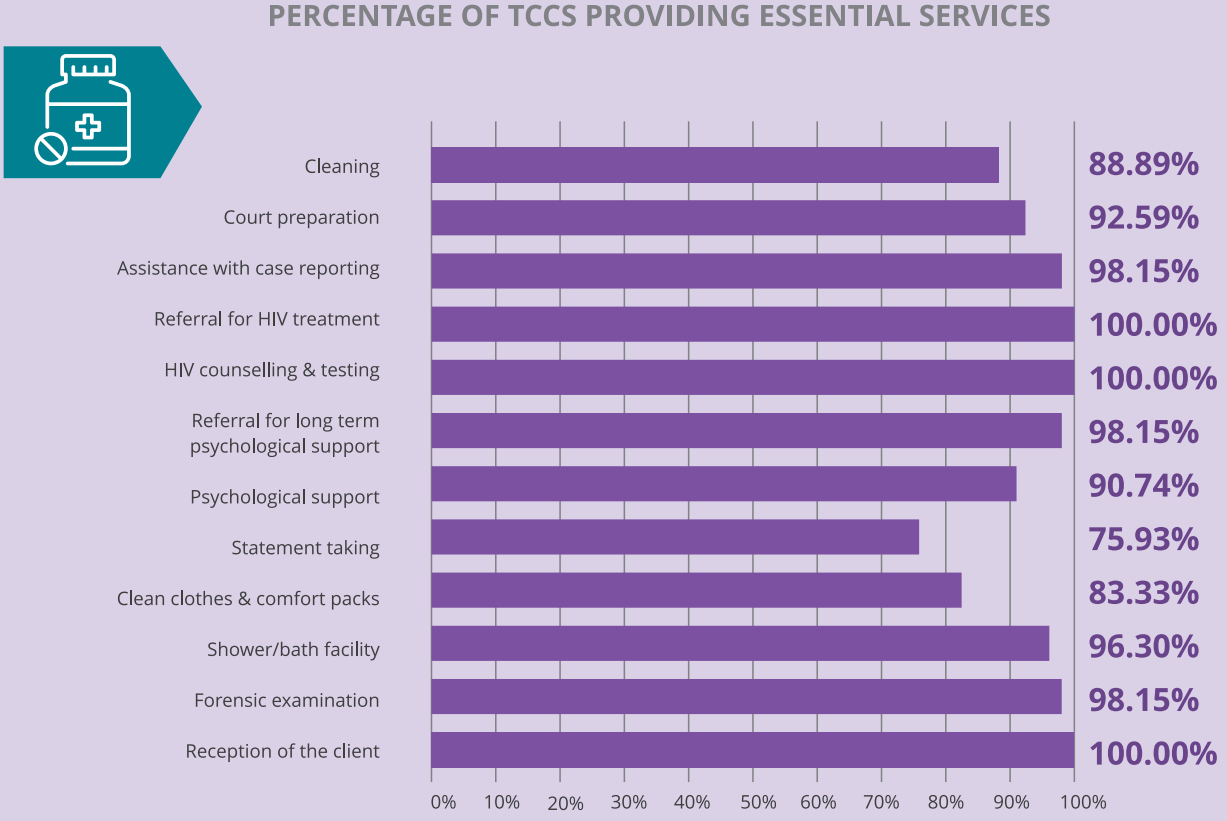
All of the TCCs provided reception services, HCT and HIV treatment referral services. Ninety-eight percent of the TCCs provided case reporting services, 92.6% provided court preparation services and 75.9% provided statement taking services. Seventy percent of the TCCs were linked to a sexual offences court. Ninety-eight percent of the TCCs provided forensic examinations, 83.3% provided comfort packs, 96.3% had shower and/or bath services, 83.3% provided clean clothes and 88.9% had cleaning services. Ninety percent of the TCCs offered short term psychological support and 98.1% provided referral for long term psychological support. Half of the TCCs offered other services not previously mentioned. It is important to note that although all these services are offered, they are not always offered within the TCC. Some of the services are provided within the hospital or at the local police station. Note that these are self-reported statistics.

Table 4. Facilities available at TCCs

Facilities	Number and percentage TCCs with facilities available		Number and percentage of TCCs with none available	
	Number	Percentage	Number	Percentage
Private ablutions with shower and toilet	52	96.3%	2	3.7%
Disabled-friendly ablutions	29	53.7%	25	46.3%
Private room for calming clients	30	55.6%	24	44.4%
Private room for children to play	36	72.2%	15	27.8%
Waiting room(s) with seating	50	92.6%	4	7.4%
Counselling office(s)	47	87.0%	7	13.0%
SAPS office	41	75.9%	13	24.1%
VAO office	41	75.9%	13	24.1%
HCT room	33	61.1%	21	38.9%
Examination room	53	98.1%	1	1.9%
NGO office	38	70.4%	16	29.6%
Wheelchair ramp	36	66.7%	18	33.3%

The majority of TCCs (96.3%) had private ablution facilities of which 53.7% were disabled-friendly. More than half of the TCCs had a private room for clients to rest in and 72.2% had a private room for children to play or wait in. Ninety-two percent of the TCCs have a waiting room with seating for their clients. Eighty-seven percent of TCCs had at least one counselling office, 75.9% had a SAPS and VAO room, 61.1% had a HCT room, 98.1% had at least one examination room, and 74.4% had an NGO office. Sixty-six percent of the TCCs had a wheelchair ramp and 33.3% had other facilities not mentioned above.

Figure 8. Percentage of TCCs providing essential services



The respondents mentioned that there are various issues that affect operations in the TCCs. These include adherence to the TCC Blueprint, unclear roles and responsibilities, management of the TCC, unavailability of 24/7 services and lack of a safe and secure environment for clients.

Even though most services are delivered as prescribed in the TCC Blueprint, different stakeholders and TCCs seem to have a different understanding of what adherence means. However, although the site coordinators are well informed about adherence, they expressed concern about the understanding of service delivery by other stakeholders.

'So, we don't have all the services that we are supposed to have according to the Blueprint and again our structure is not structured according to the Blueprint'
~ NPA key informant

'The main issue if you want to be 100% compliant; we need to have our own nurses and our own forensic nurses so that when we start with the 24-hour service at least we would have at least one nurse at night and one nurse during the day'
~ NPA key informant

1.5. Factors influencing quality of services delivered

As per the discussion in Section 1.4, most TCC facilities provide most of the necessary services according to the TCC Blueprint. However, although the services are available, it is the quality of those services that is the challenge. The team found variation in different TCCs' victim-friendliness, and issues with secondary victimisation and scope of responsibilities. There were also problems with delays in service delivery, problems with follow-up, issues with transport, a lack of supplies and equipment, and a drain on personal resources. These factors and challenges are discussed below.

Human resources

Appointments

For many years the TCCs have been under-resourced, but over the past year the human resource situation in the TCCs improved dramatically. Only five percent of the TCCs had no site coordinator, 29.6% had no VAO and 53.7% had no case manager.

Table 5. Number of NPA staff at TCCs

NPA staff	Number of TCCs			
	Yes		No	
Site coordinator	51	94.44%	3	5.56%
Victim assistance officer	38	70.37%	16	29.63%
Case manager	25	46.30%	29	53.70%

Some TCCs reported a high staff turnover and a problem filling positions due to geographical location. This is the case in the more remote provinces and areas, such as the Northern Cape and selected sites in other provinces. It is difficult to appoint case managers and the generally slow government process in appointing people contributes to this challenge.

'When coming into human resource like you can see I am alone in this centre and I am doing like everything so human resource is still needed within the centre' ~ *NPA key informant*

'Ja, we don't have a case manager. That's a big, big, big, big, big need. That one you must write in capital letters. No, because what now happens is we've tried to get feedback from the court' ~ *NPA key informant*

Another challenge that the participants were faced with was having to deal with situations or fulfilling roles that were not within their scope of responsibility. The participants dealt with these situations or fulfilled these roles because there were no other staff available.

'After hours, it is only the counsellors. We have to run around doing other people's jobs. Trying to close those gaps, you know?' ~ *NGO key informant*

'Then you are left alone. When you are left alone, you are busy with the doctor, you have to help the police fill in the, all those books of the police and the forms that they giving the doctor consent to examine the client.' ~ *NPA key informant*

Debriefing

Many key informants said that lack of emotional and debriefing support meant that there is little support for the NPA staff within the TCCs. Staff need to be debriefed more regularly and in a more structured way. Many key informants, after the interviews, mentioned that the process felt like a debriefing for them.

'It is very easy to burn out in this environment' ~ *NGO key informant*

'For me, I think even if it's not weekly there should be monthly, you know, specifically for someone to talk to someone because the type of cases that we are working with here they can be very strenuous too so it's not easy on everyone not just staff but even worse, for the medical staff because they are exposed not only to the emotional but also to the physical' ~ *NPA key informant*

'So, I think it is important that we have regular, at least monthly, debriefing and not...monthly because you can say it's optional. You must know that this Friday, the last week of the month, everyone is getting debriefed or individuals are getting debriefing where they talk about the cases, where they talk about their own personal frustrations that are affecting their work.' ~ *NPA key informant*

Competency and training needs

The participants were asked to explain the competency of the staff who work at the TCCs. It was clear that additional training is required despite any previous training that the staff may have received on GBV and management of victims of sexual assault.

> 'Okay, I believe the training that we just got from FPD on GBV, it made a lot of difference because things are clearer now. More regular training like that will really help.' ~ *NPA key informant*

NPA staff members also highlighted other training needs such as operational and project management, auxiliary staff sensitivity training, training on updated procedures and protocols, dealing with child-victims appropriately, and training on the Sexual Offences Act and related legislation.

> 'Like myself and our Victim Assistant Officer, we haven't had training specifically, on the Children's Act and we do also see abused children here' ~ *NPA key informant*

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

> 'Yes, yes and sometimes think that it will be beneficial for me if I will would be able to do the HIV tests' ~ *NPA key informant*

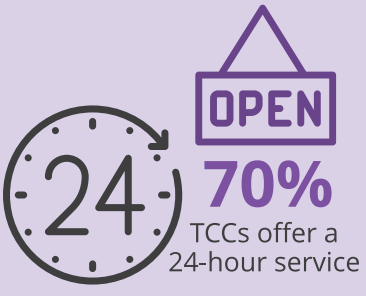
Accessibility

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

24/7 service

The majority of the TCCs indicated that they need to have a 24-hour service that can cater to clients who present at the TCC after working hours and on weekends. This is a problem because there is are high numbers of clients after working hours and over weekends. Some of the TCCs operate with the hospital causality unit after hours. But some said they needed to be able to function on their own after hours and requested for more resources to do this. Not being able to open after hours means that services available to clients are compromised. Even the TCCs that do operate after working hours often require strong support from the hospital staff and NGOs in order to provide efficient services to clients.

Seventy percent of TCCs offer a 24-hour service to their clients. Sixty-one percent are open 7 days a week and are open 24 hours. Sixteen percent are only open from Monday to Friday and during working hours.



'GBV does not keep office hours' ~ *NGO key informant*

'If we have the NGO especially, maybe they will work maybe 24/7' ~ *NPA key informant*

'And the bulk of our patients come at night and after hours, so, even with my little assistance, there was nothing I could do after hours and on weekends' ~ *NPA key informant*

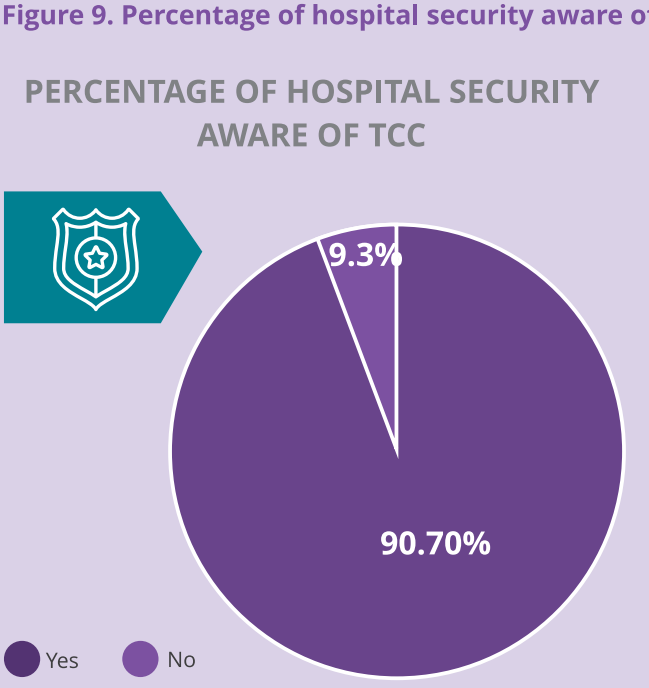
'Services are available after hours, but they are not on site here at the TCC. We would really appreciate it if the services would be on site here at the Thutuzela Care Centre. Even if there are doctors, they must come down to Thutuzela Care Centre, where they must do examination' ~ *NPA key informant*

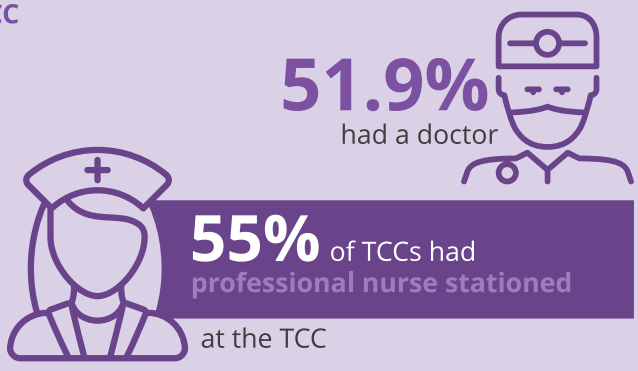
'No, but the services are being provided 24 hours but the TCC is not open 24 hours. We knock off at half past 4' ~ *NPA key informant*

Security's awareness of TCCs

Most victims are referred and transported to the TCCs after presenting to the SAPS. However, as some victims present directly at the TCCs it is important that hospital security is aware of the existence and location of the TCCs. More than 90% of the security guards who were stationed at the hospitals knew where the TCCs were. This is a significant improvement from previous studies and also helps with referring victims to the correct services after hours where necessary.

Figure 9. Percentage of hospital security aware of TCC

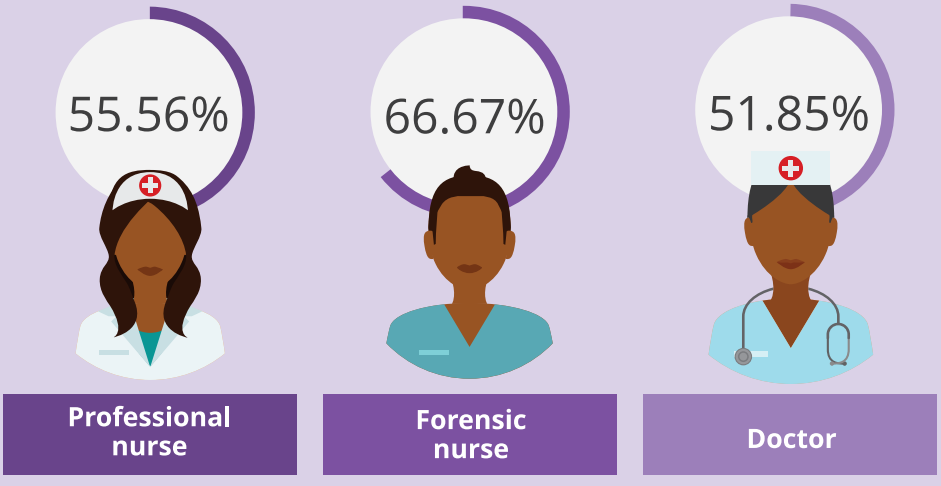




Health services

Many TCCs mentioned a shortage of allocated health staff such as doctors and forensic nurses stationed at the facility. Only fifty-five percent of the TCCs had a professional nurse stationed at the facility. Sixty-six percent had a forensic nurse and 51.9% had a doctor .

Department of Health staff at TCCs



The health staff allocated to the facility are often only available during normal office hours, or are shared with casualty. After hours and over weekends victims who present at the TCCs need to be examined at casualty, or wait for the doctor/forensic nurse on duty at casualty to attend to them. Sharing a doctor with casualty is not ideal, because the doctor might be busy with life-threatening cases, leading to long waiting times at the TCC. This can lead to secondary victimisation. Often the forensic and medical procedures are conducted after hours, and the victims needs to return to the hospital the next morning for additional blood tests and services.

'We often see that the client will walk out, because she's waiting too long for the medical examination. If the medical examination is not happening at the right time, the case can be prejudiced because you don't have strong enough evidence at court' ~ *NGO key informant*

'After hours there is a doctor, but procedures and taking of blood and things like that, they have to come the next day to the TCC' ~ *NPA key informant*

There's a concern that the EMS personnel and casualty personnel are not adequately sensitised to work with victims of GBV. Access to medical care can be improved with better training of the EMS personnel. More than one participant mentioned to the interviewers that there were some doctors who did not want to prioritise the TCC patients or who treated the clients with little sympathy/empathy and appeared irritable.

Participants felt that doctors and nurses do not prioritise rape victims. The participants mentioned that their rationale is that a patient who is dying is more important than someone whose injuries are not life-threatening. Some site coordinators did understand this and agreed with this reasoning, but it remains an obstacle to care.

'If you have a victim and maybe there are other cases that they are dealing with in casualty, the rape case is not an emergency to them then it will be the last thing so you can just imagine if you are sitting with the victim and it's at night'. ~ *NPA key informant*

'They say a gunshot is more important than a person that has been raped so if our victims had to be examined there we would have a problem.' ~ *NPA key informant*

An important component of the TCC service is ensuring that PEP is supplied within 72 hours of the sexual assault. This is not always the case, sometimes because the victim comes to the TCC too late and sometimes because doctors and forensic nurses take a long time to see the TCC clients because they are busy in ER.

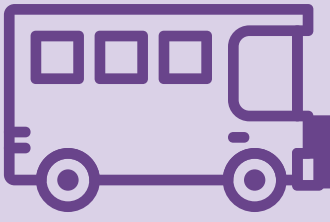
'Sometimes we only have three hours left to provide PEP in the 72 hours, but the doctor is still busy with a woman who is in labour, then the 72 hours lapses'.
~ *NGO key informant*

Adherence to PEP is a major concern. PEP is usually only provided for a week as part of a starter pack, and the client needs to return to the hospital to collect the rest. Many clients don't have funds for transport to return for PEP and additional medical services.

Other challenges include contacting and assessing victims.

'A lot of people default on their medication because they don't have the money to come back, or to get on a bus' ~ *NPA key informant*

'How sure are we that all the victims that go there they get the PEP. Some get a six-day starter pack and don't come back to get the whole starter pack. Others they end up giving them the whole starter pack without being tested' ~ *NPA key informant*



MAJORITY OF CLIENTS
don't have funds for **TRANSPORT**

'The problem sometimes is the transport money for the people. That's also why sometimes they default with their medication. If you really go into the matter you will find out its transport. Even Red Cross sometimes assists us with that if we really have a problem. They will go and fetch the person and bring them here and take them home.' ~ *NPA key informant*

'Because you cannot track them to ensure they use they medication" ~ *NPA key informant*

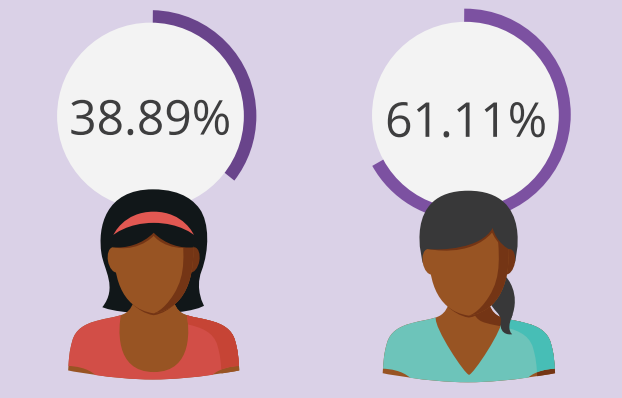
Some key informants highlighted the problems of HIV testing, and other blood tests, when children are involved. They explained that they need parental consent, and this is sometimes not possible.

Psychosocial support

Many TCCs mentioned a shortage of essential staff such as social workers and forensic social workers to assist with short- and long-term psychosocial support as well as court preparation. Sixty-one percent of the TCCs had a social worker and none had a forensic social worker. It was not possible to confirm whether the social workers are employed by DSD or by the NGOs working within the TCCs.

Number of psychosocial staff at TCCs

Number of NGO staff at TCCs



Sixty-one percent of the TCCs had trauma counsellor and 33.9% had HCT counsellors. These staff members are employed by the NGOs who are working within the TCCs.

Immediate psychosocial support and trauma containment is generally provided by the VAO during the day and by NGO counsellors after hours. Funding for counselling, especially funding provided by DSD for the NGOs, is related to a specific number of clients served per month. This prevents access to counselling in months when there's a higher caseloads at TCCs. Not all TCCs have an NGO linked to them and this reduces immediate trauma containment and short term psychosocial support for the victims.

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

'Because some of them they don't have contact details like a cell phone. The only thing that they tell you is I'm staying at the farm, so and so.' ~ *NPA key informant*

'The second thing, they do not receive counselling because we can't get hold of them. A lot move after the incident.' ~ *NPA key informant*

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

'Another issue ... the survivors ... the follow-up. It's the transport money because if the survivor, let me say it's a child, she should come with a gran or somebody other to accompany, how much they would pay, sometimes they must take two taxis, you know, that is our many, many challenges.'
~ NPA key informant

'So when they come for the first time, it's easy because the police transport them, but now for the second time no one can transport them, so that's why our follow up is very, very poor.'
~ NPA key informant

There are also concerns about the ethics of care and the type of follow up care that is provided.

'We need to ask ... does the TCC have an effect ... is this contributing to social cohesion?'
~ NGO key informant

Language barriers in providing psychosocial support must also be considered, as very often the psychologists available do not speak the mother tongue of the victims. This is an even greater concern in the case of child victims.

Equipment and supplies

The table below shows the essential equipment that should be present at the TCCs. All the TCCs had a computer. However, only 75.9% had access to the internet. The majority of TCCs had telephones (88.9%). In terms of medical equipment, only 37.0% of the TCCs had a gynae couch or lithotomy table. Eighty-one percent of the TCCs had speculums, 61.1% had colposcopes and 77.8% had sufficient lighting for examination purposes.

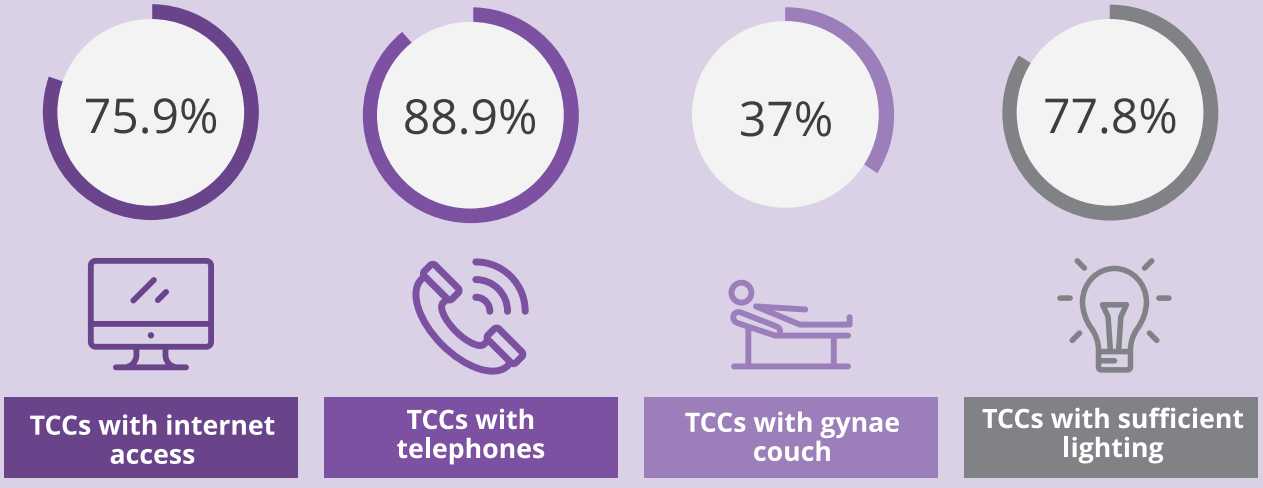


Table 6. Essential equipment available at TCCs

Equipment	Number and percentage TCCs with none available		Number and percentage of TCCs with equipment available	
	Number	Percentage	Number	Percentage
Computer(s)	0	0%	54	100%
Telephone(s)	6	11.1%	48	88.9%
Access to internet	13	24.1%	41	75.9%
Sufficient lighting	12	22.2%	42	77.8%
Speculums	10	18.5%	44	81.5%
Colposcopes	21	38.9%	33	61.1%
Gynae couch/lithotomy table	34	63.0%	20	37.0%

However, those TCCs that have access to a telephone, can usually only receive calls and not make them. In some instances the hospitals allow one person, mostly the site coordinator, to have a code to make outside calls, but this is rare. NGO staff generally are not allowed to make use of the hospital phones, and they use their own cell phones, usually with air time provided by the relevant NGO.

> 'We use our own cell phones, we don't use these x7 speed dials that is' ~ *NPA key informant*

As discussed earlier, there is often insufficient food, general groceries and comfort packs at the TCCs. They also need operational supplies such as paper, cartridges, stationary, cleaning materials etc. The NGOs are not allowed to use the TCC operational supplies, and have to bring their own. The NGO staff within the TCCs also don't have access to copiers and printers, making their work very difficult.

A lot of the participants think that their facility did not have the equipment or supplies necessary to deliver a high quality service to their clients. Some of the supplies mentioned were cleaning materials, stationary, clothes and food. Testing kits and beds for the victims to rest on before and after examination are also lacking, as is basic office equipment, like chairs and tables.

'Our equipment we don't have desk we use chairs, benches for the victim to sit we don't have our environment is not conducive at all because you find that the doors, the walls are dirty, the floors are not clean. Another thing the desks we share the computer; we don't have a photocopy machine''
~ NPA key informant

'Sometimes the hospital tells us that they are out of bread, so in those cases we use our own money to buy bread for victims ... even when there's no tea, juice, milk and sugar ... the forensic nurses give us their own money to buy and serve the victims'
~ NPA key informant

Clothing, specifically underwear for women, is also mentioned as a problem, as the underwear is usually taken as part of evidence. The NPA does provide underwear, but not necessarily in the correct size.

'And another challenge is, I just want to add on, the challenges is that we don't have panties for adult woman, we have got panties only for small children. So when one is raped, she has to leave now the panty for DNA then they go now without panties' *~ NPA key informant*

Transport

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

'You see, so there is that issue is when you victims needs to be transported back home it becomes a problem.' *~ NPA key informant*

'The concern is that the victims are cut off from transport and they miss their follow up counselling sessions due to that. My main concern is we can't reach the people that side' *~ NPA key informant*

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

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

1.6. Stakeholder challenges

Stakeholder cooperation and cohesion, at almost all levels of government, was mentioned by numerous key informants. The relationship between stakeholders have been described as 'turf wars', and 'a real battle'. It has been mentioned that other government departments have a sense of resentment because the NPA alone gets funding for this.

'No real cohesion and inter-sectoral collaboration' ~ *NGO key informant*

'Petty politics is huge' ~ *NGO key informant*

'There's a lot of turf wars, if you can call them that, between the departments, DSD, DoH, NPA as to who and where the TCCs need to sit' ~ *NPA key informant*

'It seems they are fighting over clients' ~ *NGO key informant*

'There's a lack of understanding of how the model is supposed to work, not all departments understand their roles and this is why there are turf wars between departments' ~ *NPA key informant*

'Government departments are providing services but they're doing it in silos, and now they miss out on opportunities to actually, not necessarily, to provide services for victims' ~ *NGO key informant*

The general finding is that the inter-sectoral relationship are functioning at national level, but from provincial, district and facility level it disintegrates. At the lower government levels is seems that there is not adequate commitment from the various departments to focus on the TCC model. One of the major challenges mentioned is that the NPA do not have an administrative provincial presence to work with, specifically with DoH and DSD at provincial level.

'The multi-disciplinary approach is brilliant and it has to happen, but if you have the NPA, DSD, NDoH, all trying to assert themselves it becomes very difficult to implement this'
~ *NGO key informant*

It must also be considered, that at district and facility level, the challenges between stakeholders are not between departments, but rather related to personalities and attitudes.

According to the respondents, there are stakeholders who do not understand or take their responsibilities as mandated. Misunderstandings about the roles of different stakeholders are leading to conflict and delay in the operations in the TCC particularly when one party does not take full responsibility.

The challenges mentioned with the individual stakeholders are discussed below.

NPA

There has been some concern about whether NPA head office is aware of the realities within TCCs and what is happening within facilities. Some NGOs mentioned strained relationships at all levels with the NPA.

> 'The NPA see themselves as the "boss of everything" in the TCC system' ~ *NGO key Informant*
>
> 'NPA is seen as the ones who owns the TCC, and other people are not seen as important in the system or equal contributors for the beneficiaries' ~ *NGO key informant*

Other challenges with the NPA include organisational conflict and a lack of support from the NPA national office. There is a clear need for a provincial administrative NPA presence. There is a sense that NPA TCC staff within sites don't get enough administrative support from head office.

> 'I mean, it is expected from me to do my job correctly. If I don't do it correctly, then I have to take the punch for whatever I did wrong, and I feel it has to be the same on a provincial level, at the provincial offices and at the head office' ~ *NPA key informant*
>
> 'The head office does not support us' ~ *NPA key informant*
>
> 'I don't get support with them, if we do have a challenge and we inform them, they do not support us at all.' ~ *NPA key informant*

DoH

There are generally a good relationships between the NPA and DoH at national and provincial level. There have been some concerns regarding the establishment of the Kgomotso Care Centres that deliver very much the same services as the TCCs, without the judicial component.

At facility level, the relationship between the TCC and the hospital is often dependent on hospital management's attitude and practice regarding the TCCs. Issues related to doctors and nurses in casualty were discussed earlier. The need is to ensure that facility DoH staff are adequately sensitised to the needs of victims of GBV, as well as the protocols to be followed and completing the correct forms. There are problems around healthcare workers who are unwilling to help staff of the TCCs, lack of priority for managing rape victims and lack of availability of essential staff.

During the interviews, it came out that doctors at many of the hospitals do not want to handle rape victims, as these patients tend to be too emotional, which prolongs the examination process. This is especially troublesome after hours, as there are not as many doctors and nurses available.

Hospitals find it difficult to release health staff to the TCCs because of conflicting demands on their time. However, TCCs are willing to negotiate with the management of other stakeholders to reach a solution.

DSD

It is reported that there is generally a good relationship between the NPA and DSD at national and provincial level. There been some concerns expressed regarding the establishment of the Khusuleka centres, but these do not deliver the same services as the TCCs.

However, key responders think that DSD does not provide enough social workers within the TCCs. There are also not enough forensic social workers to assist with court preparation or enough psychologists to assist with long-term psychosocial support.

> 'Social Development must do their part, because I think we are struggling with social workers, with lay counsellors, whereas Social Development is part of this, when the TCC were established. That, right now, they are not playing any part'.
> *~ NPA key informant*

> 'When we get a child victim we pray that it's not a child protection case. Getting DSD involved during the day is difficult, but it's a nightmare after hours. I know of cases where the client had to literally sleep at the TCC to wait for the social worker from DSD to arrive' *~ NGO key informant*
>
> 'Sometimes a child will be admitted to hospital because DSD does not respond, then they don't follow up and a child can stay in hospital a whole week, once it was two weeks'. *~ NGO key informant*
>
> 'DSD should be on board when most of your cases are minors, but they're not. On paper they're there, but they're not there' ~ *NGO key informant*

Within the TCC model DSD should fund psychosocial services, either by delivering it with their own staff, or funding NGOs to deliver the services. This is not happening to the extent that it's needed.

Another major concern is the availability of DSD to assist referred clients, and to remove child victims from their homes if needed. There have been numerous complaints that local level DSD is very slow in responding to the needs of child victims. It's been reported that children are either sleeping over at the TCC, or admitted to hospital, in cases where DSD have been slow in removing child victims from the household.

There have been a number of concerns about the reporting of indicators and the provision of statistics to DSD. The NGOs mentioned that they do not have access to the information required by DSD to maintain their funding, but they do not control the relevant statistics and documentation, as the paper work is kept by the hospital because of confidentiality. As a result, DSD often threatens to discontinue the funding to NGOs within the TCCs. One key informant mentioned that because of the conflict between DSD and DoH, the NGOs are suffering.

'You know what people say, if elephants fight, only ants get killed' ~ *NGO key informant*

SAPS

Most key informants reported excellent relationships with, and good support from, SAPS. Only one key informant mentioned that the relationship between SAPS and the TCC was not good, but she also put in a disclaimer that she is researcher, and not a practitioner. Their specialised FCS units are functioning well and are contributing to the functioning of the TCC model. Only 27.78% of the TCCs had a dedicated SAPS officer stationed at the TCC.

At facility level, there have been additional issues, but these are site specific, and not related to the general support received from SAPS. When speaking about the police, key informants at facility level mentioned that there were issues relating to a lack of support in legal matters, a lack of transport support, poor service protocol, secondary victimisation and a delayed response to emergencies. With regards to the lack of support in legal matters, participants mentioned that the police do not provide feedback to the victims on the progress of their cases, which makes the situation for the victim even more complicated.

'Sometimes they come with the challenges of transport'. ~ *NPA key informant*

'A protection order now needs to be served then they say no there is no car.' ~ *NPA key informant*

NGOs

One of the main challenges experienced by the NGOs in the TCC model is that they are not seen as equal partners in the TCC model and that there are skewed power relationships. The model appears not to be providing adequate support to the NGOs.

'NGO occupy a low status in the TCC model' ~ *Key informant civil society*

NGOs also expressed concern regarding the management of relationships between NPA staff, DoH staff, DSD staff and SAPS if there is more than one NGO associated with a TCC. There are sometimes strained relationships between DoH staff and NGO staff. Numerous key informants have reported that nurses tend to use the counsellors in the NGOs to do some of their work. Sometimes this is subtle, sometimes it is overt and the NGOs feel threatened if they do not respond to the requests of the DoH personnel at facility level. In some cases they are even asked to do nursing work, such as weighing clients and taking blood pressure, which they are not trained to do. They are also asked to complete documentation on behalf of the nurses.

'Counsellors would say that if we don't do it, that nurse would give us attitude' ~ *NGO key informant*

TCC staff highlighted problems experienced with the NGOs as well, such as organisational conflict, dual roles, a lack of prioritising of victims and unwillingness to help the TCCs. The issues relating to organisational conflict seem to relate mainly to finances and people overstepping their boundaries. TCC staff feel that NGOs intrude on their own responsibilities. There are clear challenges and pressure related to the fact that NGO staff receive a significantly lower salary than NPA staff, and serious concerns about the low salaries that the NGO staff receive, which should be addressed.

'Sometimes they feel like they do the same job as me because we are in the same office and what, what. And then they are thinking that maybe you are getting a salary and they're not. You know, forgetting how you got there, where you had to study to get there and you applied for the job and everything and that but then it's not even a problem but then I think finances sometimes they tend to, you know, I'm doing a job like hers but she's getting money and I'm not getting money and it's something that they always complain about because they are NGO' ~ *NPA key informant*

There are some concerns about defining the exact roles of the NGO staff versus the NPA staff as well as DoH staff. There is a concern that NGO staff tend to overstep their boundaries and take on tasks they should not be involved in.

'The challenge that I have with them is the fact that sometimes they do things that they are not supposed to do like interpreting the medical results' ~ *NPA key informant*

'I think they didn't know that they are here to offer counselling as a service. They ended up wanting to be like, the bosses of the centre' ~ *NPA key informant*

However, other NGO staff and NPA staff reported that the relationship between the NGOs and the TCCs are functioning well.

'We try and work as a team, we take each other's hand, because we have to work as a team to be successful' ~ *NGO key informant*

'We have our own challenges but in terms of working spirit, we are working very, very well.' ~ *NGO key informant*

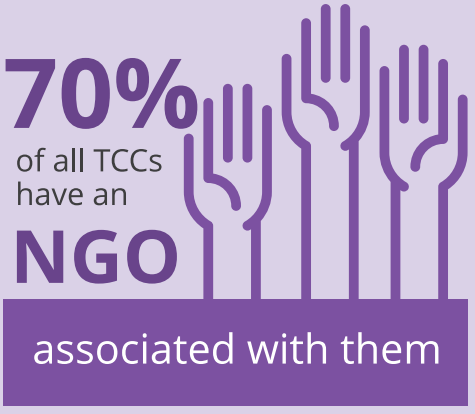
It is important to realise that the TCC staff and the NGO staff also work well together, and support and debrief each other.

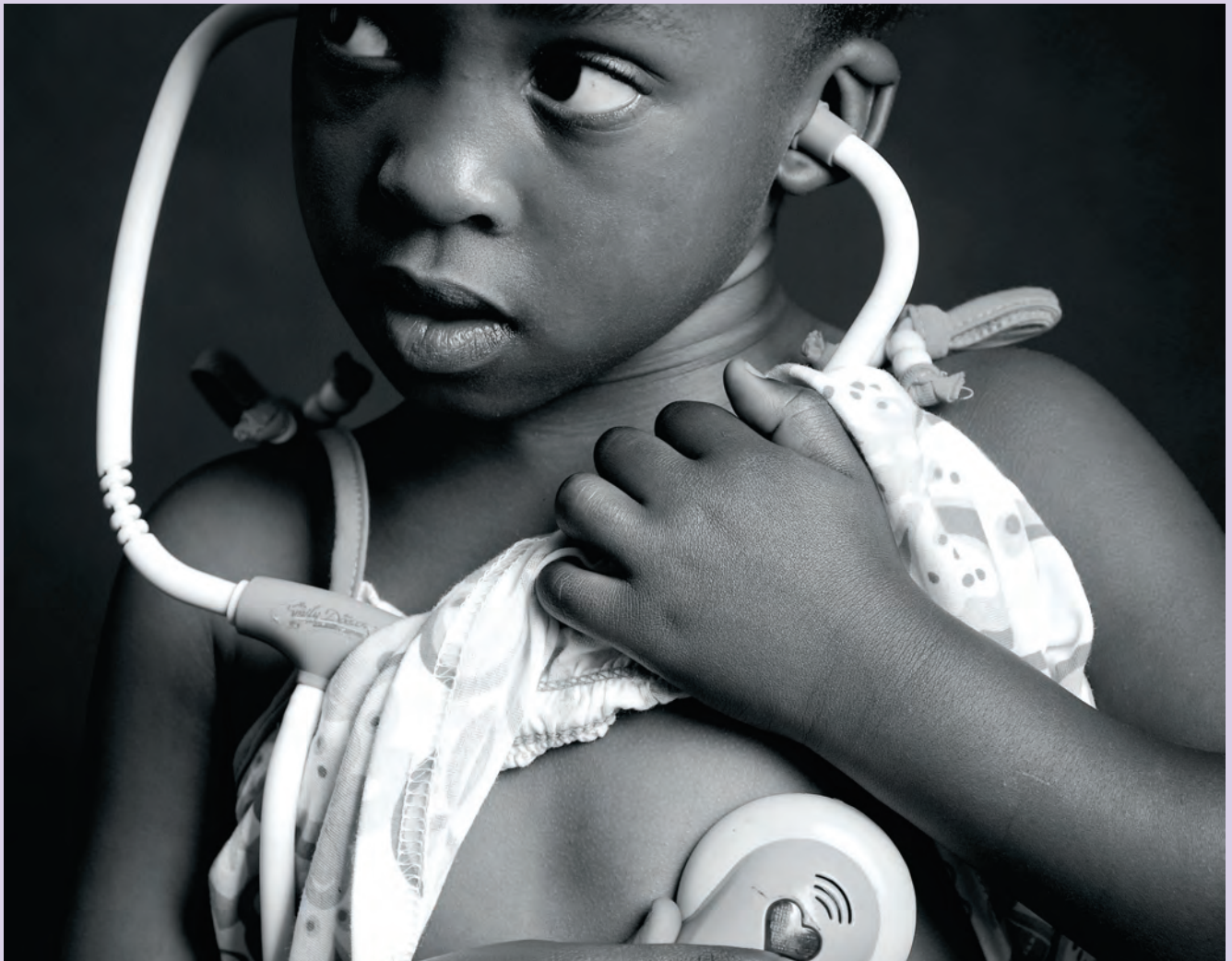
'If one of us maybe has a bereavement or any kind of work that you have at home, the team goes to your place to give support.' ~ *NPA key informant*

'Yes, we have braais, we have secret pals making sure that we keep that team spirit going on' ~ *NGO key informant*

1.7. NGOs as service providers

It is important to understand the full contribution of NGOs within the TCC model. The participants were asked to explain the value of their organisation at the TCCs. We found that the NGOs offered a variety of services for the victims of sexual assault and differed in their functioning within the TCCs. The participants also discussed how their absence would affect the TCCs. Just over 70% of all TCCs have an NGO associated with them.



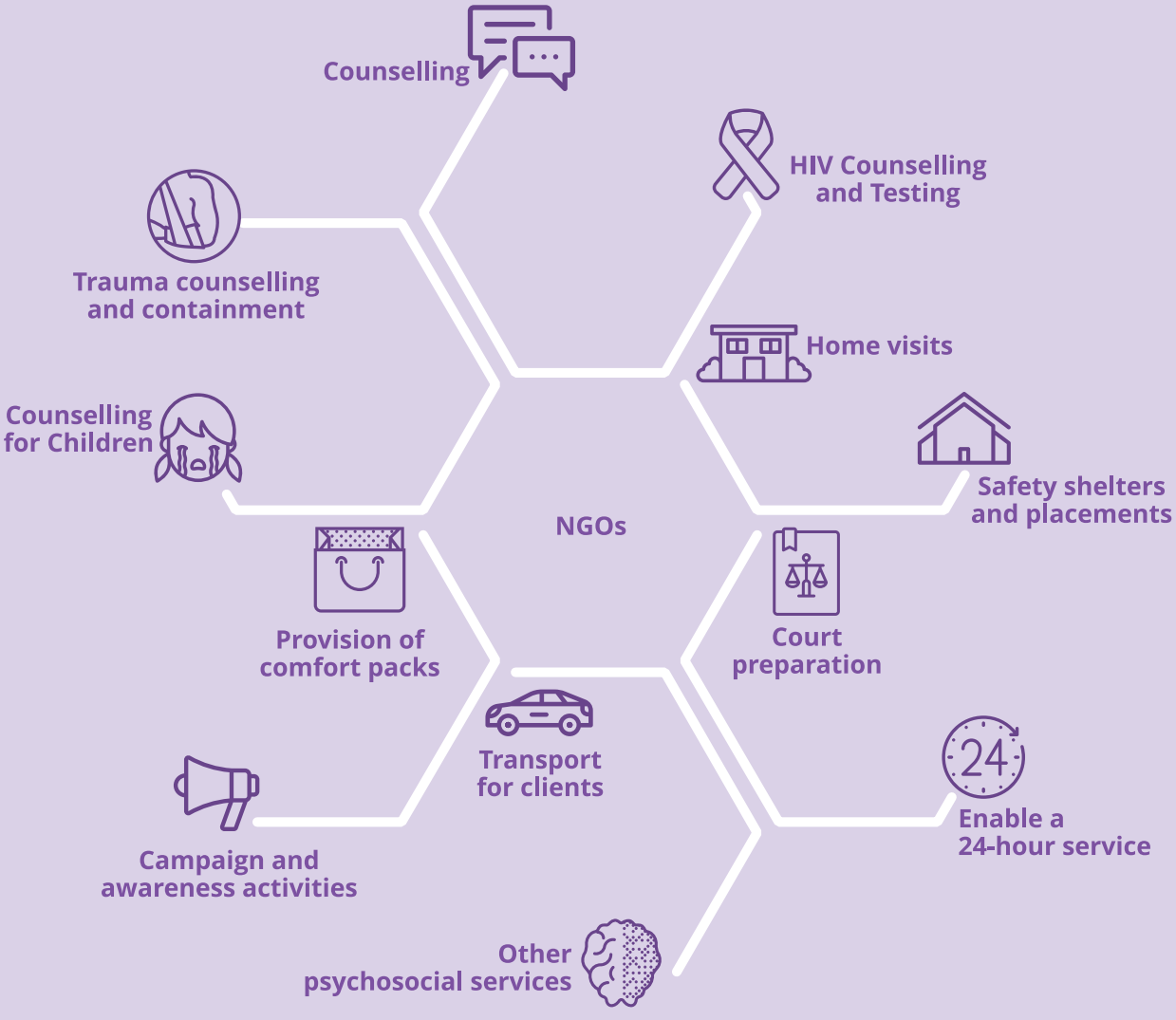


The following is a list of the NGOs providing services in TCCs:

Figure 10. NGOs providing services in TCCs

NGOs assist with providing services and the smooth running of the TCC. There were many reported benefits to having an NGO associated with the TCC, including providing continuous support to clients, rallying communities together for campaigning activities, bringing awareness and support for the TCCs, keeping the TCCs open 24 hours a day and on weekends, and providing supplies and resources. The 24-hour service seemed to be most important, particularly because most cases of sexual assault occur at night or over weekends and holidays.

Figure 11. Services provided by NGOs



'Ja, after hours and on weekends, they remain and they do according to the TCC protocol. They just call the doctor and the doctor will come. They call the police. So, if they were not present you will see our TCC will not be open 24 hours. So they are of very big value' ~ *NPA key informant*

'We, for one thing, we wouldn't be able to be 24 hours open if they're not here because they are actually the ones who make it possible that it's open 24 hours' ~ *NPA key informant*

'We have to acknowledge the crucial role that the NGO is playing ... they're not just also there, they have really important role' ~ *NGO key informant*

One of the most important services is trauma containment. Other services offered at the TCCs were HIV counselling and testing (HCT), psychosocial support, education, the provision of supplies and referral services. HCT and education were related topics that were discussed with the NGOs. HIV counsellors not only tested the clients for HIV, but also educated them about HIV-related issues and how to use their medication. The NGOs offer a variety of 'psychosocial support to the victims' as described by them in various terms such as '*therapy*', '*long-term counselling*', '*emotional containment*' and '*trauma containment*'.

'Our main focus is to do counselling to the clients and just to prepare them, what they are going to get and why, because when they get to that part, they know how to take it and how to adhere on the treatment.' ~ NGO key informant

'At the moment there is no HIV counsellors, it's the nurses at casualties that is doing that. It gets done with the triage, we feel the patients do not get quality service there. We are going to make the HIV counselling part of our service.' ~ NGO key informant

NGOs make a useful contribution to the supply of food and drinks, toiletries and clothing for the clients who go to the TCCs for help.

'It brings the comfort packs .... with underwears and toiletries including clothes. [NGO] brings them, they get recorded and kept by the TCC staff.'~ *NPA key informant*

'We give them food, especially children.' ~ *NGO key informant*

Some of the NGOs also refer victims for other social services.

'Assess if there is need for social intervention or not' ~ *NGO key informant*

'We do referrals and also we talk to them on a daily basis' ~ *NGO key informant*

NGOs also bridge the gap between the TCCs and the surrounding communities. Most participants viewed this role as useful for clients from the surrounding communities.

1.8. Changes in the funding environment

At the start of this compliance audit and gap analysis it was announced that NACOSA, under the Global Fund funding agreement, will only continue to fund 14 (and later 17) of the 41 NGOs they funded within the TCC model. This possible change in the funding environment demanded that the study also assess the influence of changes in the funding environment. In the meantime, NACOSA announced that it will continue to fund the current NGOs within the TCCs. However, it is important to understand how changes in the funding environment will affect service delivery within the TCCs.

After the announcement that funding will be stopped, some NGO downscaled the services they deliver, for example retrenching staff, with loss of expertise. When funding becomes available again, these NGOs will have to recruit and retrain new staff members.

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

- There will be a lack of counselling services to victims, both short and long term.
- Without adequate counselling services, fewer cases will go to court.
- It is unlikely that any TCC will be able to deliver after-hours services if the NGOs are not available to do so.

'From my point of view I would say it is the fact that we at [name of NGO] keep the centre open 24/7. We work weekends and holidays. If we are not here the centre will not be open 24/7. It will be very bad as most things happens over a weekend.'
~ NGO key informant

'If the counsellors were not here, I think it wouldn't work because we work with the emotions of the victim, it plays a big role here.' *~ NPA key informant*

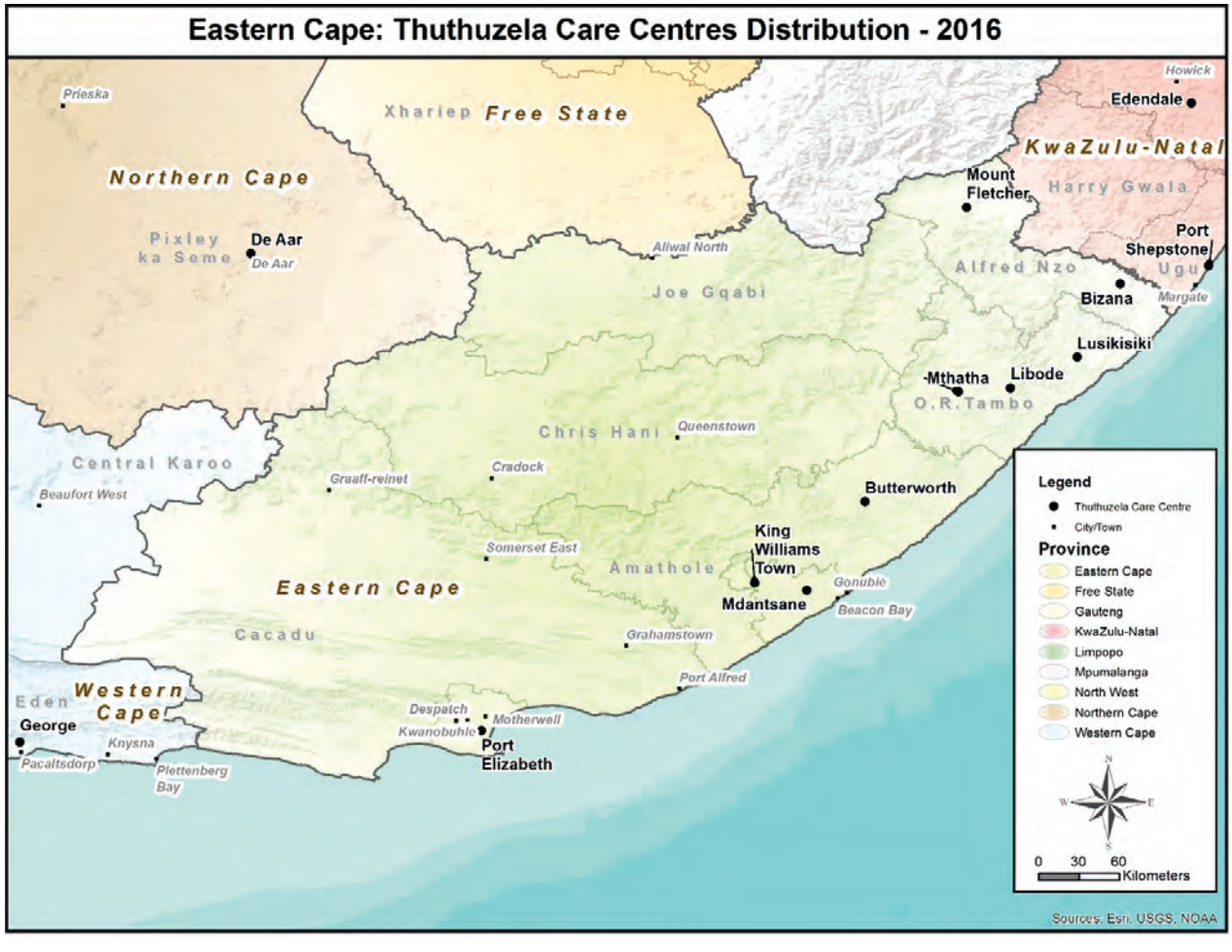
There is a need for a sustainable, consistent and stable funding environment to ensure that the necessary services can be delivered at all TCCs. The current uncertain funding environment is damaging and does not lead to trust between TCCs and victims.

'We can't have "here today, gone tomorrow" services' *~ NGO key informant*

2. TCCs in the Eastern Cape

Eastern Cape

Port Elizabeth	Dora Nginza TCC, Dora Nginza Hospital
Bizana	Bizana TCC, St Patricks Hospital
King Williams Town	Grey Hospital TCC, Grey Hospital
East London	Mdantsane TCC, Makiwane Hospital
Butterworth	Butterworth TCC, Butterworth Hospital
Libode	Libode TCC, St Barnabas Hospital
Mthatha	Mthatha TCC, Mthata General Hospital
Lusikisiki	Lusikisiki TCC, St Elizabeth Hospital
Matatiele	Taylor Bequest TCC, Taylor Bequest Hospital



FPD interviewed two regional managers in the Eastern Cape. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

2.1. Governance and operational challenges

The governance structure in which the case manager reports to the regional manager and the VAO and site coordinator report to head office, creates a problem. Staff are exploiting this, which undermines the functionality of the TCCs. More provincial oversight is needed to ensure the proper functioning of the TCCs in the province.

> 'Very often you will hear that a site coordinator is on leave and you are not aware, I will only hear that there's nobody at the TCC when I'm called and when a client comes to the TCC and then the TCC is closed' ~ *NPA key informant*

There is also a concern about communication and governance between stakeholders since the IDMT was replaced.

2.2. Facilities and sites

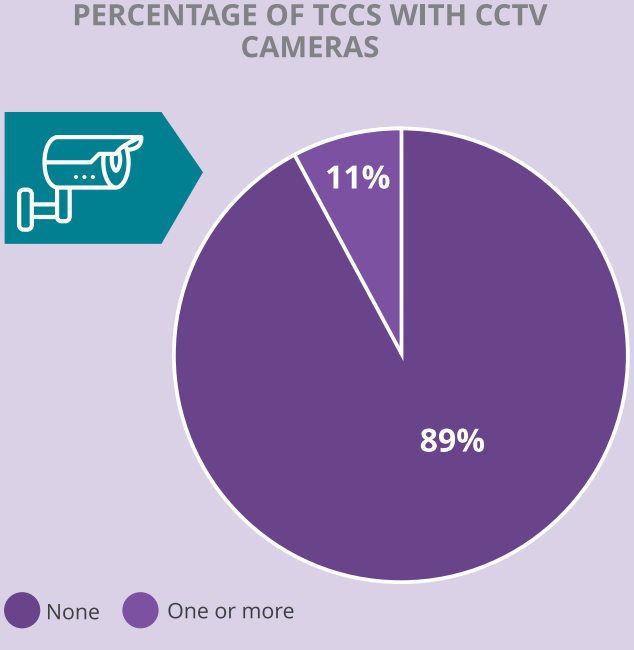
The majority (56%) of TCCs in the Eastern Cape are located inside a hospital. The TCCs based in park homes need urgent maintenance as some is falling apart. Currently, there is no sustainable plan to repair and replace park homes when they start to fall into disrepair.

Location of Eastern Cape TCCs

Some TCCs are very small with inadequate office space and consulting rooms. This is specifically highlighted for Bizana TCC.

With regards to security, most (89%) TCCs in the Eastern Cape do not have CCTV cameras.

Figure 12. CCTV Cameras in Eastern Cape TCCs

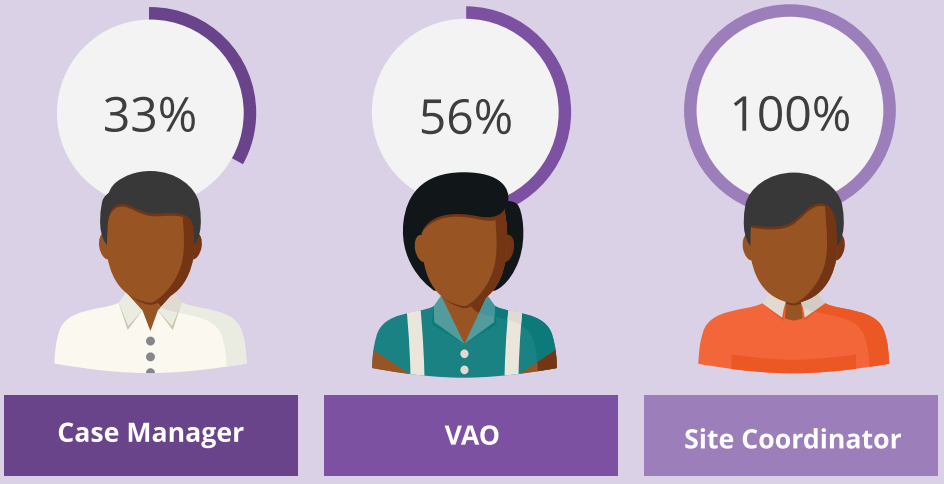


2.3. Factors influencing quality of services delivered

Human resources

All of the TCCs in the Eastern Cape had a site coordinator. A total of 56% had a VAO and 33% had a case manager. The slow government processes for the appointment of staff is given as a reason for this.

Percentage of TCCs with NPA staff



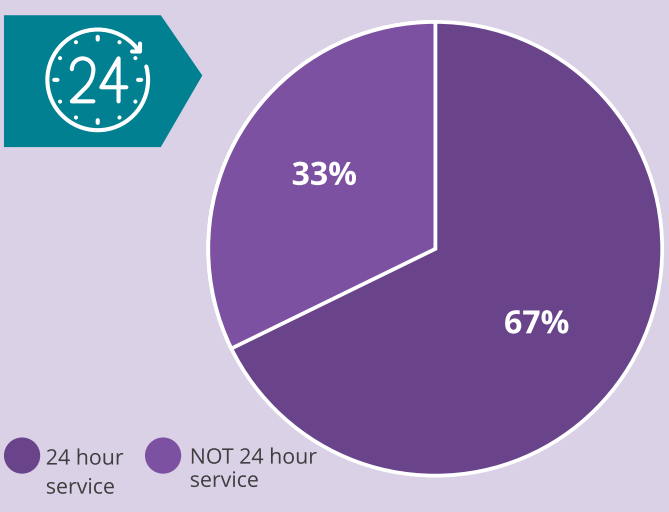
Staff members experience very high stress levels and are not debriefed often enough. Mdantsane TCC, in particular, has a high case load, limiting the ability of the staff to deliver services as required.

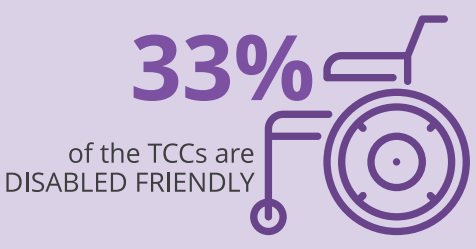
Accessibility

The majority (67%) of TCCs in the Eastern Cape provide a 24-hour service, as a result of NGO involvement.

Figure 13. Hours of service of Eastern Cape TCCs

PERCENTAGE OF TCCS PROVIDING A 24 HOUR SERVICE





Most TCCs had good privacy available. Only 33% had both a separate entrance and a separate examination room for suspects. None of the TCCs were completely child friendly. Most did not have toys for children. Only 33% of the TCCs were disabled friendly, with both wheelchair access and a disabled-friendly ablution facility.

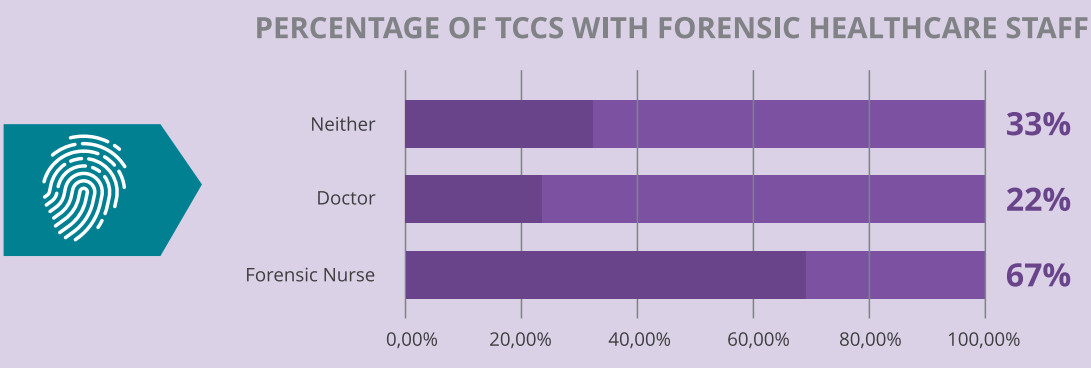
Victim-friendliness of Eastern Cape TCCs

Health services

A total of 67% of TCCs have at least one forensic nurse and 22% have a doctor. 33% of TCCs in the Eastern Cape have neither. In those cases, a doctor is allocated to the emergency section of the hospital. Casualty cases take priority over TCC victims and there are often long delays before doctors come from casualty to assist with the TCC victims.

'Sometimes we have to call the doctors about five times, they will say, oh, it's you again, and still not come to the centre' ~ *NPA key informant*

Figure 14. Forensic healthcare staff at Eastern Cape TCCs



Psychosocial support

The key informants expressed serious concerns regarding the psychosocial support that victims receive. There are not enough social workers and psychologists allocated to the TCCs to provide psychosocial support. At Dorah Nginza TCC they receive additional psychosocial support from the Department of Psychology at Nelson Mandela Metropolitan University. At some TCCs victims can wait up to 3 months to get an appointment with a social worker.

Psychosocial support is provided mainly by the NGOs within TCCs, and where the TCCs don't have and NGO allocated to them, counselling is provided by the nurses, site coordinator and VAO.

2.4. Equipment and supplies

The key informants mentioned that the TCC sites struggle with basic office stationary such as paper and toner for printers. There are serious delays in orders being delivered from head office and getting basic groceries, like tea and sugar, is a constant struggle. Comfort packs were sponsored, but many TCCs no longer have access to these. They also highlighted that ICT resources are inadequate. Some TCCs don't have access to a fax or scanner, internet and not all TCCs have external phone lines. The TCCs in the Eastern Cape don't have enough equipment and supplies to deliver a good quality service.

'We need to send emails through a DoH staff member' ~ *NPA key informant*

2.5. Stakeholder challenges

The key informants highlighted the territorial challenges experienced because of the multi-disciplinary approach the TCCs model is based on. In general, it seems that the relationships function, but need constant work. There are also concerns regarding the lack of consequences if other stakeholders don't contribute according to the guidelines of the TCC Blueprint.

'TCCs are seen as a NPA structure, and not a government structure, and that sort of undermines, you know, the proper functioning of the TCC and the accountability'. *~ NPA key informant*

'There [are] no consequences if the other stakeholders are not doing what the need to do, there's no consequences for the doctors, the nurses, the NGO, because we don't have the necessary authority' *~ NPA key informant*

DoH

It is reported that the relationship between DoH in the Eastern Cape and the TCCs are generally good, but there are concerns about the fact that TCC staff cannot keep DoH staff within the hospitals accountable for non-delivery of work. Specific comments are that not all doctors are adequately trained in completion of the J88 form and that doctors are reluctant to testify in court if the case is being prosecuted.

A major concern is relationships with and the attitudes of the CEOs in the various hospitals. Some regard the TCCs as a burden on the health system and not all understand how the model functions. There's also a concern about the high turn-over of CEOs in the hospitals. This means that the TCC model needs to be re-introduced and relationships rebuilt.

DSD

There are concerns about the relationships with DSD and their commitment to the TCC model. At provincial level, the relationship and commitment is on track, but there are problems at facility level. Many DSD partners don't attend the monthly implementation meetings and there are requests that the NPA provide office equipment (desks, computers, telephone lines) for social workers based within the TCC sites.

'At provincial level the relationships are cordial, I would say, but is a problematic department. It is nice and good to talk at provincial level, but when it comes to local level it becomes a problem' *~ NPA key informant*

SAPS

In general the relationship with SAPS is very good at facility level. In some cases the victim statements are still taken at the police station and not at the TCC, depending on the management in police stations.

NGOs

The majority (67%) of the TCCs in the Eastern Cape have an NGO working in the TCC.

Services provided by NGOs in Eastern Cape

- Trauma Counselling & containment
- HCT
- Comfort packs
- Campaign activities

The NGOs deliver an important service to the TCCs, but there are sometimes strained relationships between the NGOs and the NPA staff. In cases where there is no NGO linked to the TCC there is an arrangement that the security guard on duty will call the doctor if a victim presents after hours.

> 'This kills the whole purpose of the TCC, as this is supposed to be a victim-friendly centre'
> *~ NPA key informant*

NGOs do not always understand the TCC model and their role, so need training.

Table 7 highlights the TCC site-specific findings.

Table 7. Summary of Eastern Cape TCC findings

	Dora Nzinga TCC	Bizana TCC	Grey Hospital TCC	Mdantsane TCC	Butterworth TCC	Libode TCC	Mthatha TCC	Lusikisiki TCC	Taylor Bequest TCC
TCC location	Inside hospital	Inside hospital	Park home	Inside hospital	Park home	Inside hospital	Inside hospital	Park home	Park home
Security guard/s assigned to TCC	✗	✗	✗	✗	✗	✗	✗	✗	✗
CCTV camera/s	✗	✗	✓	✗	✗	✗	✗	✗	✗
Secured entrances	✓	✗	✓	✗	✓	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✗	✗	✓	✗	✓	✗	✓	✓	✓
Sign outside TCC with name	✓	✗	✓	✓	✓	✗	✓	✓	✓
24 hour service	✓	✗	✓	✓	✗	✓	✗	✓	✓
TCC linked to Sexual Offences Court	✓	✗	✓	✓	✓	✓	✓	✓	✗
Waiting time	2 hrs	45 min	10 min	1 hr	10 min	3 hrs	2 hrs	2 hrs	3hrs
Essential services offered	✓	✗	✗	✓	✗	✗	✓	✓	✗
Essential facilities available*	✗	✗	✗	✗	✗	✗	✗	✗	✗
Essential equipment available*	✗	✗	✗	✗	✓	✓	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓	✓	✓	✓	✓
Victim assistance officer	✗	✓	✓	✓	✗	✓	✗	✗	✓
Case manager	✓	✗	✗	✓	✓	✗	✓	✗	✗
Forensic nurse	✓	✗	✓	✓	✓	✓	✓	✗	✗
Doctor	✓	✗	✗	✗	✗	✗	✓	✗	✗
Social worker	✓	✗	✗	✗	✗	✗	✓	✓	✗
SAPS officer	✓	✗	✗	✓	✗	✗	✗	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓	✓	✓	✓	✓
NGO at TCC	✓	✗	✗	✗	✗	✗	✗	✓	✓

** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

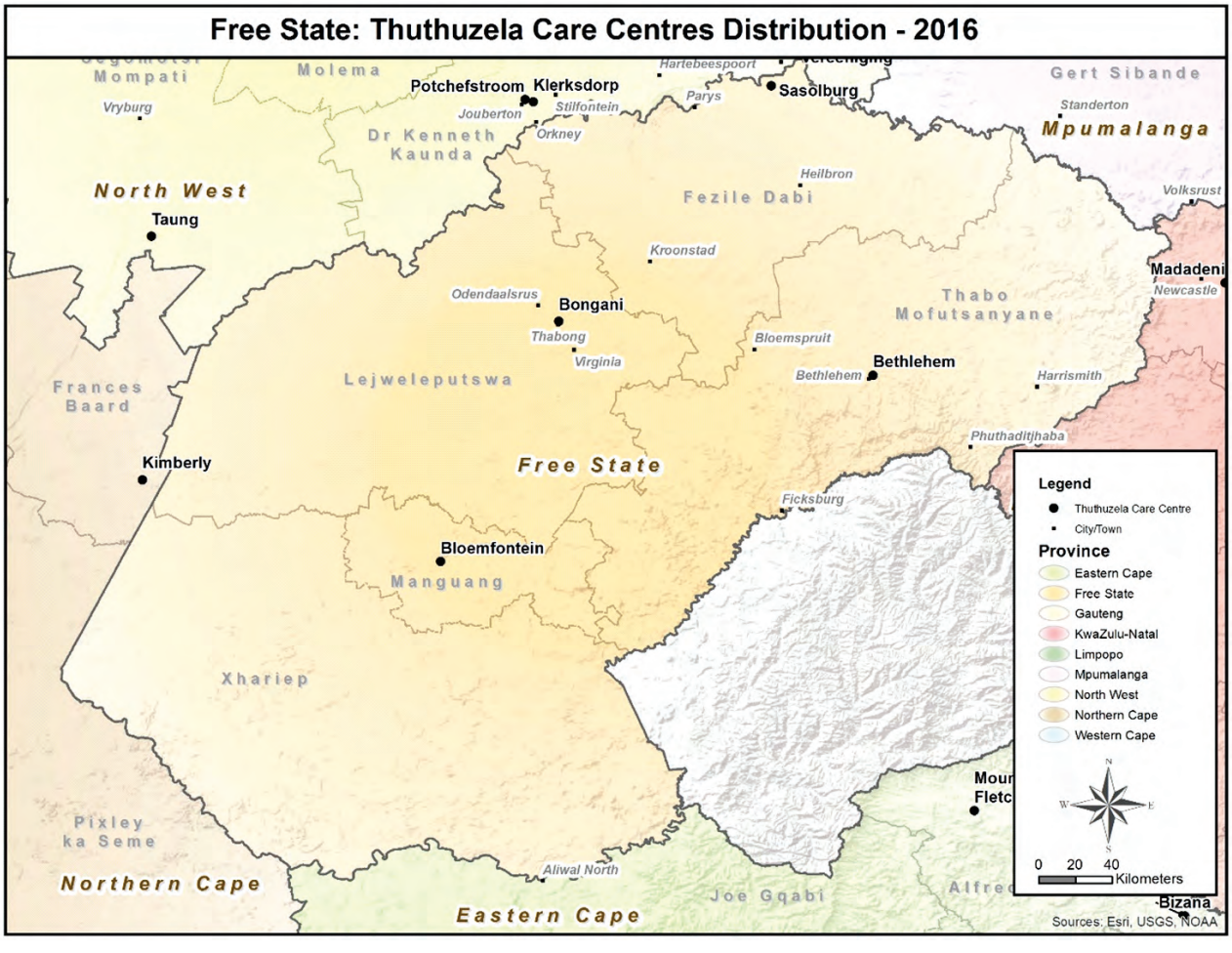
** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

3. TCCs in the Free State

Free State

Welkom
Sasolburg
Bethlehem
Bloemfontein

Bongani TCC, Health Complex *(Old Provincial Hospital)*
Metsimaholo TCC, Metsimaholo District Hospital
Phekolong TCC, Phekolong Hospital
Tshepong TCC, National District Hospital



FPD interviewed one regional manager in the Free State and one key NPA staff member who assisted with the management of the TCCs in the Free State. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

3.1. Governance and operational challenges

One of the main governance aspects highlighted by the key informants in the Free State is that a provincial coordinator is needed to coordinate the VAO and site coordinators. The gap between the sites and the national manager is too wide. Another concern is that the provincial regional manager is based in Pretoria, and not in the province. As a result the manager cannot visit the TCCs often enough.

'The TCCs are scattered, it is not as if you drive one morning and visit all of them in one day, you know' ~ *NPA key informant*

'This is like management over the phone, distant management ... so far it has been working, but not as effective as I would have liked it to be' ~ *NPA key informant*

Another concern is that regional managers have other responsibilities beyond the TCCs, and this reduces their ability so spend adequate time on the TCCs.

3.2. Facilities and sites

In the Free State, 75% of the TCCs are located in park homes and only 25% within the hospital.

Location of Free State TCCs

Only 25% of the TCCs have a security guard allocated to the TCC and none of the Free State TCCs have CCTV cameras. Most TCCs (75%) do not have any security guards assigned to them.

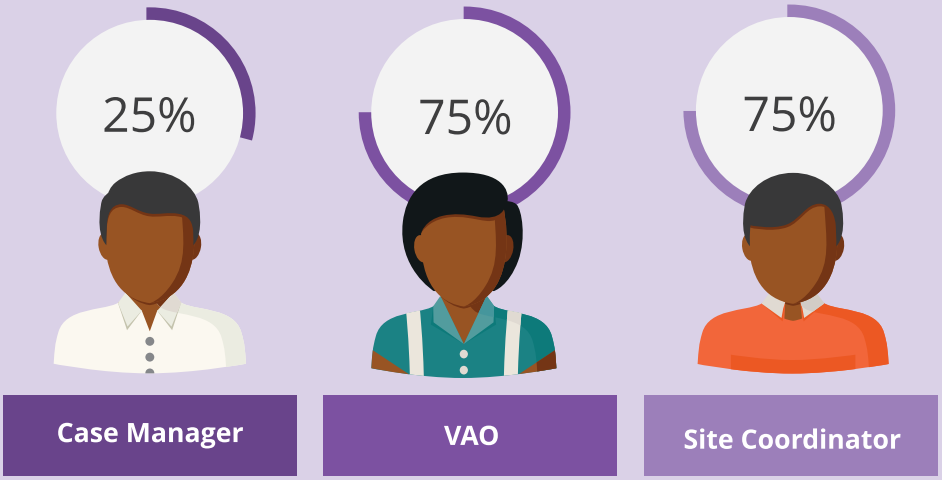
Security guards in Free State TCCs

3.3. Factors influencing quality of services delivered

Human resources

Most sites are adequately staffed. All four of the TCCs had at least a site coordinator or VAO, but the main concern is that only one TCC has a case manager. Staff are not adequately debriefed.

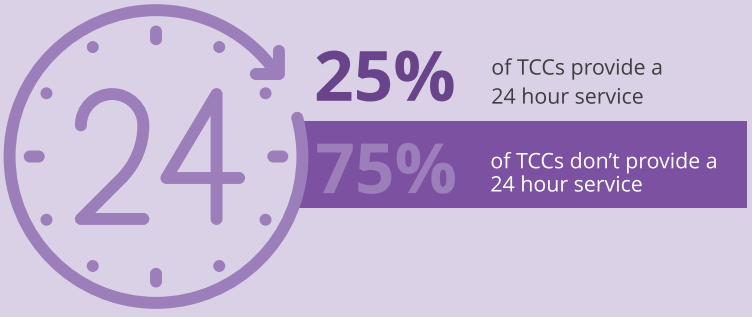
Percentage of TCCs with NPA staff



Accessibility

The majority of TCCs in the Free State do not provide a 24 hour service. The one TCC that does provide a 24 hour service can do so because of Lifeline, the NGO within the TCC.

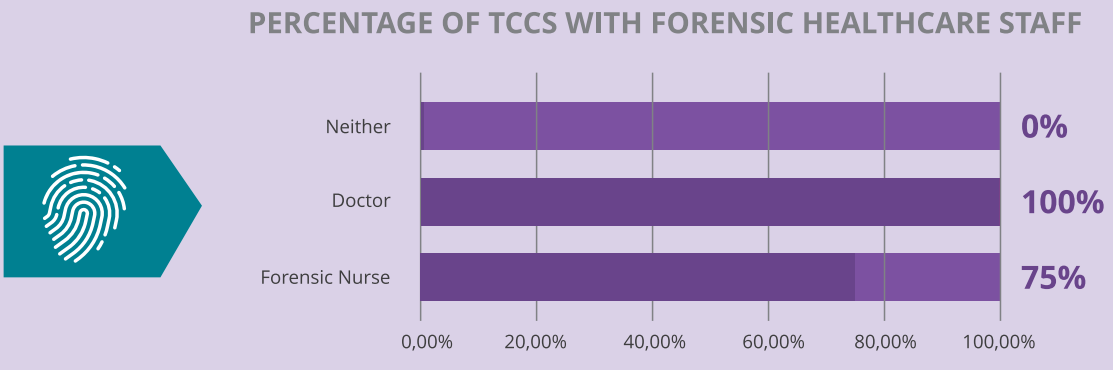
Hours of Service in Free State TCCs



Health services

All of the TCCs had either a forensic nurse or doctor to conduct forensic medical examinations.

Figure 15. Forensic Healthcare Staff in Free State TCCs



Psychosocial support

The key informants think that psychosocial support is inadequate. They also mentioned that there are language barriers in the provision of psychosocial support, particularly when the victims are not South African.

Equipment and supplies

All TCCs in the Free State have the basic facilities that are essential to deliver services, but there is serious concerns about some equipment. Only one TCC reported that they have all the equipment required to deliver all their services.

3.4. Stakeholder challenges

The ideal is that all stakeholders, DoH, DSD and SAPS, be based within the TCCs. However, this is not the case, which affects service delivery.

'It is not the one stop station it was supposed to be' ~ *NPA key informant*

DoH

Relationships with DoH are good, but there is a sense that they are hosting the TCCs. This sense of dependency is inhibiting the delivery of services. It often happens that forensic nurses are doing duty in casualty, and then victims must wait in casualty, instead of being assisted within the TCC.

DSD

The relationship with DSD is not at the level that it is supposed to be. At many sites they are not attending the monthly implementation meetings and they are not delivering, adequate, satisfactory services to victims.

'It feels as if they are stalling their services and work at a snail's pace' ~ *NPA key informant*

SAPS

The relationship with SAPS in the Free State is very good and the TCCs feel that they benefit from the services delivered by the police.

'We have a good relationships with SAPS, they are rendering services to the best of their ability' ~ *NPA key informant*

NGOs

Only one TCC in the Free State had an NGO providing services. Lifeline is working within Bongani TCC. They allow the TCC to be open 24 hours a day and provide lay counselling services and collaborate during campaigns. In general, the key informants reported that the relationships between the NGO and the TCC is functioning very well. The NGO delivers important after-hours services and follow-up counselling.

'The NGOs add value to the functioning, like I was talking about the after-hours support services, and there must be the follow-up services as well' ~ *NPA key informant*

Table 8 highlights the TCC site specific findings.

Table 8. Summary of Free State TCC findings

	Bongani TCC	Metsimaholo TCC	Phekolong TCC	Tshepong TCC
TCC location	Inside hospital	Park home	Park home	Park home attached to facility
Security guard/s assigned to TCC	✗	✗	✗	✓
CCTV camera/s	✗	✗	✗	✗
Secured entrances	✗	✓	✓	✓
Separate perpetrator/suspect entrance	✗	✓	✓	✓
Sign outside TCC with name	✓	✓	✓	✓
24 hour service	✗	✗	✓	✗
TCC linked to Sexual Offences Court	✓	✓	✗	✓
Waiting time	30 min	30 min	less than 30 min	30 min
Essential services offered	✓	✓	✓	✓
Essential facilities available*	✓	✓	✓	✓
Essential equipment available*	✗	✗	✗	✓
Site coordinator	✓	✓	✗	✓
Victim assistance officer	✓	✓	✓	✓
Case manager	✓	✓	✓	✓
Forensic nurse	✓	✗	✓	✓
Doctor	✓	✗	✗	✓
Social worker	✓	✗	✗	✓
SAPS officer	✗	✗	✗	✓
Staff received refresher training	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓
NGO at TCC	✓	✗	✗	✗

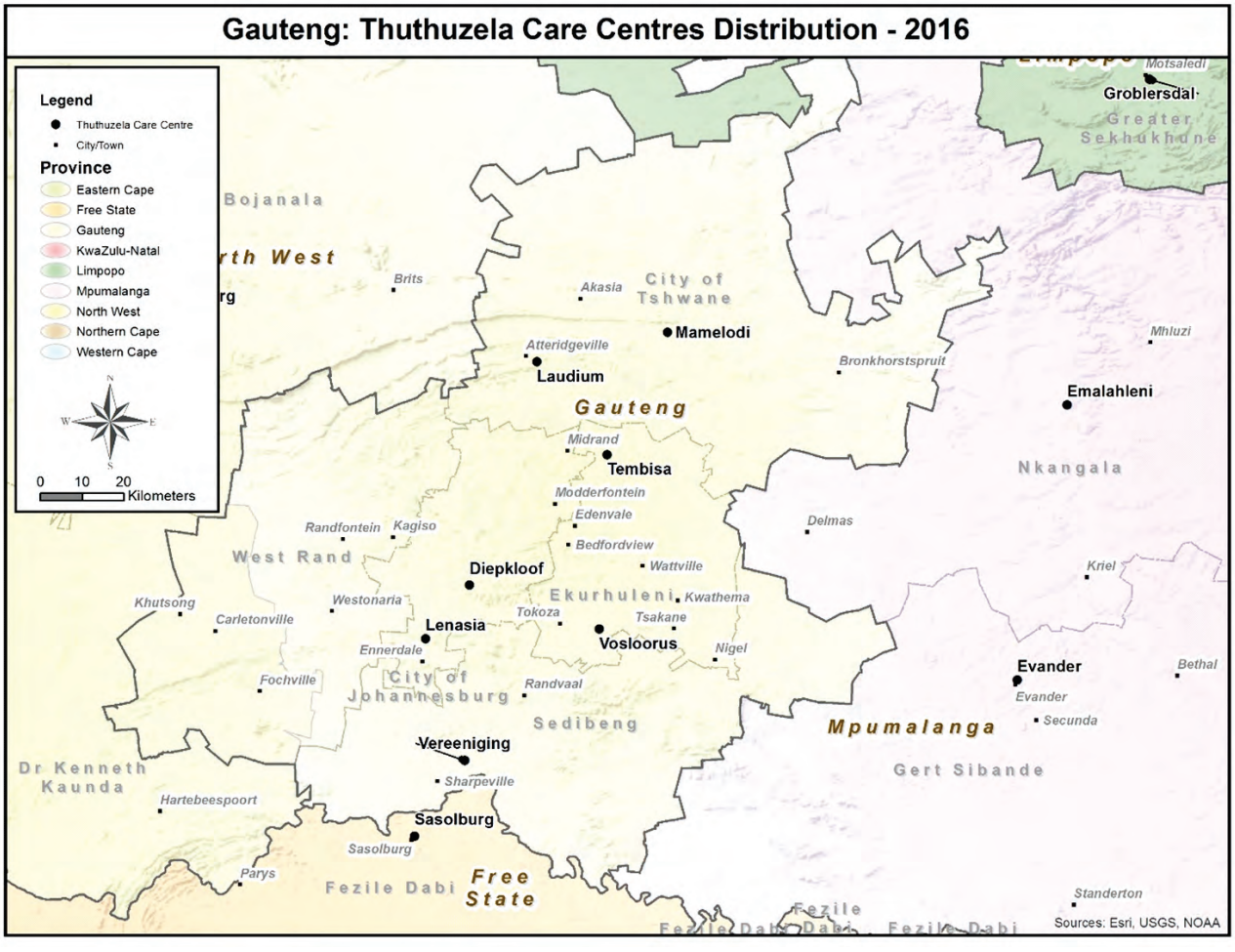
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

4. TCCs in Gauteng

Gauteng

Mamelodi	Mamelodi TCC, Mamelodi Day Hospital
Diepkloof	Nthabiseng TCC, Chris Hani Baragwanith Hospital
Lenasia	Lenasia TCC, Lenasia Hospital
Laudium	Laudium TCC, Laudium Hospital & Community Health Centre
Vosloorus	Thelle Mogoerane TCC, Thelle Mogoerane Regional Hospital
Vereeniging	Kopanong TCC, Kopanong Hospital
Tembisa	Masakhane TCC, Tembisa Hospital



FPD interviewed one regional manager in Gauteng. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

4.1. Governance and operational challenges

There appear to be challenges with regards to reporting lines within Gauteng. The site coordinators and VAOs report to the Director: Administration in head office. The regional manager is based within the province, making oversight and governance easier. The regional manager can visit the TCCs more often, ensuring that problems are addressed immediately.

'Monitoring of staff is a big challenge, because they don't report to me, I manage case managers, and sometimes there's a gap' ~ *NPA Key informant*

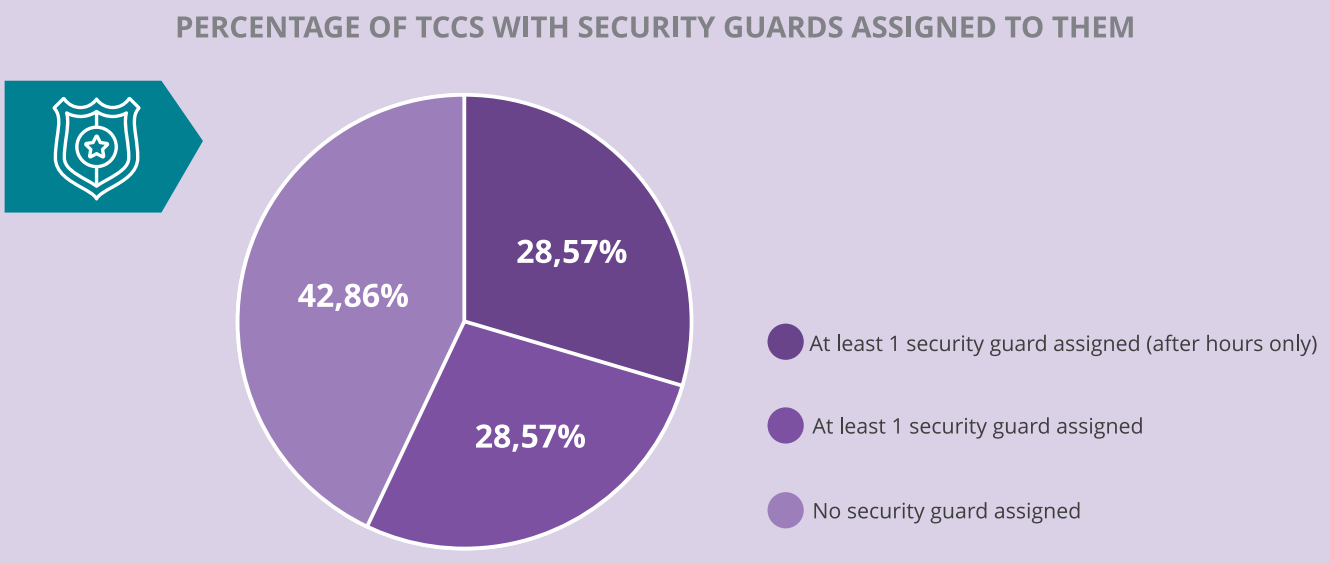
4.2. Facilities and sites

The majority of TCCs are located in park homes, approximately 29% are located in a building outside the main hospital and 14% are located inside the hospital.

Location of Gauteng TCCs

Approximately 43% of TCCs do not have a security guard assigned to them. Approximately 29% have a security guard assigned to the TCC after-hours and 29% have at least one security guard assigned to the TCC full time.

Figure 16. Security guards in Gauteng TCCs



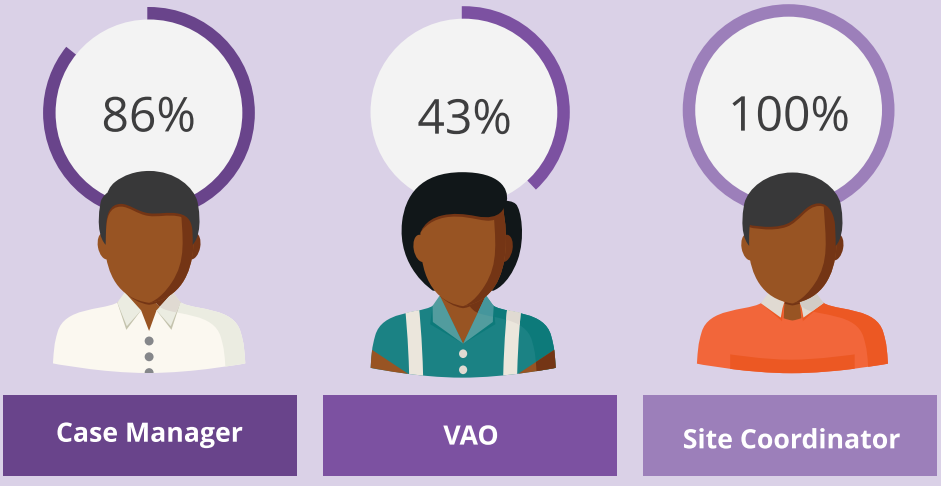
43% of TCCs in Gauteng have CCTV cameras

4.3. Factors influencing quality of services delivered

Human resources

The TCCs in Gauteng are well staffed. All of the TCCs had a site coordinator, nearly half (43%) had a VAO, and approximately 86% had a case manager.

Percentage of TCCs with NPA staff

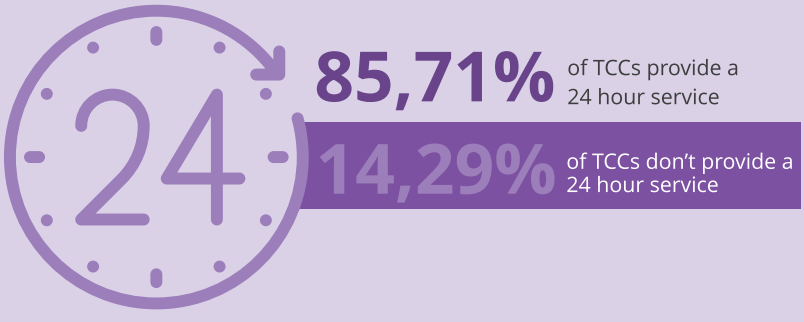


However, there is a relatively high turn-over of staff within the TCCs, specifically among the VAOs. The reason for this appears to be the limited career paths in this position. The training budget is apparently not adequate. All the TCCs reported that staff do not receive adequate debriefing.

Accessibility

The majority of TCCs (85.7%) are able to provide services 24 hours a day, with the NGO associated with the TCC providing the after-hours service in 80% of cases.

Hours of Service in Gauteng TCCs



Overall, the TCCs in Gauteng were victim-friendly. They all have wheelchair access, 85.7% have separate entrances and exam rooms for suspects, 85.7% have a private and confidential environment, and 71% are child friendly.

However, there needs to be more community awareness of the TCCs, as this will ensure better access and use from community members.

Health services

The TCCs in Gauteng all had either a forensic nurse or doctor, allowing them to perform forensic medical examinations without problems.

Equipment and supplies

Only four out of the seven TCCs have all the essential facilities required to deliver services and none have all the equipment required to deliver quality services. Mamelodi TCC receives many donations in the form of comfort packs, groceries and other things.

4.4. Stakeholder challenges

It is reported that the TCC staff sometimes struggle with attitudes of individuals in other departments. This is mainly as a result of individual attitudes, rather than departmental problems. High staff turnover in other departments affects the functioning of the TCCs, because new staff need training on the TCC model and their role within this. Management of stakeholders at provincial level is not adequate and there's no mechanism in place to ensure adequate accountability from all stakeholders.

NGOs

All TCCs in Gauteng have an NGO linked to them. In 80% of cases, the after-hours services are provided by the NGO.

Services provided by NGOs in Gauteng

'Without them the TCC will not be a success' ... ~ *NPA key informant*

Most (86%) of NGOs provide counselling services. Other services provided by NGOs include HCT, safety placements, home-visits, and other psychosocial services.

Table 9 highlights the TCC site specific findings.

Table 9. Summary of Gauteng TCC results

	Mamelodi TCC	Nthabiseng TCC	Lenasia TCC	Laudium TCC	Thelle Mogoerane TCC	Kopanong TCC	Masakhane TCC
TCC location	Inside hospital	Building outside hospital	Park home	Park home	Building outside hospital	Park home	Park home
Security guard/s assigned to TCC	✗	✓ *after hours*	✓ *after hours*	✗	✓	✗	✓
CCTV camera/s	✗	✗	✓	✓	✓	✗	✗
Secured entrances	✗	✗	✓	✓	✗	✓	✓
Separate perpetrator/suspect entrance	✗	✓	✓	✓	✗	✓	✓
Sign outside TCC with name	✗	✓	✓	✓	✓	✓	✓
24 hour service	✓	✓	✗	✓	✓	✓	✓
TCC linked to Sexual Offences Court	✓	✓	✗	✓	✓	✓	✗
Waiting time	30 min	30 min	5 min	5 min	5 min	5 min	5 min
Clients offered refreshments	✗	✓	✓	✓	✓	✓	✓
Essential services offered	✓	✓	✓	✓	✓	✓	✓
Essential facilities available*	✗	✓	✓	✗	✓	✓	✗
Essential equipment available*	✗	✗	✗	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓	✓	✓
Victim assistance officer	✗	✗	✗	✓	✓	✓	✗
Case manager	✓	✓	✗	✓	✓	✓	✓
Forensic nurse	✓	✓	✓	✓	✓	✓	✓
Doctor	✓	✓	✓	✓ *on-call hospital*	✓	✓	✓
Social worker	✗	✓	✓	✓	✓	✓	✓
SAPS officer	✗	✗	✗	✗	✓	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓	✓	✓
NGO at TCC	✓	✓	✓	✓	✓	✓	✓

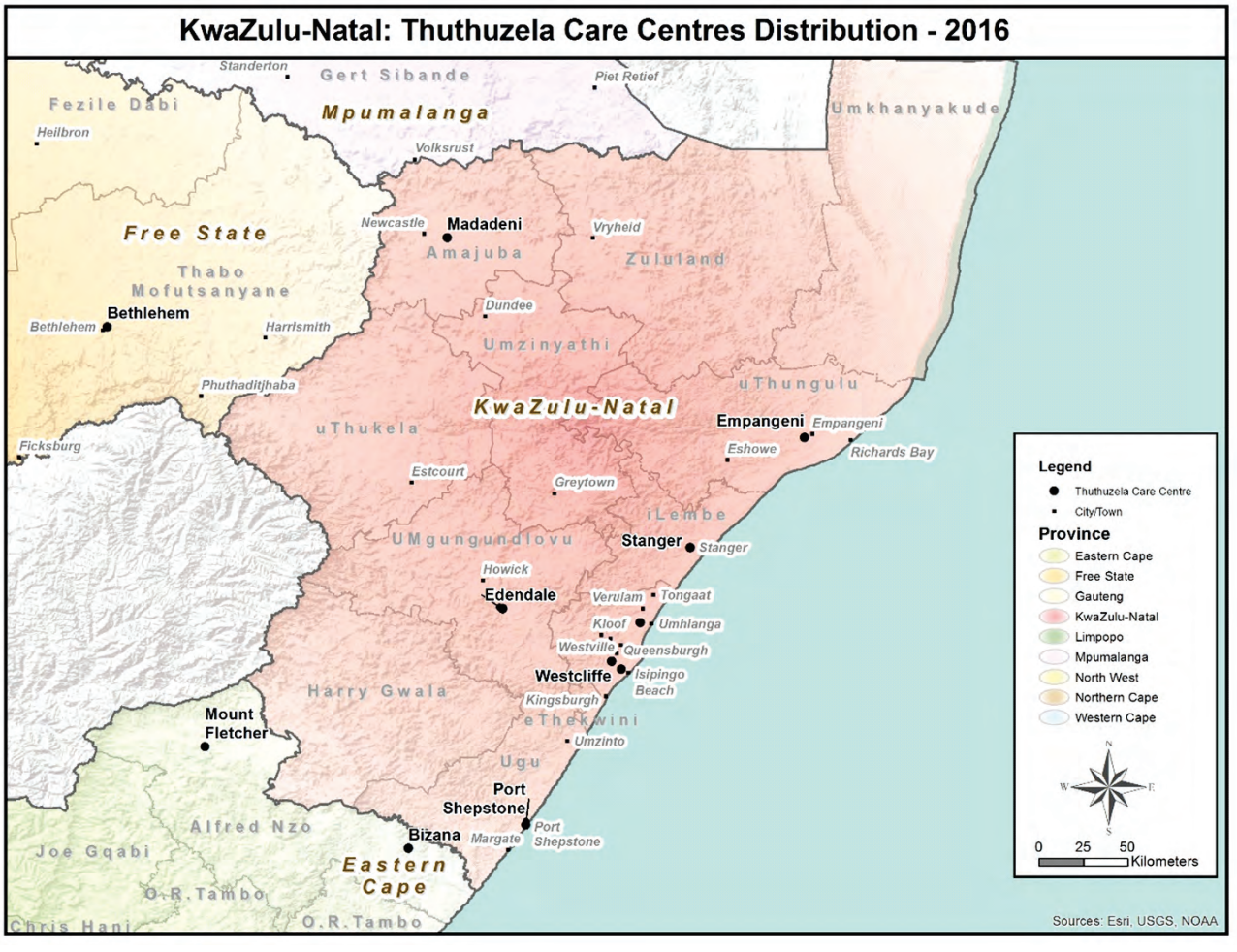
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

5. TCCs in KwaZulu-Natal

KwaZulu-Natal

Newcastle	Madadeni TCC, Madadeni Hospital
Port Shepstone	Port Shepstone TCC, Port Shepstone Regional Hospital
Umlazi	Umlazi CC, Prince Mshiyeni Memorial Hospital
Phoenix	Phoenix TCC, M Ghandi Memorial Hospital
Durban	RK Kahn TCC, RK Khan Hospital
Pietermaritzburg	Edendale TCC, Edendale Hospital
Stanger	Stanger TCC, Stanger Provincial Hospital
Empangeni	Empangeni TCC, Ngwelezane Hospital



FPD interviewed three regional managers in KwaZulu-Natal. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

5.1. Governance and operational challenges

The dual reporting system where case managers report to the NPA regional managers and site coordinators and VAOs report to head office is creating problems. This relates specifically to taking leave and the absence of disciplinary action within the province. The probation and performance review of these staff members are decided at head office, although it is the regional managers who know the actual performance of these staff members. One of the regional managers reported that they experience systematic sabotage within this system.

The communication channels between all stakeholders, internally and externally, need improvement.

A final problem related to governance and operational issues is that regional managers have many other responsibilities, and don't always have adequate time to allocate to the needs of the TCCs.

5.2. Facilities and sites

The majority (62.5%) of TCCs in KwaZulu-Natal are located in park homes. One TCC (12.5%) is located in a building outside the hospital and two (25%) are located inside hospitals.

Location of KwaZulu-Natal TCCs

There is a major concern that there is no plan in place for upgrading or moving out of park homes after their 10-year habitable period. Some will be integrated into hospital revitalisation projects, but many will not. Only one TCC reported that they have adequate facilities to deliver the required services.

Only half of the TCCs in KwaZulu-Natal have security guards assigned to them, and one has CCTV cameras.

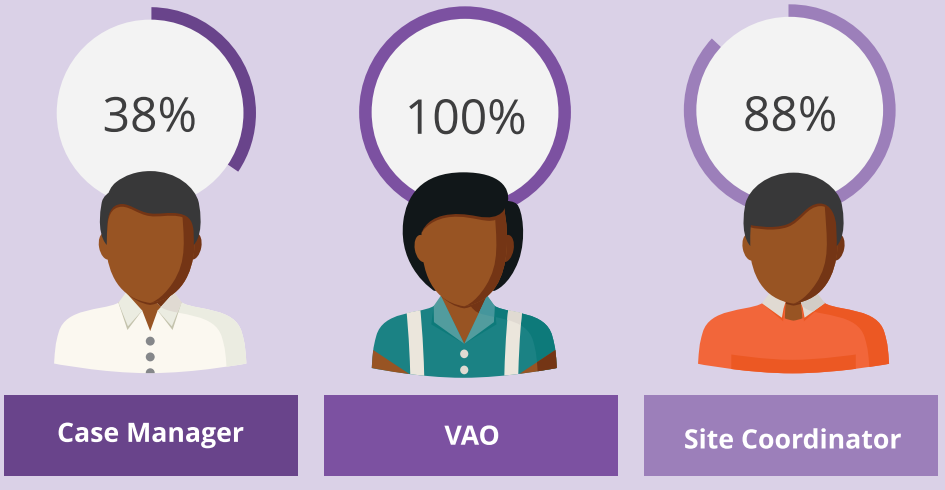
Security guards in KwaZulu-Natal TCCs

5.3. Factors influencing quality of services delivered

Human resources

The majority (87.5%) of the TCCs in KwaZulu-Natal have a site coordinator; all have a VAO. All have either a site coordinator or VAO. Only three TCCs (37.5%) in KwaZulu-Natal have a case manager.

Percentage of TCCs with NPA staff



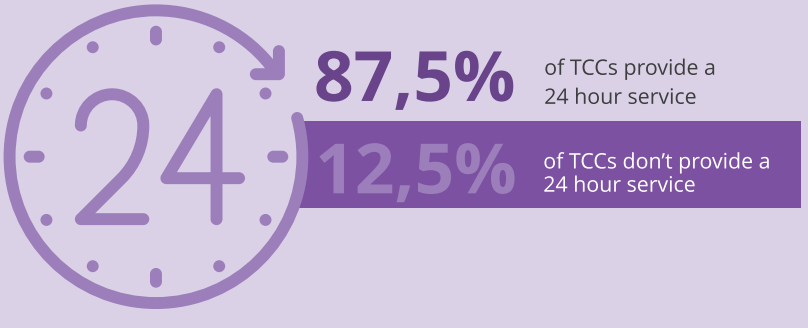
The regional managers expressed concerns about disciplinary problems related to the dual reporting system. They also highlighted that the TCCs with a higher case load need a dedicated administrator.

All TCCs reported inadequate debriefing.

Accessibility

Most (87%) of TCCs in KwaZulu-Natal are open 24 hours a day.

Hours of Service in KwaZulu-Natal TCCs



Health services

Most TCCs in KwaZulu-Natal had a doctor (88%) or forensic nurse (75%) allocated to them. In addition 25% (2 TCCs) had only a doctor, 37.5% (3 TCCs) had only a forensic nurse and 37.5% (3 TCCs) had both. All had either a doctor or forensic nurse.

Equipment and supplies

Basic groceries and comfort packs are frequently not available. NACOSA provided the comfort packs at the NACOSA-funded NGOs, but this is no longer always happening. None of the TCCs in KwaZulu-Natal have the essential equipment needed to provide quality services.

Psychosocial support

Language barriers between the victims and social workers and psychologists are limiting the value of the psychosocial support in the system.

5.4. Stakeholder challenges

In general, the intersectoral relations are good at provincial level, but not at facility level. This needs to be addressed.

DoH

The relationships with certain hospital CEOs are strained. There is a feeling that they don't always buy into the TCC model.

NGOs

All the TCCs within KwaZulu-Natal have an NGO associated with them, including Lifeline, Childline and Child Welfare. In many cases they provide an invaluable service, but there have been cases where they hinder the functioning of the TCCs.

Services provided by NGOs in KwaZulu-Natal

- Counselling for Adults
- Counselling for Children
- Safety Shelters
- HIV Counselling & Testing
- Other psychosocial services

5.5. Other

There is insufficient IEC and community awareness material, in the right language, available at the TCCs. This inhibits community awareness of the TCC model.

Table 10 highlights the TCC site-specific findings.

Table 10. Summary of KwaZulu- Natal TCC findings

	Madadeni TCC	Port Shepstone TCC	Umlazi TCC	Phoenix TCC	RK Khan TCC	Edendale TCC	Stranger TCC	Empangeni TCC
TCC location	Inside hospital	Park home	Inside hospital	Building outside hospital	Park home	Park home	Park home	Park home
Security guard/s assigned to TCC	✓	✗	✗	✓	✗	✓	✗	✗
CCTV camera/s	✓	✗	✗	✗	✗	✗	✗	✗
Secured entrances	✓	✓	✓	✓	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✓	✗	✓	✗	✓	✗	✓	✓
Sign outside TCC with name	✓	✓	✓	✗	✓	✓	✗	✓
24 hour service	✓	✓	✓	✓	✓	✓	✗	✓
TCC linked to Sexual Offences Court	✓	✗	✓	✓	✓	✓	✗	✓
Waiting time	30 min	30 min	30 min	1 hr	15 min	1 hr	30 min	20 min
Essential services offered	✗	✗	✗	✗	✗	✗	✗	✗
Essential facilities available*	✓	✗	✗	✗	✗	✗	✗	✗
Essential equipment available*	✗	✗	✗	✗	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓	✓	✓	✗
Victim assistance officer	✓	✓	✓	✓	✓	✓	✓	✓
Case manager	✗	✓	✗	✓	✓	✗	✗	✗
Forensic nurse	✓	✓	✓	✗	✓	✓	✓	✗
Doctor	✗	✓	✓	✓	✓	✓	✗	✗
Social worker	✓	✗	✓	✓	✓	✓	✓	✓
SAPS officer	✗	✓	✓	✓	✗	✓	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓	✓	✓	✓
NGO at TCC	✓	✓	✓	✓	✓	✓	✓	✓

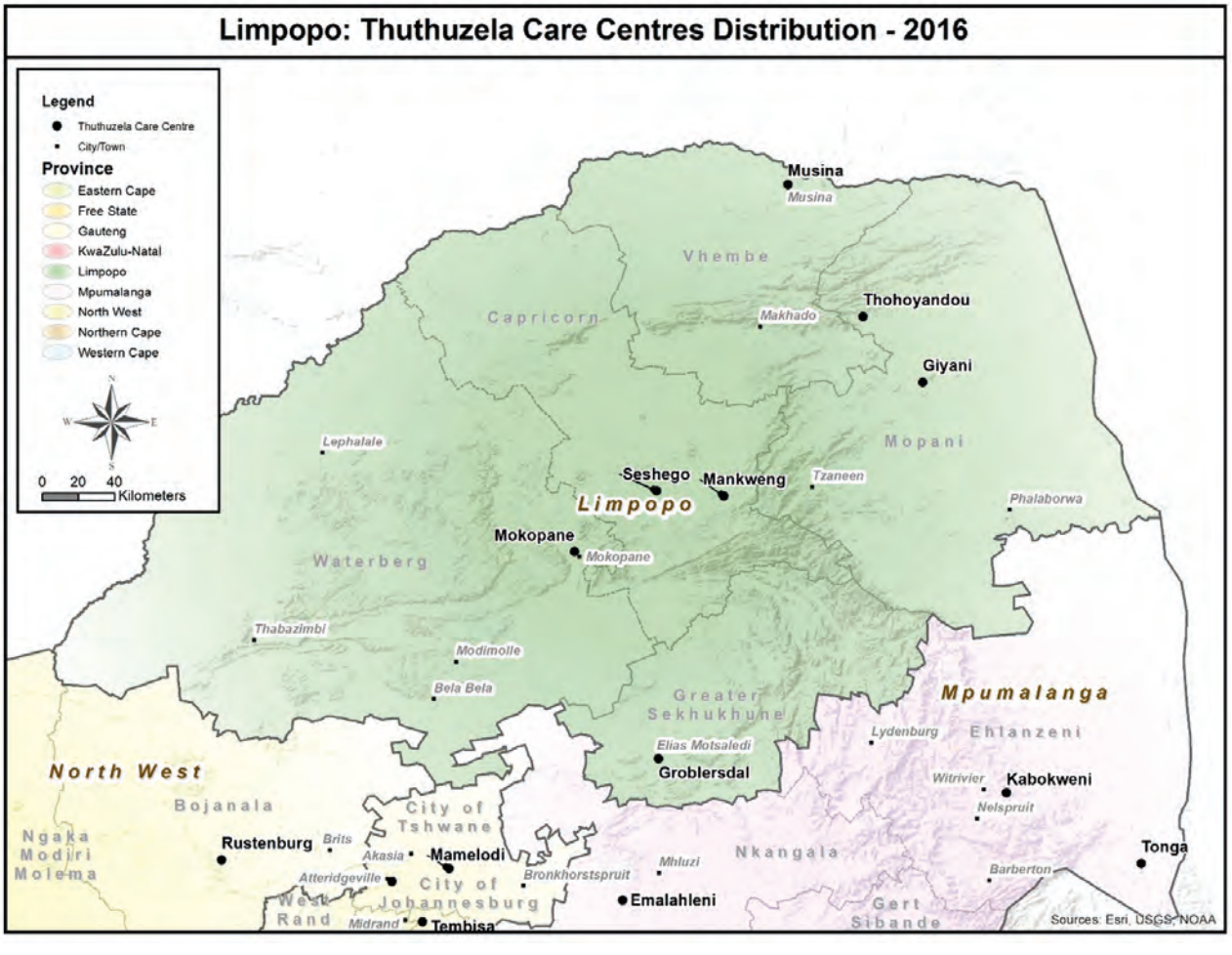
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

6. TCCs in Limpopo

Limpopo

Groblersdal	Groblersdal TCC, Groblersdal Hospital
Mokopane	Mokopane TCC, Mokopane Hospital
Mankweng	Mankweng TCC, Mankweng Hospital
Seshego	Seshego TCC, Seshego Hospital
Musina	Musina TCC, Musina Hospital
Thohoyandou	Tshilidzini TCC, Tshilidzini Hospital
Giyani	Nkhensani TCC, Nkhensani Hospital



FPD interviewed one regional manager in Limpopo. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

6.1. Governance and operational challenges

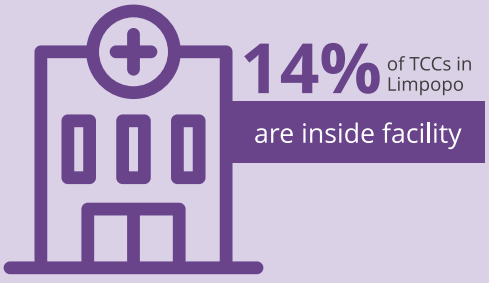
One of the main challenges in Limpopo is that there is only one regional manager who is responsible for seven TCCs, while also having other national responsibilities. In relation to this, the regional manager is based in head office, and does not have adequate time to visit the TCCs regularly.

At facility level, the monthly implementation meetings are generally going well.

6.2. Facilities and sites

Most TCCs (57%) are located in park homes. Only one TCC reported that they have the required facilities to deliver services.

Location of Limpopo TCCs



14% of TCCs in Limpopo are inside facility

29% situated in buildings outside hospital

57% of TCCs in Limpopo are in park homes

Most (85%) of TCCs do not have any security guards assigned to them, and only about 15% have CCTV cameras.

Security guards in Limpopo TCCs

14,29% One/more security guards

85,71% No security guards

14,29% of TCCs in Limpopo have one/more CCTV cameras

6.3. Factors influencing quality of services delivered

Human resources

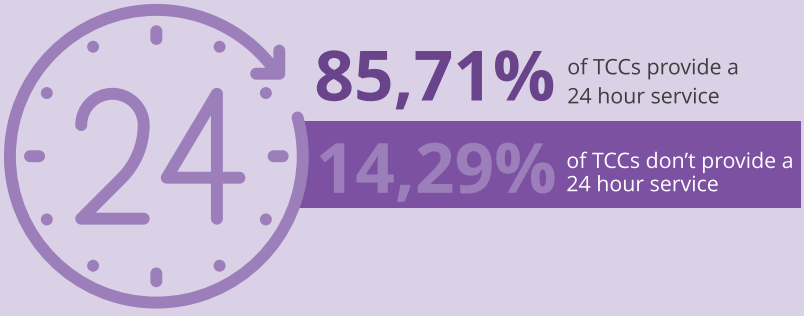
All of the TCCs in Limpopo have a VAO or site coordinator. Only 28% have a case manager. All TCCs reported that staff do not receive adequate debriefing.

Percentage of TCCs with NPA staff

Accessibility

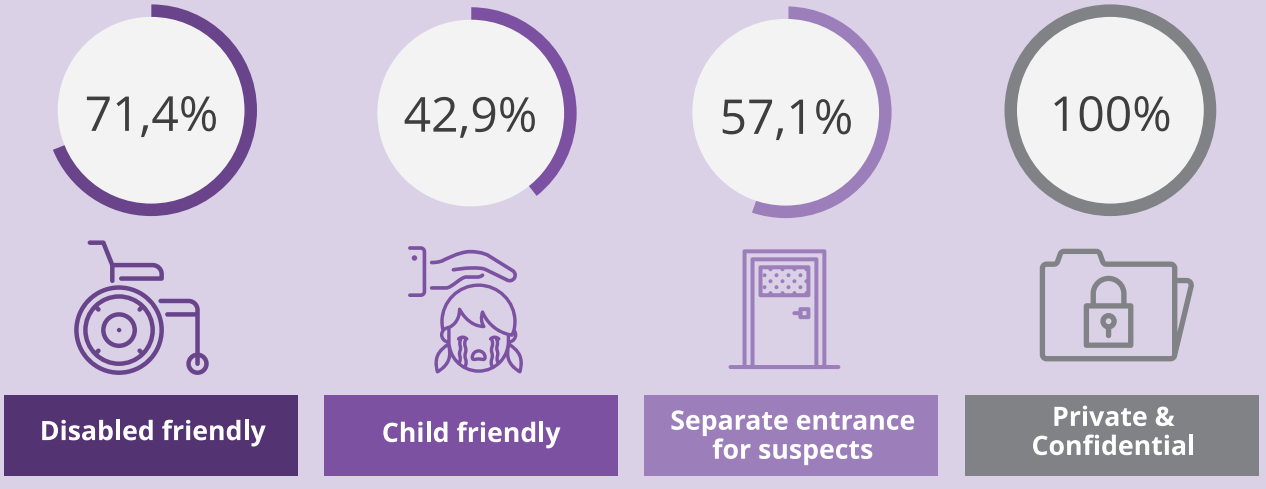
Most (85%) TCCs in Limpopo are open 24 hours a day. Only two of these TCCs reported that NGOs within the TCC assist them with this.

Hours of Service in Limpopo TCCs



Overall, the TCCs in Limpopo were victim-friendly. All TCCs had a private and confidential environment. Approximately 70% of TCCs were disabled friendly, but only 40% were child friendly. Approximately 60% of TCCs had separate entrances and exam rooms for suspects.

Victim-friendliness of Limpopo TCCs



Some victims are reluctant to visit TCCs because use of specific facilities is demarcated by the DoH depending on where a person lives, but this should not influence victims accessing the TCCs.

Health services

Only four TCCs in Limpopo have a forensic nurse, only one TCC has a part-time doctor. Two TCCs do not have either have a forensic nurse or a doctor.

Psychosocial support

None of the TCCs in Limpopo have a social worker or a SAPS officer allocated to them. This is limiting the psychosocial support that victims receive and increases secondary victimisation.

Equipment and supplies

The TCCs in Limpopo are experiencing severe challenges with equipment and supplies. One of the main challenges is access to the internet and adequate computers. There is also not enough medical equipment within the TCCs to provide the health services requires. Only one TCC reported that they have the equipment essential to deliver the required services.

Transport

Access to transport is a major concern for the TCCs in Limpopo. There is no transport available for TCC staff members to attend campaigns and assist with community awareness. Access to transport is also concern for victims, as this prevents them returning to the TCCs for follow-up services, accessing follow-up PEP and follow-up psychosocial support.

6.4. Stakeholder challenges

There is a concern that not all stakeholders are buying into the TCC model, mainly because of communications structures between the different stakeholders.

DoH

Not all hospital CEOs are cooperating with the TCC model, and this influences the ability to deliver the required health services to victims.

DSD

At facility level the TCCs experience challenges with DSD. There are cases where they are not accepting the TCC referrals, and this compromises continued psychosocial support.

NGOs

Just under half of the TCCs in Limpopo have an NGO associated with them.

Limpopo TCCs with an NGO

Some victims are reluctant to visit TCCs because use of specific facilities is demarcated by the DoH depending on where a person lives, but this should not influence victims accessing the TCCs.

Health services

Only four TCCs in Limpopo have a forensic nurse, only one TCC has a part-time doctor. Two TCCs do not have either have a forensic nurse or a doctor.

Psychosocial support

None of the TCCs in Limpopo have a social worker or a SAPS officer allocated to them. This is limiting the psychosocial support that victims receive and increases secondary victimisation.

Equipment and supplies

The TCCs in Limpopo are experiencing severe challenges with equipment and supplies. One of the main challenges is access to the internet and adequate computers. There is also not enough medical equipment within the TCCs to provide the health services requires. Only one TCC reported that they have the equipment essential to deliver the required services.

Transport

Access to transport is a major concern for the TCCs in Limpopo. There is no transport available for TCC staff members to attend campaigns and assist with community awareness. Access to transport is also concern for victims, as this prevents them returning to the TCCs for follow-up services, accessing follow-up PEP and follow-up psychosocial support.

6.4. Stakeholder challenges

There is a concern that not all stakeholders are buying into the TCC model, mainly because of communications structures between the different stakeholders.

DoH

Not all hospital CEOs are cooperating with the TCC model, and this influences the ability to deliver the required health services to victims.

DSD

At facility level the TCCs experience challenges with DSD. There are cases where they are not accepting the TCC referrals, and this compromises continued psychosocial support.

NGOs

Just under half of the TCCs in Limpopo have an NGO associated with them.

Limpopo TCCs with an NGO

The NGOs are delivering important services within the TCCs. Childline and the TVEP allow Groblersdal TCC and Tshilidzini TCC respectively to be open 24 hours a day.

Services provided by NGOs in Limpopo

- Counselling
- Trauma Containment
- Arranging transport for clients

6.5. Other

There is a concern that the TCC model's indicators focus on the justice system and case management, and not on justice for the victims or the psychosocial needs of victims.

Table 11 highlights the TCC site-specific findings.

Table 11. Summary of Limpopo TCC results

	Groblersdal TCC	Mokopane TCC	Mankweng TCC	Seshego TCC	Musina TCC	Tshilidzini TCC	Nkhensani TCC
TCC location	Park home	Park home	Building outside hospital	Park home	Park home	Building outside hospital	Inside hospital
Security guard/s assigned to TCC	✗	✗	✗	✗	✗	✗	✗
CCTV camera/s	✗	✗	✗	✗	✗	✗	✗
Secured entrances	✓	✓	✓	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✓	✓	✗	✓	✓	✗	✗
Sign outside TCC with name	✓	✓ *no name*	✓	✓	✓ *no name*	✓	✓
24 hour service	✓	✓	✓	✓	✗	✓	✓
TCC linked to Sexual Offences Court	✓	✗	✓	✗	✓	✓	✗
Waiting time	none	50 min	30 min	none	45 min	30 min	10 min
Essential services offered	✓	✓	✓	✓	✓	✓	✓
Essential facilities available*	✓	✗	✗	✗	✗	✗	✗
Essential equipment available*	✓	✗	✗	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓	✓	✓
Victim assistance officer	✓	✓	✓	✓	✓	✓	✓
Case manager	✗	✗	✓	✗	✗	✓	✗
Forensic nurse	✗	✓	✓	✓	✗	✗	✓
Doctor	✓	✗	✗	✗	✗	✗	✗
Social worker	✗	✗	✗	✗	✗	✗	✗
SAPS officer	✗	✗	✗	✗	✗	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓	✓	✓
NGO at TCC	✓	✗	✗	✗	✗	✓	✓

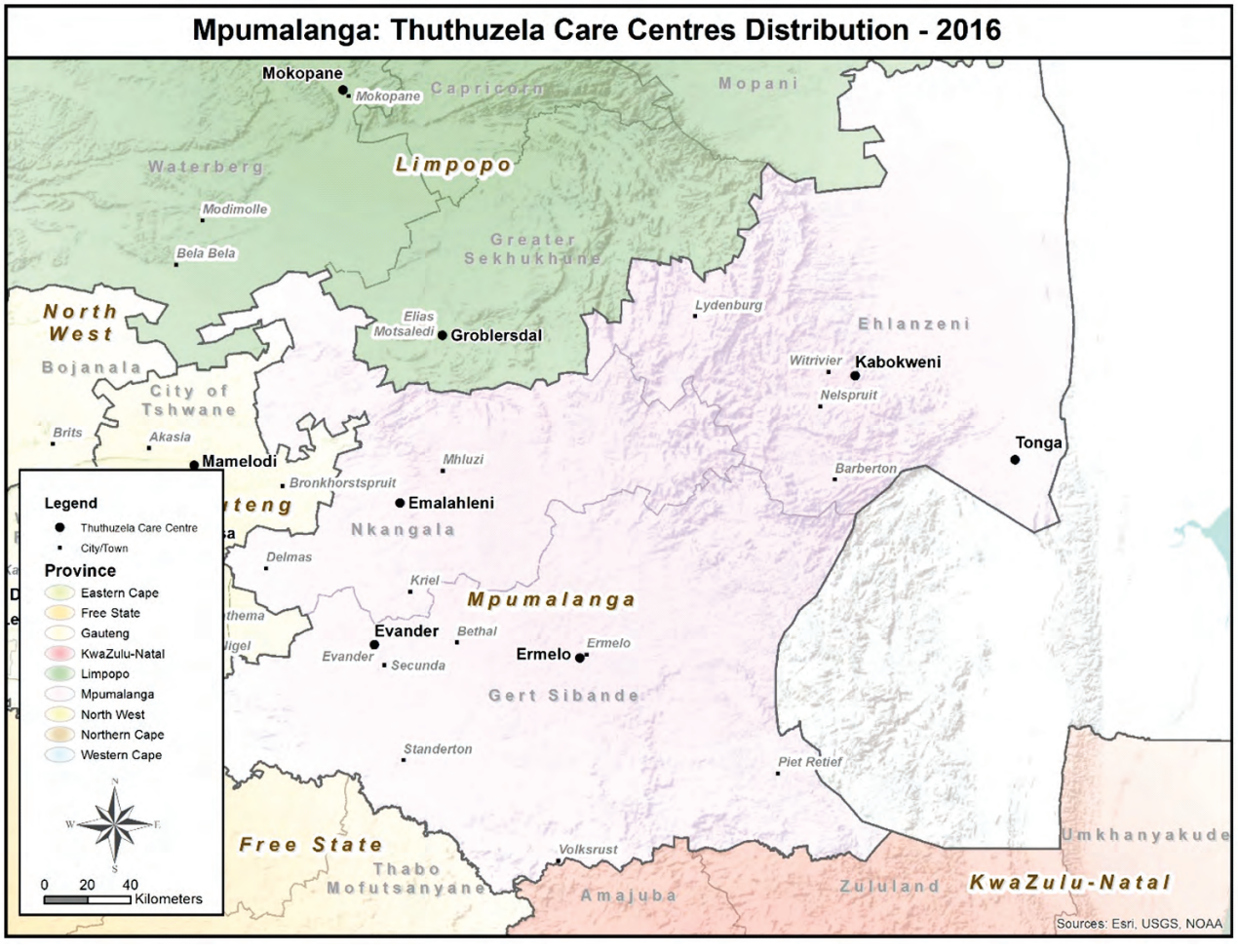
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

7. TCCs in Mpumalanga

Mpumalanga

Kabokweni	Themba TCC, Themba Hospital
Tonga	Tonga TCC, Tonga Hospital
Ermelo	Ermelo TCC, Ermelo Hospital
Evander	Evander TCC, Evander Hospital
Emalahleni	Emalahleni TCC, Witbank Hospital



FPD interviewed one regional manager and a case manager in Mpumalanga. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

7.1. Governance and operational challenges

The Mpumalanga TCCs reported challenges with the dual reporting system, where the case manager reports to the regional manager in the province and site coordinators and VAOs report to the Director: Administration at head office. There is a sense that the administrative staff are abusing the system.

> 'It is not that we want to police them, but how would you know that the system is not abused?'
> *~ NPA key informant*

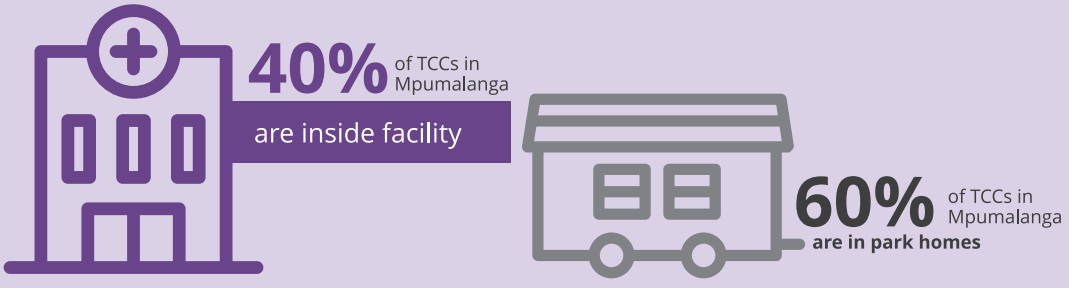
Another issue is that the regional manager has many other responsibilities and cannot allocate enough time and attention to the TCCs.

Lastly, the hospital CEOs and DSD do not regularly attend the monthly implementation meetings.

7.2. Facilities and sites

60% of TCCs in Mpumalanga are located in park homes and the rest inside the hospitals. Two of the TCCs reported that they have the essential facilities to deliver the required services.

Location of Mpumalanga TCCs



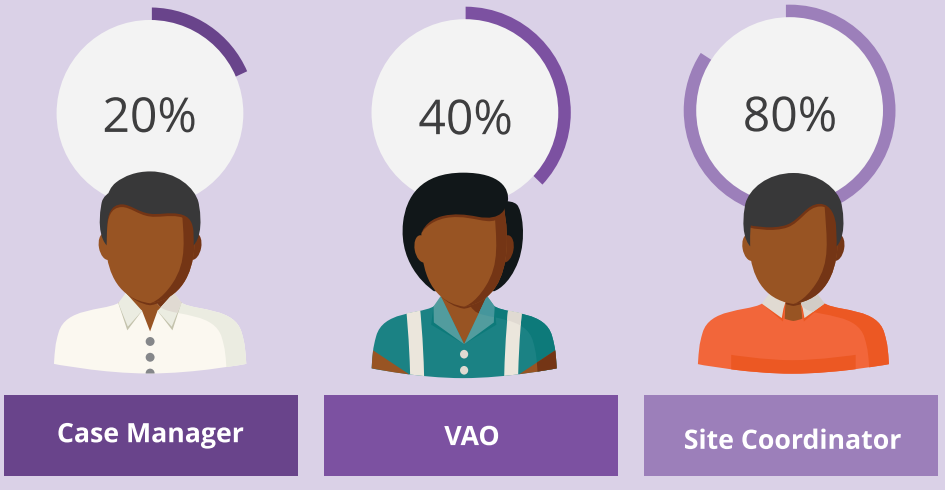
None of the TCCs in Mpumalanga had security guards assigned to them or have CCTV cameras.

7.3. Factors influencing quality of services delivered

Human resources

A total of 80% of TCCs in Mpumalanga have a site coordinator, 40% have a VAO, and 20% have a case manager (1 TCC). All had either a site coordinator or VAO, but only one TCC (Emalahleni) had both. Staff at all the TCCs in Mpumalanga reported that they are not receiving adequate debriefing.

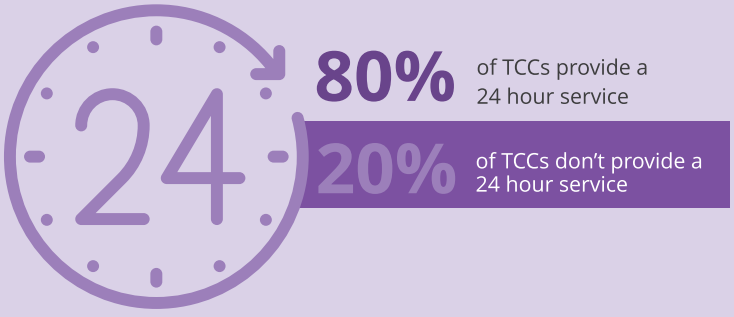
NPA Staff in Mpumalanga TCCs



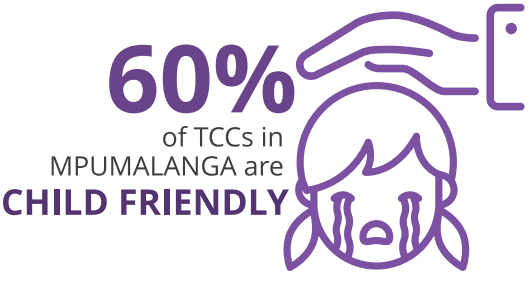
Accessibility

The majority of TCCs (80%) in Mpumalanga provide a 24 hour service. Only 60% of the TCCs that provide a 24 hour service have an NGO working in them.

Hours of service in Mpumalanga TCCs



With regards to victim friendliness, most (80%) of TCCs had a confidential and private environment. 60% of the TCCs had separate entrances and exam rooms for suspects, were child friendly and were disabled friendly.



Victim-friendliness of Mpumalanga TCCs

Health services

All of the TCCs in Mpumalanga have at least one forensic nurse. None of the TCCs have a doctor allocated to the TCC. One of the major challenges is that the forensic nurses are often shared with the casualty department, as a result causing delays to the TCC model.

All the TCCs in Mpumalanga deliver the essential services.

Psychosocial support

Only one TCC had a social worker allocated to them and none have a police officer within the TCC. This is affecting psychosocial support and can lead to secondary victimisation.

Equipment and supplies

The TCCs in Mpumalanga do not have adequate access to phone lines. Most are connected to the hospital system, and can only receive and not make phone calls. There is no clarity on who is responsible for purchasing comfort packs, groceries and paper. There is also no clarity within the hospital structure about who should provide phone lines, photocopiers and cleaning services within the TCC. Only one TCC reported that they have all the essential equipment needed to deliver services.

7.4. Stakeholder challenges

DoH

There is a sense that DoH is not buying into the TCC model and that some hospital CEOs are reluctant to allocate staff to the TCCs.

DSD

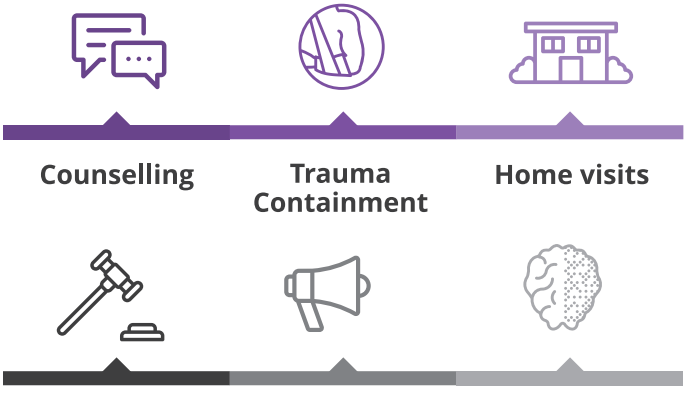
DSD is assisting well and preparing visits within the court and prosecution system. However, victims are not always being referred to DSD for follow-up and long-term psychosocial support.

NGOs

The NGOs are delivering a very important service within the Mpumalanga TCCs and 60% of the TCCs in Mpumalanga have an NGO working with them

Mpumalanga TCCs with an NGO

The services offered by most NGOs working in TCCs in Mpumalanga are counselling, trauma containment and home visits, court preparation and awareness campaigns.



'They do the work that many of the VAOs are supposed to do within the TCCs' ~ *NPA key informant*

Table 12 highlights the TCC site-specific findings.

Table 12. Summary of Mpumalanga TCC findings

	Themba TCC	Tonga TCC	Ermelo TCC	Evander TCC	Emalahleni TCC
TCC location	Inside hospital	Park home	Park home	Park home	Inside hospital
Security guard/s assigned to TCC	✗	✗	✗	✗	✗
CCTV camera/s	✗	✗	✗	✗	✗
Secured entrances	✓	✓	✓	✓	✗
Separate perpetrator/suspect entrance	✗	✓	✓	✓	✗
Sign outside TCC with name	✓	✓ no name	✓ no name	✓	✓
24 hour service	✓	✗	✓	✓	✓
TCC linked to Sexual Offences Court	✓	✓	✗	✓	✗
Waiting time	30 min	none	15 min	10 min	30 min
Essential services offered	✓	✓	✓	✓	✓
Essential facilities available*	✗	✓	✗	✓	✓
Essential equipment available*	✗	✓	✗	✗	✗
Site coordinator	✓	✗	✓	✓	✓
Victim assistance officer	✗	✓	✗	✗	✓
Case manager	✓	✗	✗	✗	✗
Forensic nurse	✓	✓	✓	✓	✓
Doctor	✗	✗	✗	✗	✗
Social worker	✗	✗	✓	✗	✗
SAPS officer	✗	✗	✗	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓
NGO at TCC	✓	✓	✓	✗	✗

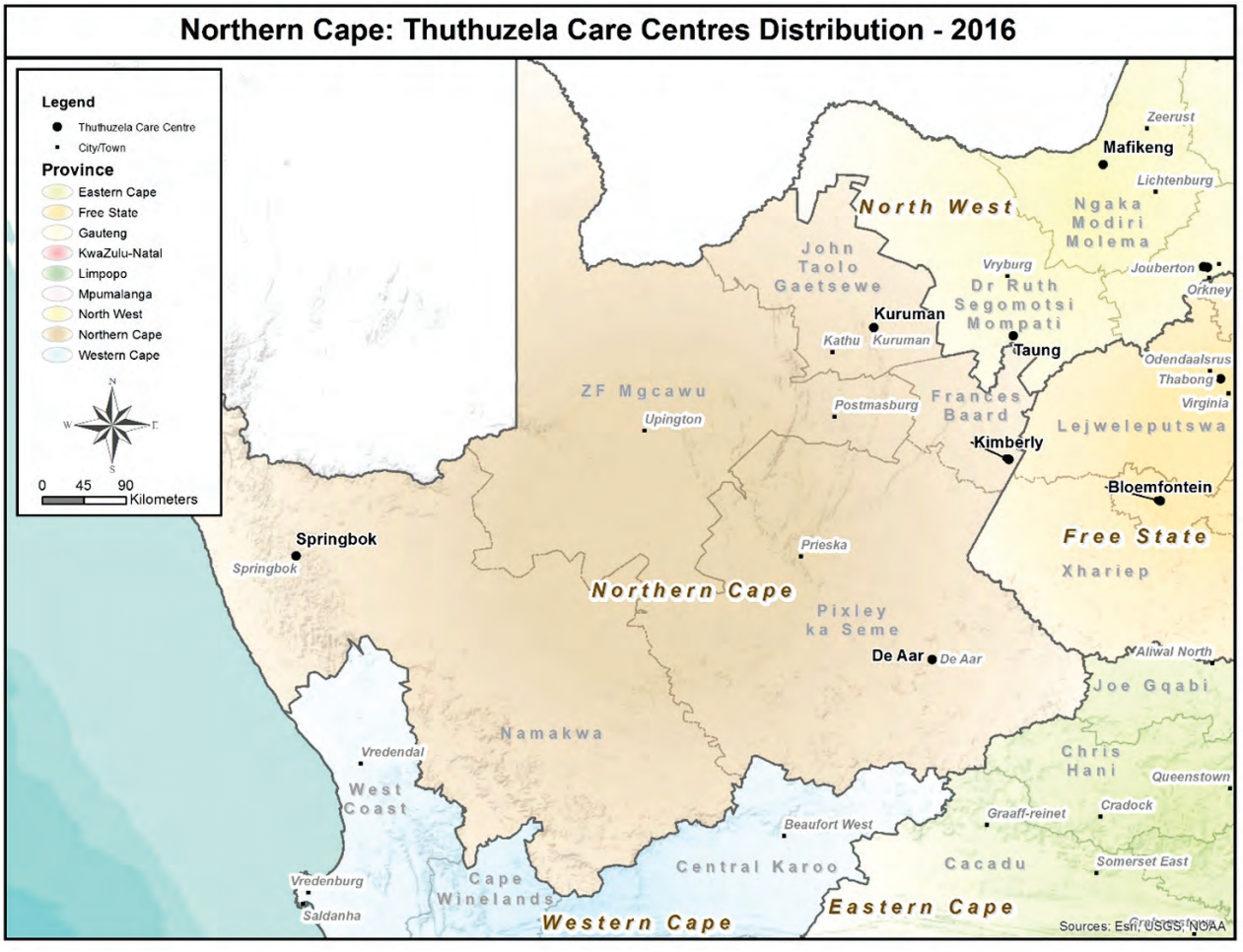
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

8. TCCs in Northern Cape

Northern Cape

Springbok	Springbok TCC, Van Niekerk Hospital *(Springbok Hospital)*
Kuruman	Kuruman TCC, Kuruman Hospital
Kimberly	Galeshwe TCC, Galeshwe Day Hospital
De Aar	De Aar TCC, Central Karoo Hospital



FPD interviewed one regional manager in the Northern Cape. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

8.1. Governance and operational challenges

The monthly implementation meetings are going well and this assists with the functioning and governance of the TCCs in the Northern Cape. There is, however, a problem with the dual reporting lines, where the case managers reports to the regional manager and the site coordinators and VAOs report to the Director: Administration at head office. Lastly, the regional manager is not based in the Northern Cape, influencing strategic management and decision making.

8.2. Facilities and sites

Half of the TCCs in the Northern Cape are located in park homes, one is located inside the hospital and one is located in a building outside the hospital.

Location of TCCs in the Northern Cape

Only one TCC in the Northern Cape had security, and this TCC had contracted a private security company. None of the TCCs in the Northern Cape have CCTV cameras.

Security guards in Northern Cape TCCs

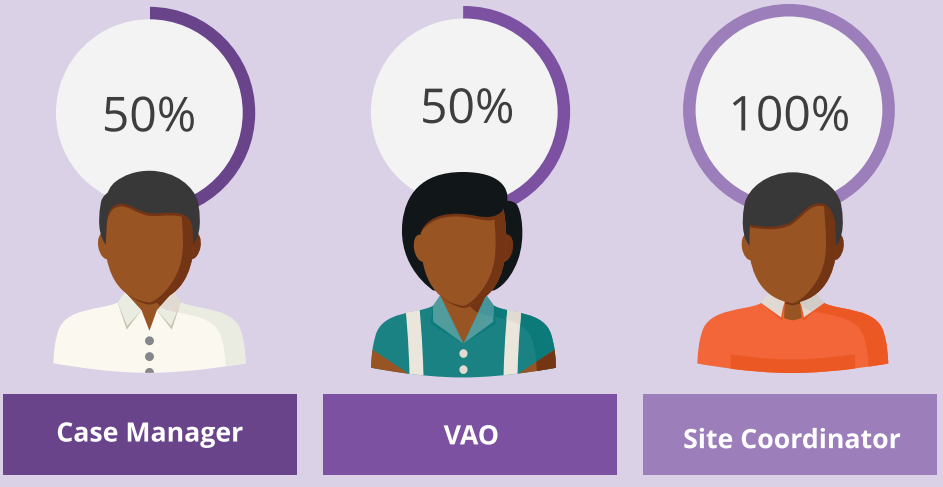
8.3. Factors influencing quality of services delivered

Human resources

All of the TCCs in Northern Cape have a site coordinator. Only two (50%) have a VAO and case manager. Recruitment and retention of staff in the Northern Cape is a problem. All TCCs in the Northern Cape mentioned that they do not receive adequate debriefing.

> 'There's a definite challenge around human resource within all departments in the Northern Cape'
> *~ NPA key informant*

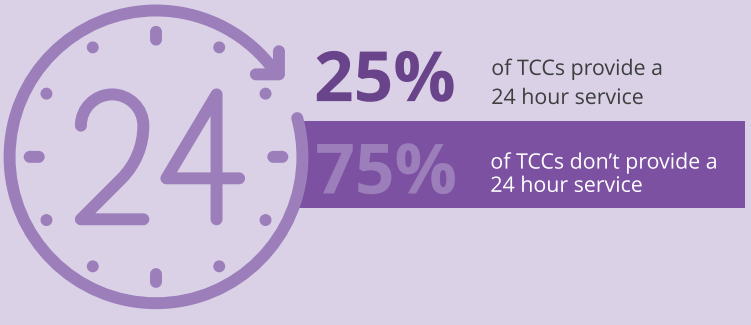
NPA Staff in Northern Cape TCCs



Accessibility

Only one TCC in the Northern Cape (25%) is open 24 hours a day. They are able to do so because of the NGO working within the TCC.

Hours of service in Northern Cape TCCs



'NPA staff work office hours only, they start at 08:00 in the morning and leave at 16:30, after that, the NGOs steps in with their volunteers' ~ *NPA key informant*

Overall the TCCs in the Northern Cape were victim friendly. They all had a private and confidential environment. None of the TCCs had a separate examination room for suspects which means that suspects and clients are examined in the same room. Half of the TCCs were child friendly and three TCCs were disabled friendly.

Victim-friendliness of Northern Cape TCCs

There are numerous challenges with regards to accessibility to the TCCs in the Northern Cape. This is a large province, which limits access to the TCCs. Some victims travel up to three hours to access a TCC after sexual assault. There is also a language barrier between the TCC staff and the victims, which limits the accessibility to the TCCs.

Health services

Only one TCC had a doctor and one TCC had three forensic nurses. Two TCCs (50%) had neither a doctor nor forensic nurse, compromising their ability to conduct medical forensic examinations at the TCC. Two of the TCCs, Kuruman and Springbok, do not have health services on site. At De Aar, the casualty centre of the hospital is very close.

Psychosocial support

Only one TCC in the Northern Cape has a social worker within the TCC and none have a SAPS officer within the TCC. This is influencing the ability to provide psychosocial support and can lead to secondary victimisation.

Equipment and supplies

None of the TCCs in the Northern Cape have adequate equipment and supplies to deliver the services required.

8.4. Stakeholder challenges

There is a problem with ensuring that all stakeholders are on board. Many government departments see the TCCs as an NPA project, and do not accept their responsibility.

> 'It's not a reluctance, but there's no urgency. I don't think it's malicious, but there's a sense that there's time to do things' ~ *NPA key Informant*

DoH

It is reported that there is a high turnover of hospital CEOs in the Northern Cape. As a result, there is a continuous need to brief any new CEO about the model.

DSD

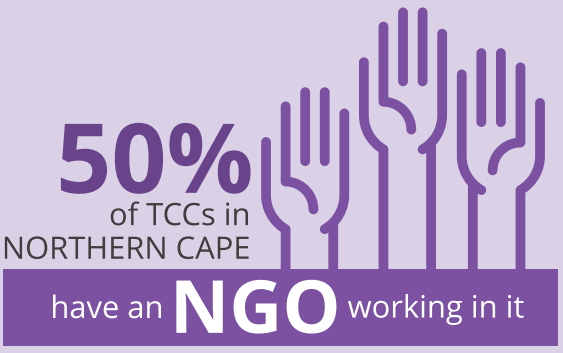
It is a big concern that there are no social workers at all dedicated to the TCCs in Northern Cape. This is influencing the psychosocial support provided to the victims.

> 'Reasons given for the staff situation is shortage of staff, both from DSD and NDoH'
> *~ NPA key informant*

NGO

Two TCCs in the Northern Cape have an NGO associated with them. They both offer counselling and HCT. One NGO ensures that a TCC can be open after-hours.

TCCs in the Northern Cape with an NGO



Services offered by NGOs in the Northern Cape

Table 13 below highlights the TCC site-specific findings.

Table 13. Summary of Northern Cape TCC findings

	Springbok TCC	Kuruman TCC	Galashwe TCC	De Aar TCC
TCC location	Park home	Park home	Building outside hospital	Inside hospital
Security guard/s assigned to TCC	✗	✗	✓	✗
CCTV camera/s	✗	✗	✗	✗
Secured entrances	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✗	✓	✗	✗
Sign outside TCC with name	✓	✓	✗	✓
24 hour service	✗	✗	✗	✓
TCC linked to Sexual Offences Court	✗	✗	✓	✓
Waiting time	10 min	none	none	20 min
Essential services offered	✓	✗	✓	✓
Essential facilities available*	✓	✗	✓	✗
Essential equipment available*	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓
Victim assistance officer	✗	✓	✓	✗
Case manager	✗	✗	✓	✓
Forensic nurse	✗	✗	✓	✗
Doctor	✗	✓	✗	✗
Social worker	✗	✗	✓	✗
SAPS officer	✗	✗	✗	✗
Staff received refresher training	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓
NGO at TCC	✗	✗	✓	✓

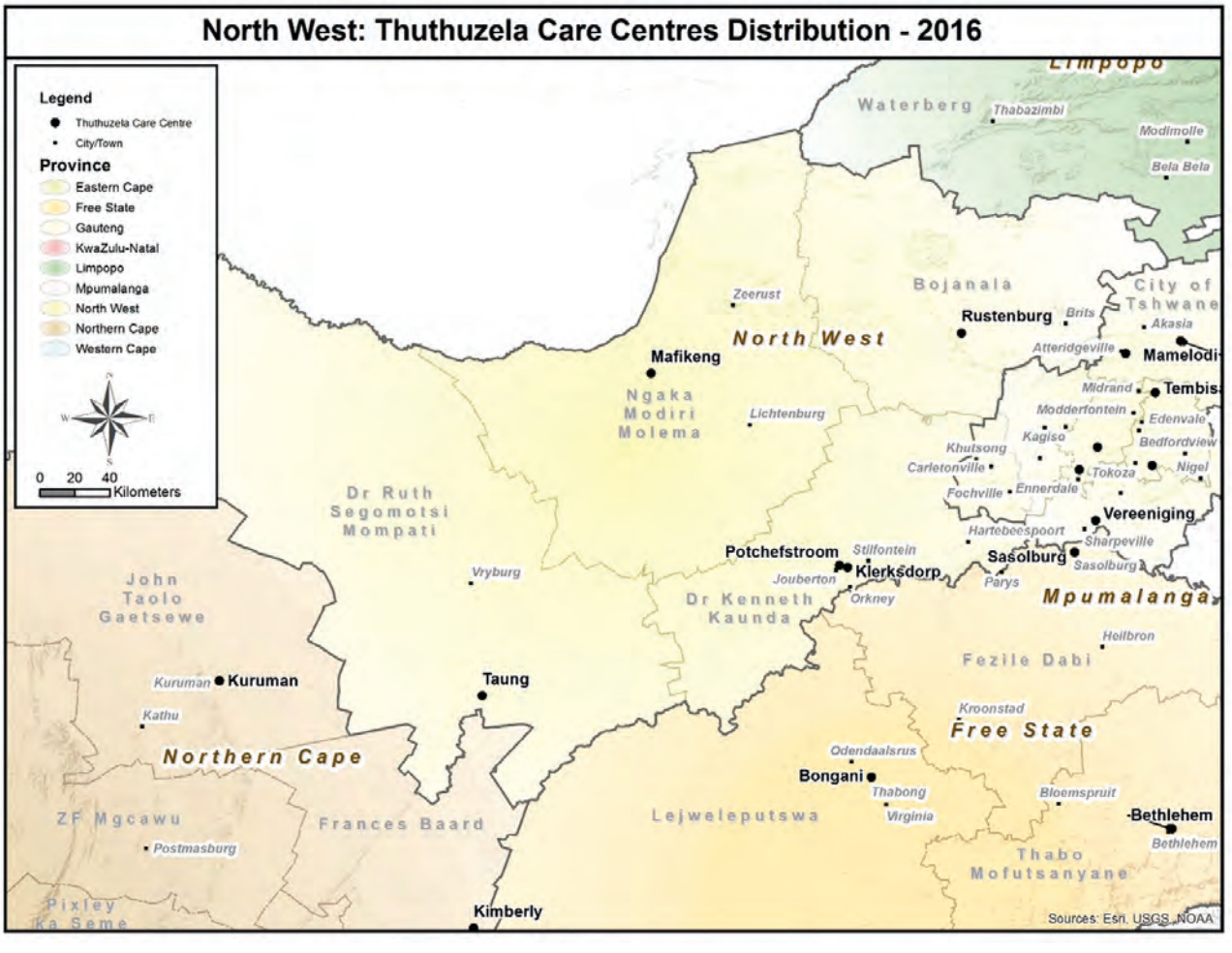
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

9. TCCs in North West

North West

Rustenburg	JS Tabane TCC, JS Tabane Hospital
Potchefstroom	Potchefstroom TCC, Potchefstroom Hospital
Mahikeng	Mahikeng TCC, Mahikeng Provincial Hospital
Klerksdorp	Klerksdorp TCC, Klerksdorp Hospital
Taung	Taung TCC, Taung District Hospital



FPD interviewed one regional manager in the North West. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below.

1.9. Governance and operational challenges

The general functioning of the TCCs in the North West is good and the monthly implementation meetings are assisting with this. Each TCC has its own challenges, which need to be addressed separately. There are apparently disciplinary problems related to the dual reporting lines.

'You simply don't have control over some of the staff' ~ *NPA key informant*

There is inadequate communication between TCCs and the relevant judicial and court processes, and this inhibits case finalisation.

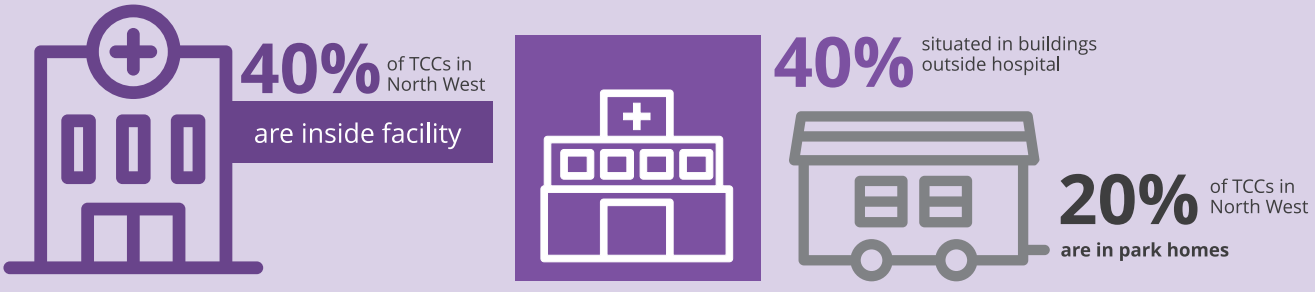
Another problem is that the regional manager is also responsible for various other tasks, compromising time available for TCC-related work. The regional manager of the North West TCCs is based within the province.

'It feels I'm constantly putting out fires' ~ *NPA key informant*

9.2. Facilities and sites

A total of 20% of the TCCs in the North West are located in park homes. 40% are located inside the hospital building and the remaining 40% are located in a building outside the hospital. Only one TCC reported that they have the essential facilities required to deliver services.

Location of TCCs in the North West



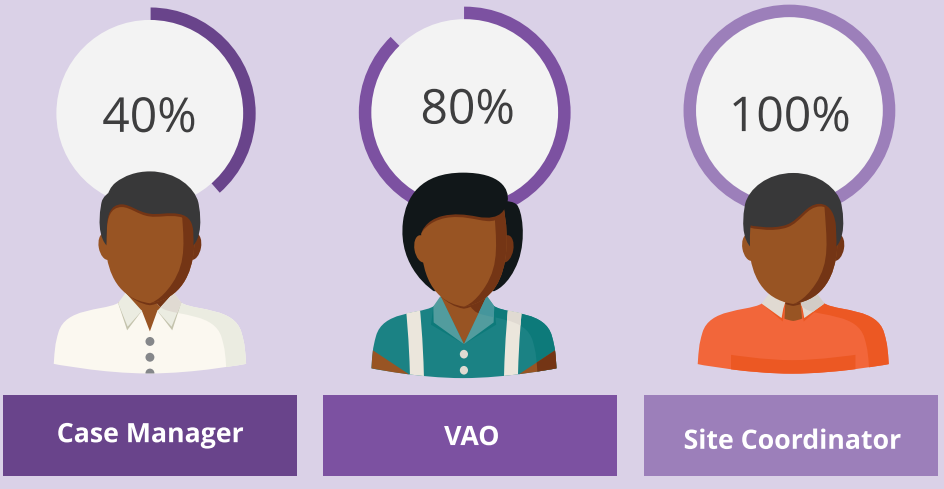
The majority (80%) of TCCs in the North West do not have any security guards allocated to them. None of the TCCs in the North West have CCTV cameras.

9.3. Factors influencing quality of services delivered

Human resources

All TCCs in the North West have a site coordinator, 80% have a VAO, and 40% have a case manager. None of the TCCs reported that the staff receive adequate debriefing.

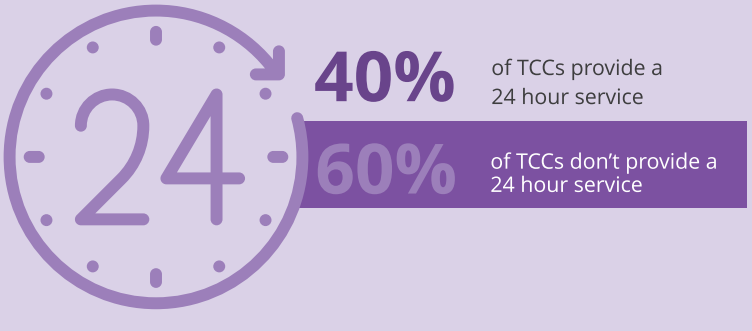
Percentage of TCCs with NPA staff



Accessibility

The majority (60%) of TCCs in the North West are not open 24 hours a day. The two TCCs that are able to provide services 24 hours a day are able to do so because of the NGOs working in them. The TCCs and NGOs are Potchefstroom TCC (Tlokwe Crisis Centre) and Mahikeng TCC (Lifeline).

Hours of service in North West TCCs



Only one TCC (Potchefstroom TCC) in the North West is completely disabled friendly, with both wheelchair access and disabled friendly ablutions. One TCC (Potchefstroom TCC) was child friendly, with a room and toys for children to play with.

None of the TCCs had both a separate entrance and examination room for suspects. Two TCCs (40%) had a separate exam room for suspects. None of the TCCs reported having a separate entrance for suspects.

Victim-friendliness of North West TCCs

Health services

A total of 60% of TCCs in the North West have at least one forensic nurse and 40% have a doctor. Only one TCC (20%) had neither a doctor nor a forensic nurse. There is a major problem with ensuring that forensic nurses remain within the TCCs. It is reported that after their one year training, they start at the TCCs, but are frequently transferred by the District DoH to other facilities. As a results the victims then need to wait in the casualty section at the hospital for the required medical and forensic investigation. Some victims wait up to three hours for this. None of the TCCs reported that they deliver all the essential services at the TCC.

Equipment and supplies

There is inadequate access to internet and telephone lines within the provinces' TCCs. It is also reported that scanners are needed, specifically to ensure that all stakeholders have access to the required documentation. All TCCs reported that they do not have adequate equipment to deliver services.

Transport

Transport for victims is a major problem. Many do not have access to transport and as a result, they do not access the required follow-up medical services or psychosocial support. Access to transport also limits the victims' ability to attend court.

9.4. Stakeholder challenges

Not all the relevant stakeholders within the TCC model provide adequate support to the TCCs in North West.

> 'Difficult to have all stakeholders on board all of the time, this remains a major challenge'
> *~ NPA key informant*

DoH

The relationship with DoH is good at provincial level and there is commitment to the model. However, ensuring that district DoH is on-board is a problem and it appears that there is inadequate communication between the provincial DoH and district DoH about the TCCs.

Another major issue for the TCCs in North West is that DoH have launched a number of Kgomotso Care Centres in the North West and have asked the regional manager that the current TCCs be transformed to Kgomotso Care Centres. This is not going to be implemented, but the two different models are confusing to some of the other stakeholders, especially the SAPS. They are now not sure which centre to transport victims to.

NGOs

The majority (60%) of TCCs in the North West have an NGO working within the TCC.

TCCs in the North West with an NGO

Services provided by NGOs in the North West

Counselling

HCT

Table 14 highlights the TCC site-specific findings.

Table 14. Summary of North West TCC findings

	Rustenburg TCC	Potchefstroom TCC	Mahikeng TCC	Klerksdorp TCC	Taung TCC
TCC location	Inside hospital	Park home	Inside hospital	Building outside hospital	Building outside hospital
Security guard/s assigned to TCC	✗	✗	✓	✗	✗
CCTV camera/s	✗	✗	✗	✗	✗
Secured entrances	✗	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✗	✗	✗	✗	✗
Sign outside TCC with name	✓	✓	✓	✓	✓
24 hour service	✗	✓	✓	✗	✗
TCC linked to Sexual Offences Court	✓	✓	✓	✓	✗
Waiting time	very long	10-15 min	30 min	4 hrs	30 min
Essential services offered	✗	✗	✗	✗	✗
Essential facilities available*	✓	✗	✗	✗	✗
Essential equipment available*	✗	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓
Victim assistance officer	✓	✓	✓	✗	✓
Case manager	✓	✓	✗	✗	✓
Forensic nurse	✗	✓	✓	✗	✓
Doctor	✓	✗	✓	✗	✗
Social worker	✓	✓	✓	✗	✓
SAPS officer	✗	✗	✓	✗	✓
Staff received refresher training	✓	✓	✓	✗	✓
Staff receive debriefing	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓
NGO at TCC	✓	✓	✓	✗	✗

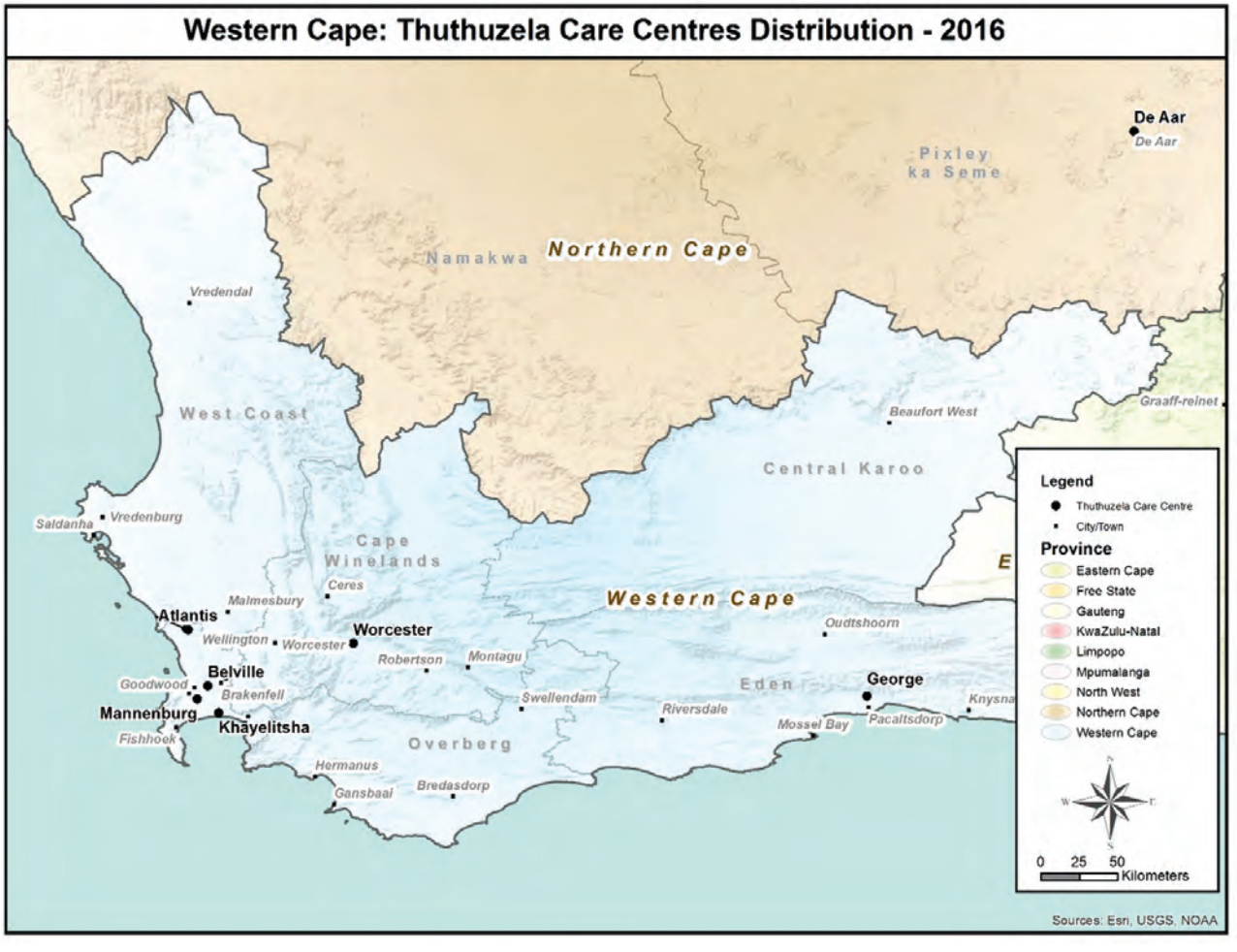
** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

10. TCCs in the Western Cape

Western Cape

Worcester	Worcester TCC, Worcester Hospital
Mannenburg	Mannenburg TCC, GF Jooste Hospital
Bellville	Karl Bremer TCC, Karl Bremmer Hospital
Atlantis	Wesfleur TCC, Wesfleur Hospital
George	George TCC, George Provincial Hospital
Khayelitsha	Khayelitsha TCC, Khayelitsha Hospital & CHC



FPD interviewed three regional managers in the Western Cape. The survey team interviewed VAOs or site coordinators within the TCCs. The findings based on the interviews and the survey are discussed below. The Kayelitsha TCC is not included in these findings, as there was no site manager or VAO available during the survey period.

10.1 Governance and operational challenges

The monthly implementation meetings between stakeholders are going well. There is a serious problem with the dual reporting lines where the case managers report to the regional managers and the administrative staff report to the Director: Administration at head office. In some instances, the relationship has been seen as adversarial.

'It is very difficult to manage a site, and be accountable to a site, when they report to somebody else'... 'this is a disparity that should not exist' ... ~ *NPA Key informant*

Some regional managers do not visit the TCCs as often as would be preferred, because the province is large. All regional managers are based in the province.

10.2 Facilities and sites

Only one TCC in the Western Cape is located in a park home. Two are located inside the hospital, and two in buildings outside the hospital. Only one TCC reported that they have the essential facilities to deliver services.

Location of TCCs in the Western Cape

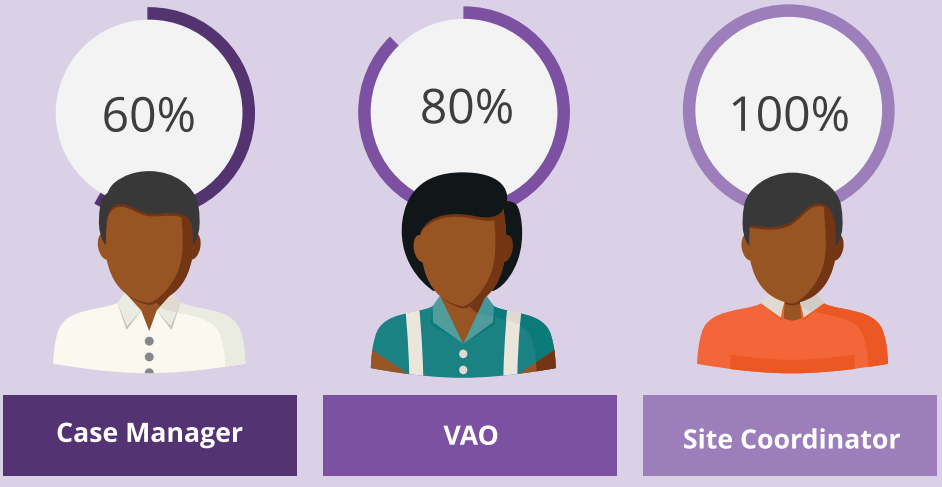
There is a concern the regarding the safety of after-hours staff. At least 60% of the TCCs in the Western Cape have CCTV cameras at the site (Mannenburg, Wesfleur and George). None of the TCCs in the Western Cape have security guards assigned to them.

10.3 Factors influencing quality of services delivered

Human resources

The staff retention at the TCCs in the Western Cape is very good. All TCCs in the Western Cape have a site coordinator. A total of 80% have a VAO and 60% have a case manager. However, it takes a long time to fill staff vacancies and this limits service delivery. It is reported that there is inadequate debriefing of staff.

NPA staff in Western Cape TCCs

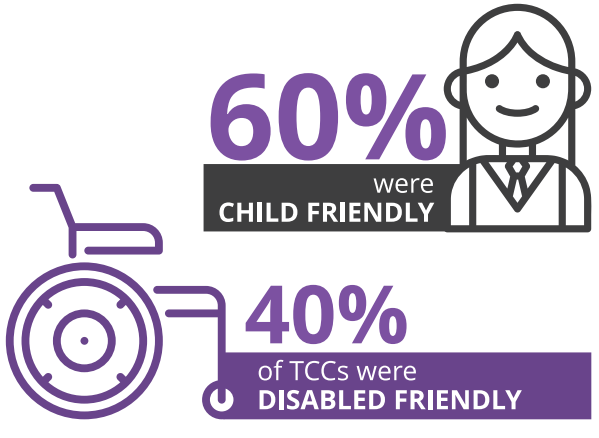


Accessibility

All of the TCCs who were part of the study are open 24 hours a day and all have NGOs working within the TCC to assist with this.

Hours of service in the Western Cape TCCs

All of the TCCs in the Western Cape have a private and confidential environment. None of the TCCs have both a separate entrance and examination room for suspects. A total of 60% of the TCCs are child friendly and 40% of them are disabled friendly.



Victim-friendliness of TCCs in the Western Cape

It is reported that there are serious language barriers between the TCC staff and child victims in particular.

Health services

A total of 80% of the TCCs in the Western Cape have a doctor allocated to them and 40% have a forensic nurse. It is reported the DoH personnel, specifically doctors, are not adequately sensitised to work with victims of GBV.

Psychosocial support

The lack of adequate counselling is affecting the court processes and there is not enough support for mentally challenged victims or child victims. There is also insufficient trauma debriefing for the victims or the personnel. None of the TCCS in the Western Cape have social workers or SAPS officers within the TCC. This limits psychosocial support and can lead to secondary victimisation.

Equipment and supplies

There is a concern that TCCs in the Western Cape do not have adequate access to computers, additional ICT services, groceries and comfort packs. This needs to be addressed. None of the TCCs reported that they have adequate equipment to deliver services.

Transport

There's a serious need to look into the transport problems experienced by victims. Limited access to transport means that victims are not accessing follow-up medical care or follow-up psychosocial support.

10.4. Stakeholder challenges

The TCCs in the Western Cape have put in a major effort to build and sustain stakeholder relationships. As a result, the TCCs have an excellent relationships with the relevant stakeholders.

DoH

It is reported that the TCCs in the Western Cape have an excellent relationship with DoH.

DSD

There is generally a good relationship between DSD and the TCCs. More forensic social workers are needed to help children give statements and there is not enough support for adult victims. In general the communication between the NPA and DSD is slow.

SAPS

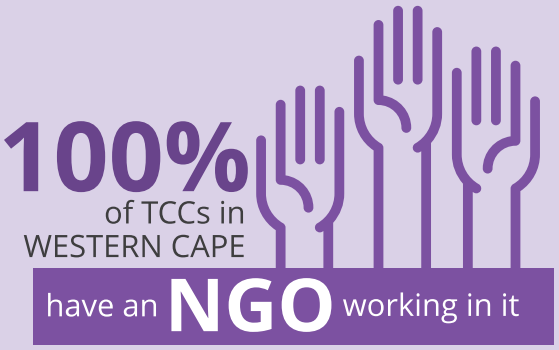
The TCCs in the Western Cape have an excellent relationships with SAPS. However the FSC units are severely understaffed.

> 'This has a ripple effect on how cases are managed and how cases are dealt with' ~ *NPA key informant*

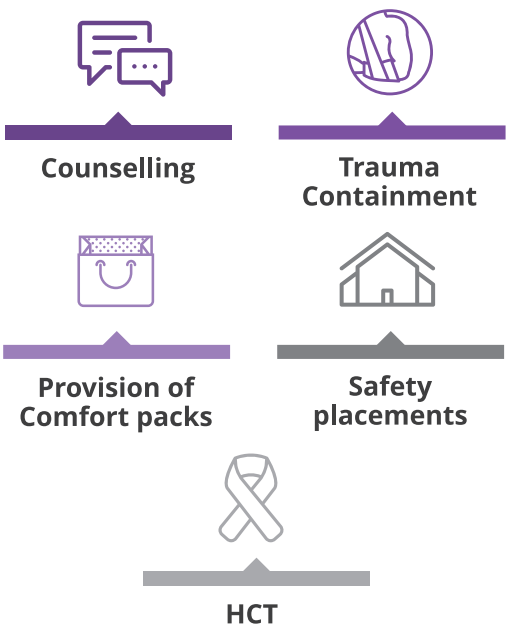
NGOs

All the TCCs in the Western Cape have an NGO and the TCCs in the Western Cape have very strong relationships with their associated NGOs they add tremendous value to the model.

Western Cape TCCs with an NGO



Services provided by NGOs in the Western Cape



More ICT materials are needed for raising awareness of the TCCs.

Table 15 highlights the TCC site-specific findings.

Table 15. Summary of Western Cape TCC findings

	Worcester TCC	Mannenburg TCC	Karl Bremmer TCC	Wesfluer TCC	George TCC
TCC location	Inside hospital	Building outside hospital	Building outside hospital	Park home	Inside hospital
Security guard/s assigned to TCC	✗	✗	✗	✗	✗
CCTV camera/s	✗	✓	✗	✓	✓
Secured entrances	✗	✓	✓	✓	✓
Separate perpetrator/suspect entrance	✗	✗	✓	✓	✗
Sign outside TCC with name	✓	✓	✓	✓	✓
24 hour service	✓	✓	✓	✓	✓
TCC linked to Sexual Offences Court	✗	✓	✗	✓	✓
Waiting time	2 hrs	none	10 min	Under 2 hrs	2 hrs
Essential services offered	✓	✓	✓	✓	✗
Essential facilities available*	✗	✗	✗	✓	✗
Essential equipment available*	✗	✗	✗	✗	✗
Site coordinator	✓	✓	✓	✓	✓
Victim assistance officer	✗	✓	✓	✓	✓
Case manager	✓	✗	✓	✗	✓
Forensic nurse	✓	✓	✗	✗	✗
Doctor	✗	✓	✓	✓	✓
Social worker	✗	✗	✗	✗	✗
SAPS officer	✗	✗	✗	✗	✗
Staff received refresher training	✓	✓	✓	✓	✓
Staff receive debriefing	✗	✗	✗	✗	✗
Staff are supervised	✓	✓	✓	✓	✓
NGO at TCC	✓	✓	✓	✓	✓

** Essential facilities include private ablution facility with bath or shower, disabled friendly ablution, medical examination rooms, waiting room, office for statement taking, VAO office, site coordinator office, NGO room, children's room, and a room for clients to rest in.*

** Essential equipment includes access to a computer, telephone, internet, forensic medical examination light, speculum, colposcope and gynae couch*

CHAPTER 5: RECOMMENDATIONS

In order to improve the service delivery and functioning of the TCCs, the team who conducted the compliance audit and gap analysis have a number of recommendations. The recommendations are structured in the same manner as the findings in the previous chapter.

1. Governance and operational recommendations

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

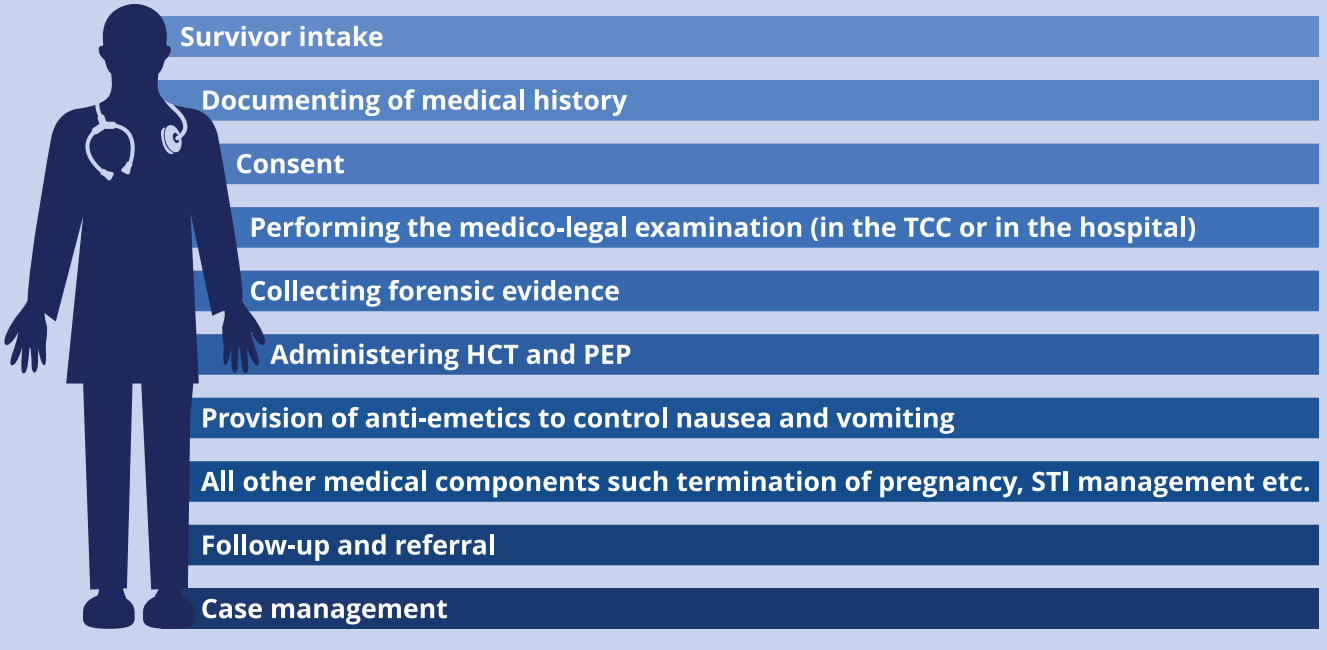
Operational management and administration needs to be decentralised. A provincial management structure should be put in place for the administrative component of the model. This will also assist with reporting structures within the TCC and the management of staff at a decentralised level.

The regional TCC managers should be based in the provinces in which they're responsible for TCCs. This will assist with better oversight of the TCCs.

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

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

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



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

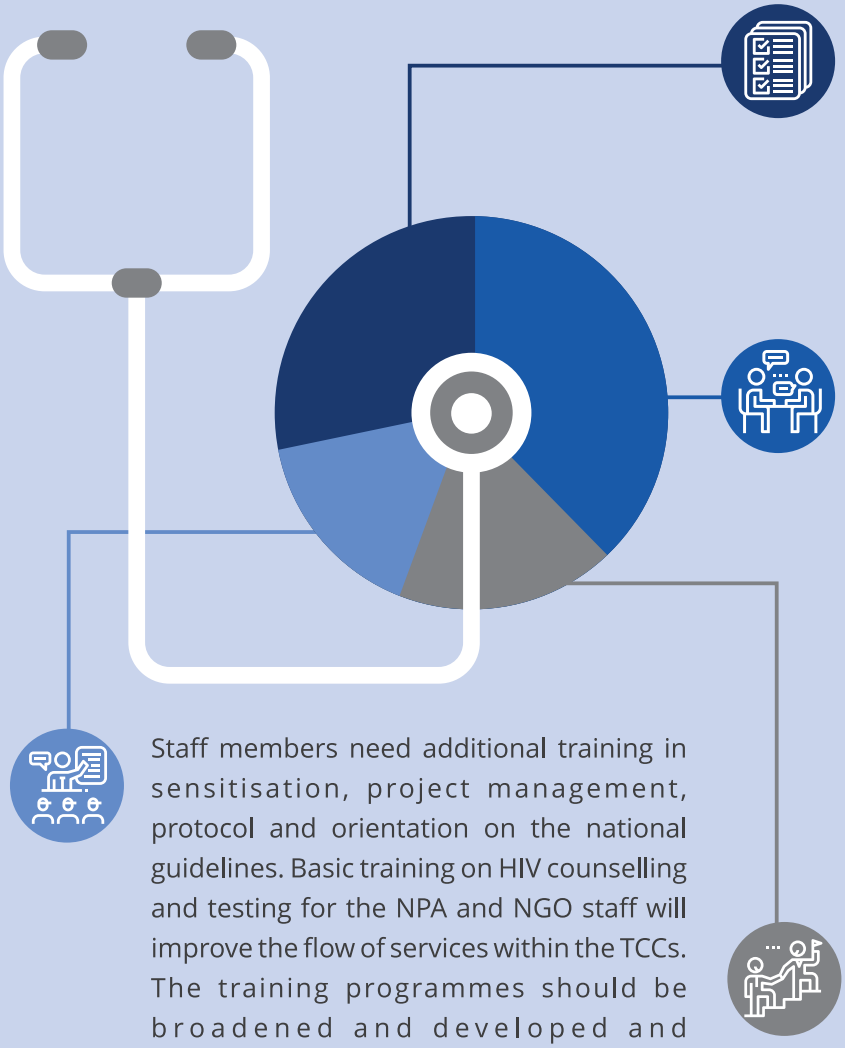
There should be better consultation with all stakeholders involved regarding the positioning of new TCCs. This should be linked to other services available in the area, stakeholder involvement and the burden of GBV cases.

2. Recommendations to improve service delivery

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

2.1. Human resources

Most TCCs do not have the full staffing complement as prescribed by the TCC Blueprint. The NPA is in the process of filling most of the vacant case manager posts. It is imperative that TCCs with a higher case load be fully staffed, preferably with the ability to function over 24 hours.



The disciplinary procedures and management of staff (specifically site coordinators and VAOs) need to be improved. A decentralised operational management and administration system at provincial level will assist with this.

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

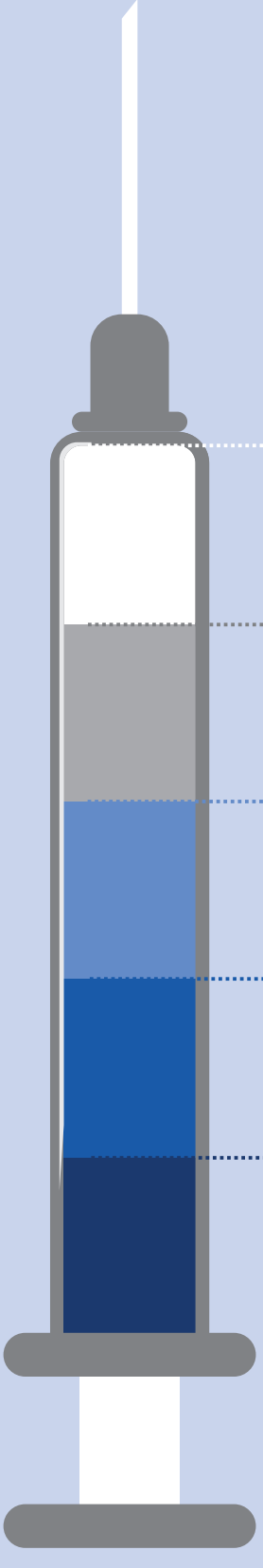
TCCs with a higher caseload require a dedicated administrator.

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

2.2. Accessibility

Ideally, all TCCs should be fully operational 7 days a week, 24 hours a day. This is, however, unlikely. To compensate for this, it is recommended that all TCC sites develop a coordinated system involving the NGOs, casualty staff, hospital security, SAPS and NPA staff so that victims of GBV are treated quickly and confidentially. Victims who present after hours must not be subjected to secondary victimisation. This system should include all the TCC requirements (private waiting room, comfort packs, clean clothes, and ablution facilities) that the victim would have access to during the day.

At site level TCCs must ensure that all TCCs have ramps for those with physical disabilities, child friendly rooms, and adequate and disabled friendly ablution facilities.



2.3. Health services

To ensure that adequate health services are delivered it is recommended that DoH ensure that all TCCs have a forensic nurse or a doctor allocated to them. The ideal is that there should be either a doctor or forensic nurse available to assist the TCC 24/7.

TCCs should not rely casualty rooms to provide essential medical services to victims. There should be a dedicated roster to ensure that there is always an after-hours forensic nurse or doctor available for the TCC. The coordinated system mentioned above will also assist with this.

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

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

It is recommended that all TCCs have a tracking tool that can track all the health-related services provided to the victim, including follow-up support and link to case management. The referral linkages should be formalised to ensure that all necessary government departments are involved, to ensure departmental ownership and accountability.

2.4. Psychosocial support

It is recommended that the NPA, together with DSD, strengthen the capacity to deliver appropriate shorter-term and long-term psychosocial support to victims. This can be delivered by NGOs, but there needs to be clarity on the funding required for this. There needs to be a clear protocol for the services delivered by NGOs and the services delivered by DSD staff.

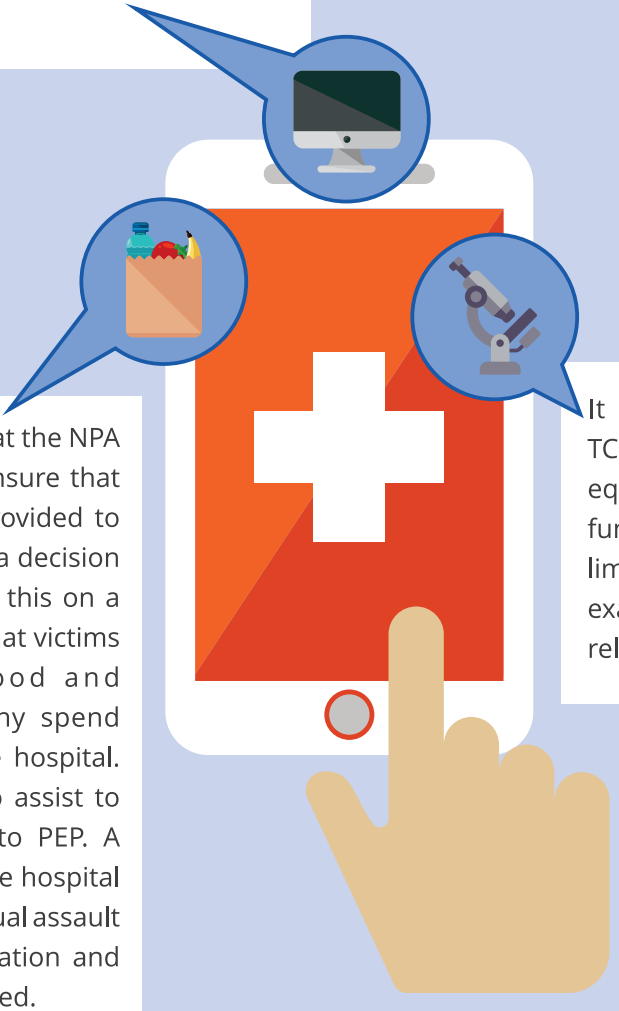
It is recommended that at least one social worker or psychologist be appointed per TCC, to ensure long-term psychosocial support. Where this is not possible, it is recommended that the NPA meet with DSD regarding the availability of social workers and psychologists and reducing the waiting times for victims.

The TCCs, together with the NGOs and DSD need to track referred clients and ensure that they receive long-term psychosocial support. It is recommended that the NPA, together with the NGOs, investigate the ways in which psychosocial support is provided to clients in rural areas and clients who are far removed from the TCC.

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

2.5. Equipment and supplies

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



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

It is recommended that all TCCs be supplied with working equipment to ensure that the functioning of the TCCs is not limited. This includes medical examination tools and all ICT related equipment.

2.6. Transport

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

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

2.7. TCC sites

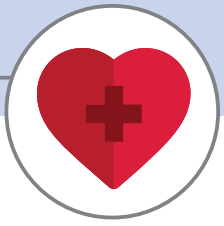
It is recommended that the NPA, donors and DoH ensure that the TCCs that are in park homes become part of the hospital refurbishment programmes.

It is important that all TCCs have adequate space to safeguard the privacy and confidentiality of victims, and to ensure that they do not come into contact with suspects.

3. Stakeholder relationships

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

There have been a number of recommendations regarding where the TCCs should be housed and if the NPA is the most appropriate department for the model. The team cannot make a recommendation in this regard. However, a possible solution might the rotate the leadership of the model every two years. This will also assist with ensuring accountability across departments.



3.1. DoH

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

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

The NPA and DoH must meet a national level to discuss the functioning and positioning of the Kgomotso Care Centres, as the current lack of communication is confusing other stakeholders, such as SAPS.

3.2. DSD

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

DSD need urgently to improve their support to child victims, as this is major concern in the current model.

DSD and the NGOs delivering services within in the TCCs meet and discuss the salaries of counsellors and lay-counsellors. It is recommended that the positions are made professional and put on the same level and pay scale as auxiliary social workers.

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

3.3. SAPS

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

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

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

4. NGOs as service providers

It is recommended that the NGOs collaborate with CBOs within rural areas to ensure that long-term psychosocial support is provided. DSD should facilitate these discussions.

All stakeholders who report on indicators (DSD, DoH, donors and NGOs) need to meet at a provincial level to agree on access to information and reporting on indicators. There must also be an agreement on how NGOs can report on their work and how DSD and donors verify this.

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

There is a need for innovation, greater efficiency and capacity development to build resilience within the NGO sector.

NGOs who are working within the TCCs need more information and training on the TCC model and their role in it.

5. Other recommendations

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

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

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

The team identified a number of important stakeholders who are not currently involved, and should become part of the model. These include the Department of Basic Education, the Department of Higher Education and Training and the Department of Correctional Services.

The current TCC-related indictors should be broadened to not only focus on output indicators relating to number of cases finalised, but also investigate and measure the outcomes on services on survivors.

IEC materials must available in the language most used in the TCC catchment area to ensure that community awareness is increased. The scope of the materials should also be broadened to ensure that care givers know how to support child victims. In addition more community awareness regarding the existence and services of the TCCs is needed.

All donations to the TCCs should be channelled through a central (or provincial) structure to ensure

that all sites have equal access to comfort packs, toys and underwear.

A key informant recommended the development of a toll free number dedicated to GBV that operates in the same manner as the SAPS 10111 number. Ideally, the local would FCS collect the victim and provide transport to the nearest TCC.

There is a major concern about the excessive amount of research conducted at TCCs, and information not shared adequately among stakeholders. TCCs and related stakeholders are experiencing research fatigue and there is a need for a more coordinated approach.

CHAPTER 6: CONCLUSIONS

This compliance audit and gap analysis was conducted between April and October 2016 using a mixed methods approach of key informant interviews and an application-based survey using tablets. Interviews and data collection took place between May and September 2016. Some statistics, specifically those on staffing, might have changed, as the NPA was appointing new case managers during this time.

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

One of the greatest strengths of the TCC is the multisectoral approach, bringing all services and stakeholders together (i.e. NPA, DoH, DSD, SAPS and various NGOs). This is also the model's greatest weakness, as not all stakeholders are equally involved and there is no way to ensure accountability. This varies across and within provinces. There is inadequate accountability from all stakeholders, and while relationships are generally good at national and provincial level, relationships and accountability need to be improved at district and facility level.

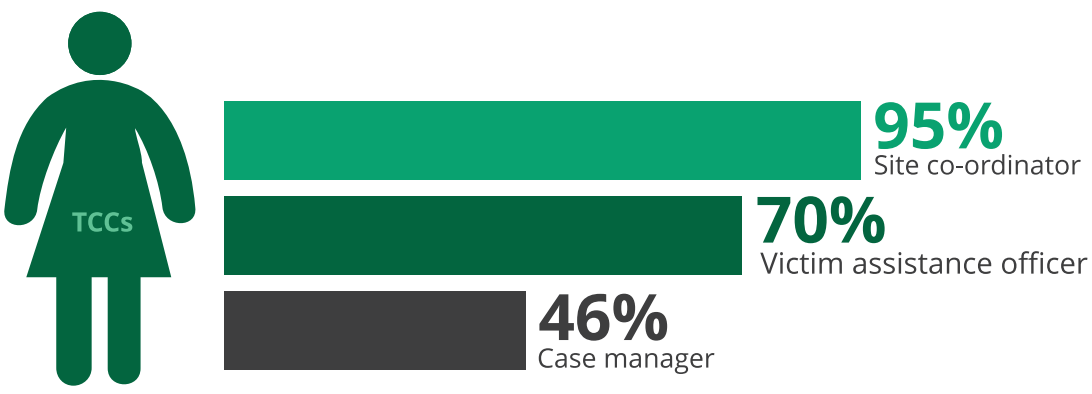
The findings show that governance of TCCs is too centralised and this is negatively influencing HR relationships. There are serious disciplinary and accountability issues that need to be addressed. Many regional managers are not based in the provinces where they are responsible for the functioning of the TCCs and this compromises their work.

Half of all TCCs are based in park homes, and the remainder are either in buildings outside the hospital or based within the hospital. At some sites there have been issues around the security of after-hours staff, particularly if the TCC is based in a park home or outside the hospital.

Victim friendliness in TCCs is still a major problem. There is still a lot of secondary victimisation of because sites are not victim friendly, EMS and SAPS staff are insensitive and counselling rooms and privacy within the TCCs is inadequate. Not all TCCs are child friendly, in spite of the fact that almost 60% of cases are children. Although 80% of all TCCs do provide comfort packs there is an additional need for basic groceries to provide food and beverages to victims.

Most, but not all, services are delivered according to the TCC Blueprint. There are still facilities that are not structured according to the Blueprint. Many key informants highlighted the lack of adequate, private counselling space.

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



Human resources

Almost 95% of TCCs have a site co-ordinator, and 70% a VAO, but only 46% have a case manager. A major problem with the TCCs is the lack of adequate and continuous debriefing in a very stressful and emotionally demanding work environment.

Accessibility

Seventy percent of all TCCs provide a 24/7 service. However, most health services are not available within the TCC after hours. Victims are either referred to the casualty department of hospitals or have to wait for a forensic nurse or doctor to come to the TCC from casualty. Ninety percent of security guards are aware of the location of the TCC.

Health services

Just over 50% of TCCs have at least one DoH staff member dedicated to them, but mainly during the day. The TCC is dependent on casualty staff after hours and during weekends. EMS personnel are not adequately sensitised to work with victims of GBV and do not prioritise victims. Post-exposure prophylaxis (PEP) is provided, but victims usually receive only a starter pack and need to return to the TCC for the remainder of the medication.

Psychosocial support

There are serious concerns about the ability of TCCs to provide long-term psychosocial support. The Department of Social Development (DSD) is not providing adequate social workers and psychologists to the TCCs and some key informants highlighted the language barriers between the victims and the DSD staff.

Equipment and supplies

Most TCCs have the equipment to ensure that they are operational. Almost 89% of TCCs have telephone lines, but most can only receive calls and cannot call out of the hospital. The NGOs working within the TCCs do not have access to these telephones and rely on their own cell phones and air time provided either by the NGO, or sometimes by the counsellors themselves. There is serious concerns about the medical equipment at the TCCs. Although 82% have speculums, only 61% have colposcopes and 37% have either a gynae couch or lithotomy table. This is influencing the health services that can be delivered within the TCC.

Transport

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

There are 21 NGOs who deliver services in 70% of the TCCs. There are some problems with regards to the relationships between the NGO staff, TCC staff and DoH staff. The TCC staff often reported that the NGOs are overstepping their boundaries. The DoH staff often shift reporting and other administrative tasks to the NGO staff. The NGOs feel undervalued and think that their contribution to the functioning of the TCCs is not valued. Without NGOs very few TCCs would be able to deliver a 24/7 service.

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

The evaluation team made a number of recommendations to improve the service delivery and functioning of the TCCs. The recommendations can be summarised as follows:

Governance and operational recommendations

There is a need to legalise the TCCs to ensure that all stakeholders take responsibility and be held accountable for their roles and responsibilities within the model.

Operational management of the TCCs, including the reporting of VAOs and site coordinators, should be decentralised to provincial level.

NPA regional managers should be based in the province they are responsible for.

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

Stakeholder relationships

There needs to be better engagement between stakeholders to ensure commitment from all the relevant stakeholders. It is recommended that the stakeholders meet bi-annually to discuss strategic operations as well as challenges within the TCC model.

NGOs

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

Improvement of service delivery recommendations

All vacant positions should be filled and staff should receive regular, face-to-face debriefing. In TCCs where it is not possible to deliver a 24/7 service there is a need to develop protocols that involve all stakeholders to ensure access to services after hours.

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

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

All TCCs must have the required medical equipment to deliver medical services. In addition to this the NPA needs to ensure that TCCs have access to basic groceries to provide victims with refreshments. It should be investigated if the associated hospital can deliver the service.

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

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

Other

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

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

It is recommended that a toll free GBV helpline is established that will link the victim directly with the local family violence child protection and sexual offences investigation unit (FSC).

Information and Education Communication (IEC) materials must be available in the main language in each areas and be upgraded.

The NPA interdepartmental training materials should be revisited and presented by an accredited institution that can link it to continuing professional development (CPD) points.

The TCCs are experiencing research fatigue. All research done on the model should be better coordinated.

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