

# “It Sucks”/ “It’s a Wonderful Service”

---

Post-rape care and the  
micro-politics of institutions



**act:onaid**

**SHUKUNISA**  
Demand the Center  
calling the system to account

Lisa Vetten  
September 2015

## **Acknowledgements**

This study would not have been possible without the organisations who gave so generously of their time in responding to my many questions. They are thanked for their willingness and patience. The Networking HIV, AIDS Community of South Africa (NACOSA) also played an important role in facilitating access to information, with the opportunity to participate in their meetings providing invaluable insight into the workings of the Thuthuzela Care Centres (TCC). The financial support for this study was provided by the AIDS Foundation and the Human Dignity Foundation (HDF) and their contributions are gratefully acknowledged. HDF supports the Young Urban Women's programme through ActionAid South Africa. ActionAid South Africa is a member of ActionAid International, a global movement of people working together to further human rights and eradicate poverty.

Publication design: Jennifer Geib {writing, layout + design} | [www.jennifergeib.com](http://www.jennifergeib.com)

## **To be cited as:**

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.

**“It Sucks”/  
“It’s a Wonderful Service”**

---

Post-rape care and the  
micro-politics of institutions

Lisa Vetten

Sept 2015

# Foreword

---



admin@mosaic.org.za  
www.mosaic.org.za  
021 761 7585

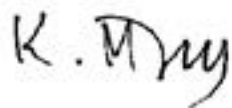
“It is through research reports like this one that we hope to improve our services so that reporting rape becomes easier for rape survivors because they are properly supported and empowered while doing so.”

“MOSAIC began offering psycho-social services in one Thuthuzela Care Centre in July 2009 and is now present in three TCCs and one forensic unit. Although the TCC concept was initiated some time ago, there is still a lot to learn towards developing and evolving the services offered to victims of sexual and domestic violence. These services extend outside of the TCC, where increased education about available services as well as prevention activities are needed. MOSAIC continues to see that the majority of the beneficiaries assisted at the TCC’s where we work are young women, this tells us that there is a great need to address the issue of sexual violence at a broader societal level. Studies like this and programmes such as the Young Urban Women project, ensure that the standard of care and service delivery is continuously improving. MOSAIC strives for service excellence and will continue to nurture the voices of our young women and develop their voices, to become the leaders of tomorrow.”

**Didi Engelbrecht**  
**Director at Mosaic**

---

“Rape Crisis is an organisation that is both a member of the Shukumisa Campaign and a service provider at a number of TCCs in the Western Cape. Our counsellors see a large number of young women at the TCCs. Recently a man came into the TCC in the early hours of the morning with his 17 year old daughter who had been raped at her matric dance. The whole family needed counselling and support through the process of making a statement to the police and finding out what the next steps would be when it came to the medical examination and collecting of physical evidence for DNA analysis in order to link the rapist to the crime and later ensure that he was found guilty in court. This report shows a lot about what is wrong with our TCCs but it also tells the story of what is working well. It is through research reports like this one that we hope to improve our services so that reporting rape becomes easier for rape survivors because they are properly supported and empowered while doing so.”

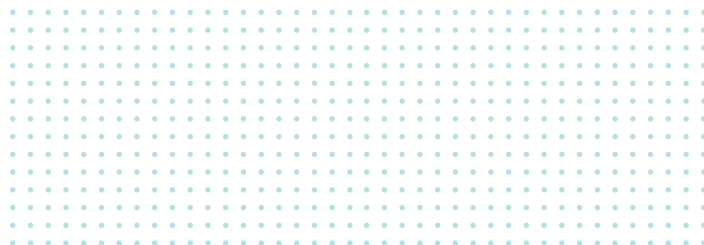


**Kath Dey**  
**Director at Rape Crisis Cape Town Trust**



info@rapecrisis.org.za  
www.rapecrisis.org.za  
021 447 1467

“Although the TCC concept was initiated some time ago, there is still a lot to learn towards developing and evolving the services offered to victims of sexual and domestic violence.”



# List of acronyms

---

Critical Incident Stress Debriefing	CISD
Department of Health	DoH
Department of Social Development	DSD
Expanded Public Works Programme	EPWP
Health counselling and testing	HCT
Interdepartmental Management Team	IDMT
National Prosecuting Authority	NPA
Networking HIV, AIDS Community of South Africa	NACOSA
Non-governmental organisation	NGO
Parliamentary Monitoring Group	PMG
Post-exposure prophylaxis	PEP
Post-traumatic stress disorder	PTSD
Psychological first aid	PFA
Rape Crisis Cape Town Trust	RCCTT
Research Triangle Institute	RTI
Sexual Offences and Community Affairs	SOCA
Sexual Offences and Related Matters Amendment Act	SOA
South African Police Service	SAPS
Thuthuzela Care Centre	TCC
United Nations Children's Emergency Fund	UNICEF

# Contents

---

Foreword	4
List of acronyms	6
Executive Summary	8
Introduction	14
Thuthuzela Care Centres	15
Addressing the mental health consequences of rape	19
Findings	25
Methods	25
Description of services provided by NGOs	27
The TCC service	31
Funding	34
Relationships within the TCCs	39
Concluding recommendations	43
Community-based service providers	44
National Prosecuting Authority	44
Department of Social Development	44
Department of Health	45
Donors	45
References	47
About the project partners	52

# Executive Summary

---

The TCC model was designed to fulfil three aims: the reduction of secondary victimisation; an increase in conviction rates; and a reduction in the length of time taken to finalise cases.

Specialised services for rape survivors were established by women's organisations in South Africa from 1976 onward. State responses however, lagged behind, with the first of these only emerging in 1992. This was the Wynberg sexual offences court, supported by a Task Group on Rape. The advent of democracy in 1994 both witnessed an increase in such initiatives (often undertaken in partnership with women's organisations), as well as a rapid rise in the number of rapes reported to the police. It was against this backdrop that the most significant and enduring of state responses to rape emerged: the Thuthuzela Care Centre (TCC), first established in 2000 at GF Jooste Hospital in the Western Cape and linked to the Wynberg sexual offences court.

The TCC model was designed to fulfil three aims: the reduction of secondary victimisation; an increase in conviction rates; and a reduction in the length of time taken to finalise cases. Services offered at the TCCs include history-taking and a medico-legal examination; prophylaxis and treatment for pregnancy and sexually-transmitted infections, including HIV; and immediate and longer-term emotional support. Prior reviews of the TCCs noted variability in the quality and availability of emotional support services to survivors not only across TCCs, but also within individual TCCs, with the absence of emotional care services most obvious at nights and over week-ends.

These weaknesses in both intake and follow-up services for rape victims are of concern, given the serious nature of rape's psychological effects. These may include mood and anxiety disorders, including post-traumatic stress disorder (PTSD);

alcohol and substance abuse and dependence; eating disorders; and psychosis. While lay counsellors based in non-governmental organisations provide the bulk of services to rape survivors, many of the therapeutic interventions developed to address rape's psychological consequences are restricted to clinicians and fall outside the scope of lay counsellors' practice. As a result little information exists, either locally or internationally, to guide community-based services to rape survivors. Equally little research has been undertaken documenting local post-rape services.

To begin addressing these gaps this study sought to describe the range of emotional support services provided to rape survivors by NGOs based in TCCs, and identify factors shaping these services. Two key themes were repeatedly emphasised by organisations in this regard: the funding of their services; and the relationships between the various institutions located within the TCC, as well as the effect of these on post-rape care.

## Methods

By February 2014 there were 51 TCCs of variable functionality distributed across South Africa, with a further four sites being built by the NGO the Foundation for Professional Development on behalf of the National Prosecuting Authority (NPA). While both these new sites, as well as the existing sites, were slated to engage the services of NGOs in 2015, this study focused on the 27 organisations providing services to 39 TCCs on or before 31 December 2014.

A total of 40 interviews was conducted with either the director or the programme



**Little information exists, either locally or internationally, to guide community-based services to rape survivors. Equally little research has been undertaken documenting local post-rape services.**

manager overseeing rape services. On occasion, up to three different people in the organisation were interviewed to ensure that information about the service was complete. Data were gathered between May 2014 and April 2015 through a combination of in-depth interviews and participant observation.

## Key findings

Organisations in this sample were a mix of the specialist and generalist, comprising those solely dedicated to combatting rape, as well as those which addressed issues of community well-being generally. Services were offered to rape survivors and, in the case of child victims, their families too with interventions taking a range of forms: support in the immediate aftermath of rape; assistance with adhering to PEP to prevent HIV infection; individual, group or family counselling and support in the short, medium and long-term; preparation for testifying in court, as well as accompaniment to court; and writing reports for court, as well as providing expert testimony. Other activities included training about rape for a range of community structures, often coupled with programmes and campaigns intended to raise awareness around the problem. Services were provided from a variety of sites in addition to the TCC and included police stations, health facilities, court buildings and organisations' offices. The combined reach of these 27 organisations was significant, accounting for at least 183 different service points across the country to rape survivors.

State and NGO services saw slightly different populations of rape survivors. State facilities attended to large numbers of victims who had been raped very recently and were, therefore, most likely to be experiencing the acute stage of trauma, while organisations with office-based services were also seeing women seeking help with historical experiences of rape, who had typically not reported the attack at the time it occurred.

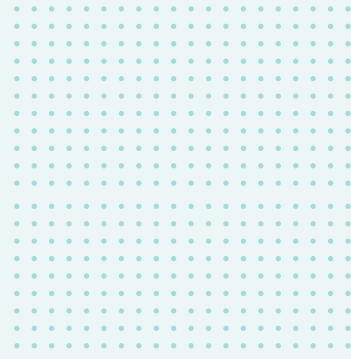
Overall, the bulk of acute stage care was being provided by lay counsellors, with almost three-quarters of organisations (19 or 70.4%) perceiving their counsellors to be capable of assisting victims for between three to 12 sessions. Most counselling practice was rooted in the humanist psychology of Carl Rogers and the skilled helper model developed by Gerard Egan. Psychologists were a rarity in these post-rape services and only two universities were actively involved in the work of organisations in this sample.

The TCC model is a creature of the NPA and located within a health facility. This design and management by a prosecutorial function of what is essentially a health service guarantees an inherent tension within the care centre component of the TCC model. The centres therefore, attempt to mediate both the interests of the criminal justice system, as well as the public health system, with the inclusion of NGOs adding, in many instances, yet another layer of complication.

One such complication was the role of NGOs within the TCC. Indeed, defining and controlling the content and nature of NGO services constituted an important arena of struggle within the TCCs. Lay counsellors' roles were not identical across the TCCs and took three slightly different forms of intervention: that of HIV counsellor, a post-rape counsellor, and a victim's advocate. Also evident at some sites was the downward task-shifting by health staff to NGOs of rapid testing for HIV, as well as pre- and post-test counselling for HIV. For all but two TCCs, follow-up of rape survivors posed a significant challenge. As this suggests, practice across TCCs was not consistent, with NGOs present in more than one TCC observing that no two sites functioned in the same way.

**27** organisations  
provided  
**183** service points

The combined reach of the 27 organisations in the research sample was significant, accounting for at least 183 different service points across the country to rape survivors



The post-rape services in this study were fragile and at least one in four organisations had experienced serious stressors between 2012 and 2014. Eleven organisations received no funding at all from the Department of Social Development (DSD) to provide the TCC service. In general, DSD approaches to funding TCC services were inconsistent both within and between provinces. The DSD contribution towards TCC counsellors was low, ranging from R500 per month, to R2 500 per month, with only one organisation receiving more than R3 000 per month. Indeed, when the DSD paid a sum of R1 500 per month or less for a counsellor's services, they were effectively paying organisations less than the Ministerial determination for Expanded Public Works Programme wages, set at R71 per day in 2013. Many organisations had the impression that their counsellors, because the lowest-paid category of worker in the TCC, enjoyed the least status and authority in the centre, and were also considered low-skilled. This, many reported, was a key contributor to the confusion around their role in the TCC, as well as the low value placed on their contribution. The status and skills of the counsellors comprised one element of the everyday micro-politics playing out between the different agencies located within the TCC.

TCCs emerged as contested spaces where power struggles played out between NPA and DoH, DSD and DoH, NGOs and NPA, NGOs and DoH and NGOs and DSD, with these battles locating agencies in hierarchical relationships to one another. As a consequence organisations' relationships with either the DoH or NPA existed on a spectrum, with the end-points summed-up in two interviewees' words as "it sucks" and "it's a wonderful service." Because compliance with the NPA protocol was selective, rather than guaranteed, the quality of relationships between institutions had come to play a particularly significant role in the quality of services to rape survivors.

Approximately one-third of organisations could be located on the "it sucks" end of the spectrum. While the relationships of a further 14 could be categorised as either neutral or good, it was the service which did not function as intended, either because it was not available on a 24/7 basis, or lacked human and material resources (such as social workers for follow-on services, or telephones with which to contact survivors and make follow-up appointments). For five organisations relationships were both good and the minimum components of the service also in place. These were the TCCs located on the opposite end of the spectrum: "it's a wonderful service."

Personalities were important to the functioning of the TCC, particularly that of the NPA site co-ordinator. Good working relationships were also the result of other factors, including the length of time the TCC had been in existence, the way changes to the pre-existing service had been handled and the number of changes to core management staff over the years. Long-established TCCs involving people with a history of working together were generally less conflictual than newer sites, or those marked by high staff turnover. What seemed to be particularly essential was regular meetings within the TCC to explain each agency's purpose and function, with the process of entry needing to be particularly carefully managed. Indeed, maintaining relationships was as core to the work of a TCC, as was the provision of quality services to rape victims. Where this was recognised, and there was a willingness to address conflict, TCC sites appeared genuinely able to work together, frankly raising issues of less-than-optimal performance with one another, which generally led to an improvement in problems. When this point was reached, it was concern for the rape survivor, rather than defence and ownership of territory, which appeared to drive how a TCC functioned.

TCCs emerged as contested spaces where power struggles played out between NPA and DoH, DSD and DoH, NGOs and NPA, NGOs and DoH and NGOs and DSD, with these battles locating agencies in hierarchical relationships to one another.

## Concluding recommendations

Locating a range of agencies within one space does not automatically result in those agencies working together. In fact, such arrangements may generate a new challenge: reconciling competing interests and reducing conflict. Further, services may be described as 'one stop' only at the moment of reporting, with follow-up care continuing to be fragmented, as well as disjointed. Indeed, emotional support services in the TCCs are treated as after-thoughts in many facilities. This is reflected in the inadequate funding for the service; the amount of space given to the service, as well as its physical location; and where in the TCC process the counsellor is located. A number of recommendations can be proposed to strengthen existing services and these are set out below.

### Community-based service providers:

Funding currently determines the nature, scope and extent of post-rape care in South Africa - rather than the nature, scope and extent of post-rape care determining the funding required by services. This situation must be reversed by establishing guidelines around the minimum core content of services to rape survivors during the acute stage of trauma, as well as over the medium to long-term. Guidelines have been collectively developed by organisations which detail the provision of acute stage post-rape care at either station or health facility level and lay a foundation for shared, standardised practice around emotional support to survivors, as well as training and debriefing for counsellors. These should be adopted.

Research is also required identifying the key components of community-based services to rape survivors; investigation of the effects of these various interventions on rape survivors and the identification of evidence-based practice for this level of service; and exploration of rape survivors' perceptions and experiences of each intervention. These priorities would also need to acknowledge the diversity of rape

survivors and ensure these varied needs are also considered.

Organisations could also consider forming a national body to act as a mechanism for self-regulation, as well as the setting of service standards for different forms of post-rape care as the data become available. Such a body could play a key role in funding negotiations with DSD by ensuring that services are at all times receiving the financial support necessary to providing good psycho-social support to rape survivors.

### National Prosecuting Authority:

To strengthen the emotional support component of the TCC service it is recommended that organisations and the NPA meet to discuss incorporating the guidelines described above into the TCC protocol. If counsellors' roles are clearly prescribed and organisations enabled to manage this component of the TCC service, it may reduce the likelihood of NPA staff seeking to control or define what constitutes emotional support. It is also essential that the NPA ensures that adequate funding is set aside for emotional support services in future.

There are significant variations to the TCC model, some of which impact negatively upon the quality of post-rape care. The NPA may wish to consider investigating how these variations may be reduced and whether or not different models may be required for areas where cost, transport and distance are barriers to accessing post-rape care.



### Department of Social Development:

It is essential that DSD both standardise their funding practices nationally to ensure equitable funding of organisations' staff both within, as well as between provinces, and take a more generous approach to subsidising post-rape care. In pursuing a strategy of under-funding they are promoting self-exploitation and high staff turnover within organisations, as well as placing organisations in a position where they potentially violate labour legislation.

Organisations should also engage with the DSD around adopting the acute stage guidelines and any others developed subsequently. The existence of such protocols will enable DSD to ensure that funding is commensurate with the desired standard of service.

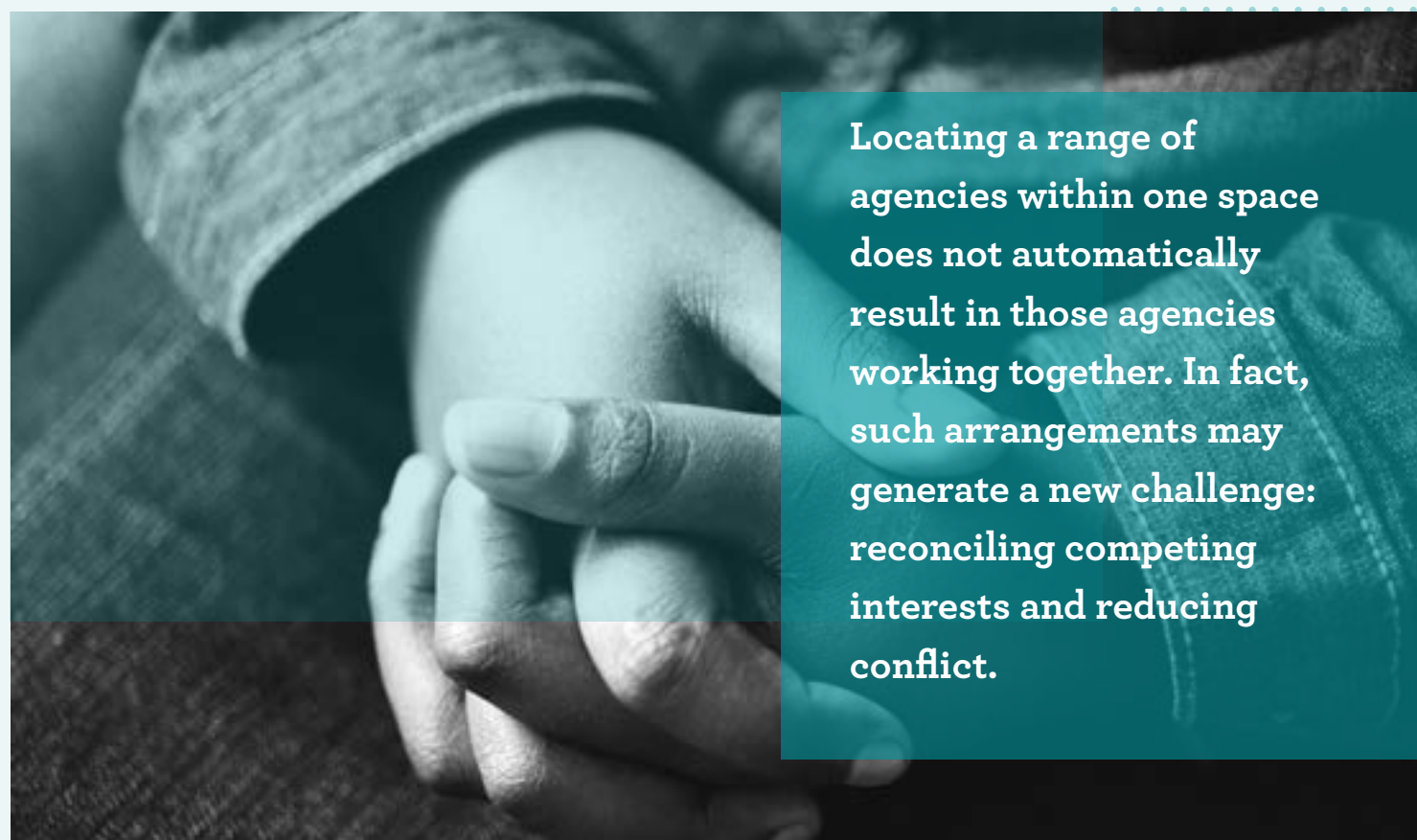
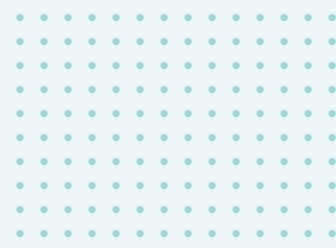
### Department of Health:

Once the TCC protocol better recognises the scope and importance of organisations' contribution to the TCC model, this may result in counsellors being treated more respectfully. That said, there may need to

be urgent intervention at those few sites where interviewees became visibly distressed while recounting their experiences with health staff – described as “bullying” by one. Further, there is evidence in this study of task-shifting from health workers to counsellors specifically in relation to pre- and post-test counselling, HIV testing and PEP follow-up. Given this, DoH must also consider funding NGOs' acute stage services to rape survivors.

### Donors:

In recent years there has been a move by donors away from funding post-rape care on the expectation that this support should come from the state. Before withdrawing support from such services it is recommended that donors ensure that this is actually the case. In addition, even if they choose not to support direct services, it is recommended that donors consider funding the research questions identified earlier, the training and development of counsellors and opportunities for organisations to develop their practice, as well as potentially form a self-regulating body.



**Locating a range of agencies within one space does not automatically result in those agencies working together. In fact, such arrangements may generate a new challenge: reconciling competing interests and reducing conflict.**

# Introduction

---

The TCCs have been described by UN Women as a “best practice model internationally”.

1976 marks a key moment in post-rape care and its politics in South Africa, for this was the year Anne Mayne, a survivor both of domestic violence and gang rape, who was also inspired by the feminist movement to end violence towards women, founded Rape Crisis Cape Town (RCCT) (Russell, 1989). From this start the number of women’s organisations dedicated to supporting and advocating on behalf of victims<sup>1</sup> of rape and domestic violence slowly grew. People Opposing Women Abuse was established in 1979 and by the close of the 1980s, a further five feminist rape crisis organisations existed in Pietermaritzburg, Durban, Grahamstown, and the ‘coloured’ areas of Heideveld and Belhar in the Western Cape (van Zyl, 1991). Four more rape crisis agencies had been set up in Port Elizabeth, George, Pretoria and Bloemfontein by 1991 (although the latter four were not necessarily feminist in orientation) (*ibid*).

But while growing in number, organisations had yet to influence state policy and practice around rape (Kaganas and Murray, 1991). That moment came in September 1992 when the acting attorney-general of the Cape, Frank Kahn, established a Task Group on Rape which brought together both government and non-government agencies in the attempt to improve the treatment of rape survivors at court (Human Rights Watch, 1995). Kahn also coupled the Task Group with the establishment of the Wynberg sexual offences court, the first of a number of attempts by the South African state to create specialised services for rape survivors. Further experimentation with specialised services by the state and community structures – sometimes separately, sometimes jointly – continued with the advent of

democracy in 1994, with these structures typically located either at police stations or health facilities (*ibid*).

South Africa’s rape statistics also appeared to be rapidly increasing during this period. In 1996 the FBI claimed that South Africa had the highest rate of reported rape in the world (Govender, 2007), and in 2000 Interpol crowned South Africa the rape capital of the world (Simon, 2000). Both these and other claims, such as a rape occurring every 83 seconds (Vogelman, 1990), or every 26 seconds (Smith, 2001) sparked considerable concern and activism which resulted in marches and protests, as well as hearings in parliament (Govender, 2007). The United Nations Special Rapporteur on Violence Against Women visited the country in 1996 (Coomaraswamy, 1997), while Human Rights Watch released two reports on violence against women in South Africa (Human Rights Watch, 1995; Human Rights Watch, 1997). It was against this backdrop that the most significant and enduring of state responses to rape emerged: the Thuthuzela Care Centre (TCC), first established in 2000 at GF Jooste Hospital in the Western Cape and linked to the Wynberg sexual offences court. Portrayed as a critical part of South Africa’s anti-rape strategy, and a response to the urgent need for an integrated strategy for prevention, response and support for rape victims, the TCCs have been described by UN Women as a “best practice model internationally” – to the extent that the Sexual Offences and Community Affairs (SOCA) Unit of the National Prosecuting Authority (NPA) has advised Ethiopia and Chile on the establishment of similar centres (2011: 57).

1 This report uses the terms ‘victim’ and ‘survivor’ interchangeably both to acknowledge rape’s very real harms, as well as the resilience demonstrated by many women, girls, boys and men in overcoming these.

This study examines how state and civil society post-rape services have converged within the TCCs by focusing on the work of the non-governmental organisations (NGO) based in these centres. While a number of the NGOs based in the TCCs have a long history and in many communities are frequently the only source of emotional support services to rape victims, whether adult or child, there is almost no research detailing their services to rape survivors (Vetten, 2014) - with one exception (Gevers and Abrahams, 2014). This report seeks to begin the process of mapping and detailing the largely-invisible work of these organisations. It is not however, an investigation into the impact of these services, nor an evaluation of the effectiveness of the TCCs as a whole.

The report begins by describing the workings of the TCCs, focusing on the counselling component of their service specifically. This is followed by a brief overview of what is currently known about rape's impact on mental health and the various clinical interventions designed to respond to these sequelae. The next section of the report then details the variety of NGO services designed to ameliorate rape's impact on victims' well-being. But because description by itself does not explain a service, its choice of approach and modes of intervention, the report also seeks to explicate some of the pragmatics of service provision, specifically the micro-politics of institutions, as well as the availability of resources, human and material, to NGOs. The report concludes with a set of recommendations aimed at strengthening post-rape care.

## Thuthuzela Care Centres

The TCC model was developed by the NPA's SOCA Unit to fulfil three aims: the reduction of secondary victimisation; an increase in conviction rates; and a reduction in the length of time taken to finalise cases. The TCC model consists

in two sets of services provided at different sites: the care centre located at a public health facility; and (ideally) a sexual offences court dedicated to the prosecution of rape cases. A particular ethos is expected to animate the TCC:

*"The word "comfort" awakens feelings of warmth, freedom from emotional and physical concerns, safety, security, being pampered and cared for and, above all, reinforcing dignity, hope and positive expectation. These attributes and feelings are embodied in "thuthuzela", the Xhosa word for comfort, are realised in the establishment of the THUTHUZELA CARE CENTRES" (emphasis original) (NPA, n.d.).*

This ethos should be embodied in the range of services provided to victims presenting at the care centre, which include:

- initial reception of the victim, followed by information outlining the services and procedures;
- history-taking and a medico-legal examination;
- prophylaxis and treatment for pregnancy and sexually-transmitted infections, including HIV;
- bath/shower, refreshments and a change of clothing;
- transportation home (or to a place of safety), referrals and follow-up support.

At some TCCs it is also possible for the victim to open a case on-site, give the police a statement and/or receive longer-term psycho-social counselling and other services (Research Triangle Institute (RTI) International, 2007). Site staff should include a case manager, victim assistance officer and site coordinator; NGO or Department of Social Development (DSD) counsellors; trained detectives and officers competent to take statements; and either SAPS or emergency medical service personnel able to transport victims (*ibid*).

"Thuthuzela", is the Xhosa word for comfort



**This study examines how state and civil society post-rape services have converged within the TCCs by focusing on the work of the non-governmental organisations (NGO) based in these centres. This report seeks to begin the process of mapping and detailing the largely-invisible work of these organisations. It is not however, an investigation into the impact of these services, nor an evaluation of the effectiveness of the TCCs as a whole.**



Ideally, the court component of the model should consist in a comfort room and one court specially set aside for the prosecution of sexual offences. The staff complement should include two prosecutors dedicated to the management of sexual offences, one full-time magistrate, one social worker, an administration clerk, an intermediary and a case manager. The prosecutor(s) and support staff are expected to undertake court preparation of victims, conduct weekly strategy meetings and case assessment, and consult with victims throughout the process (Mafani, 2014).

Use of the TCCs has been increasing steadily. In 2009/10 when 25 TCCs were in existence 13 756 matters were dealt with by the centres. In 2010/11, when the number had increased to 45, a total of 20 496 cases came through the TCCs and in 2011/12, a total of 28 557 cases were managed by 52 TCCs. This number had increased to 33 112 by 2012/13 when 51 TCCs were functional (Smith and Mafani, 2013). However, some filtering of cases may be taking place at the TCCs. Data obtained from the SOCA unit for the period 2003 - 2006 indicated that the bulk of victims (60%) attended to were children (Vetten et al, 2010). The

NPA's Performance Overview Report for the period April - October 2010 suggests this continues to be the trend (58% children versus 42% adults) (NPA, 2010:18) - even though women over the age of 18 constitute the bulk of those who report rape (Vetten et al, 2008: South African Police Service, 2009; South African Police Service, 2010). Either the TCCs are being established in areas where more children than adults report being raped (which is unlikely), or local police officers - perhaps in consultation with TCC staff - prefer to provide TCC services to children rather than women.

Table 1 lists the 25 TCCs where the most rape cases were dealt with during the first quarter of the 2012/13 financial year, with seven sites assisting more than 100 rape survivors every month. Notably all seven of KwaZulu-Natal's sites are included within the 25 busiest TCCs, five of Gauteng's seven sites and four of the Western Cape's five sites.

According to RTI International, of the 10 centres established by 2007, only four were new and inaugurated from the outset as TCCs. The other six had been pre-existing centres, with a TCC subsequently

Site	Monthly average	Site	Monthly average
Mthatha (EC)	183	Tshepong (FS)	75
Karl Bremer (WC)	131	Mdantsane (EC)	72
Natalspruit (GP)	125	Kopanong (GP)	69
Tshilidzini (LP)	110	Edendale (KZN)	65
Nthabiseng (GP)	110	Klerksdorp (NW)	50
Port Elizabeth (EC)	108	Port Shepstone (KZN)	47
Phoenix (KZN)	103	Ngwelezane (KZN)	46
Umlazi (KZN)	93	Mahikeng (NW)	45
Manenberg (WC)	86	Kimberley (NC)	43
Khayelitsha (WC)	85	Stanger (KZN)	40
RK Khan (KZN)	85	Mamelodi (GP)	35
Tembisa (GP)	85	George (WC)	33
Kopanong (FS)	77		

Source: Mafani, 2014

super-imposed over the original service. While this contributed to the latter group being more likely to be the subject of power struggles between Department of Health (DoH) and NPA personnel over management and approach, they were also better integrated with and supported by the hospital. The former group, by contrast, because not 'owned' by the hospital, had poorer infrastructure and greater difficulties obtaining supplies. Signage directing patients to the TCC was often missing while TCC staff felt isolated from the hospital (RTI International 2007: 22).

Although noting that relations between the TCC and its host hospital were generally good, the audit also noted that the degree of co-operation, integration and support varied across sites depending on financing and staffing dynamics, individual personalities and the extent to which the hospital was responsible for the services (RTI International 2007: 20). A senior hospital manager was quoted as saying: "whether hospitals support the [TCC] is largely individual. I feel a moral obligation to [rape] patients to provide high quality service, but the next superintendent may not" (RTI International 2007: 21 fn 21).

Based on these observations, RTI International suggested that two slightly different versions of the TCC model had developed. Model 1 TCCs were largely driven by the DoH whose role in service provision was clear, whereas the NPA site coordinator played the stronger management role in model 2 TCCs. Model 1 TCCs provided services within the broader context of forensic and clinical medicine and were thus likely to enjoy the services of staff skilled in this area and to be located in a facility separate from casualty. A dedicated doctor was responsible for the site, which operated on a 24-hour basis. Model 2 TCCs, by contrast, fell under the hospital's jurisdiction and were funded entirely from the hospital's budget. Staff lacked specialised skills while the centre itself was under-staffed,

reflecting under-staffing in the facility generally. Services to rape survivors typically reverted to casualty after-hours (RTI International, 2007). Thus while a blueprint was in place outlining the requirements to be met for a service to qualify as a TCC, not all TCCs met these standards.

The first evaluation of a TCC (Artz, Smythe and Leggett, 2004) concentrated on the disposition and management of sexual offence matters by the centre and did not comment on the quality of counselling care. The weaknesses in this component of the TCC service emerge in subsequent evaluation reports.

In 2007 the evaluation of the 10 TCCs then in existence noted variability in the quality and availability of support services to survivors (RTI International, 2007). This variability was evident not only across TCCs, but also within individual TCCs. Only three sites enjoyed consistent, on-site access to NGO support services, while another site had a full-time social worker appointed to it by the DSD. For the remainder, services were provided by the hospital social work staff. The absence of emotional care services was most obvious at nights and over week-ends (*ibid*). The subsequent audit conducted in 2009 to identify potential sites for future TCCs echoed RTI's earlier observations, highlighting that some health facilities' minimal engagement with local NGOs addressing sexual violence left them unable to refer survivors to further services. It was recommended that DSD's role in supporting such services be explored, as well as how community-based organisations could be involved more effectively in the workings of the TCC (Braam and Makgalo, 2009).

These weaknesses in the provision of comprehensive psycho-social care are far from being confined to the TCCs alone.

Collings' analysis (2009) of 200 consecutive cases of child rape referred for medico-legal



**“Whether hospitals support the [TCC] is largely individual. I feel a moral obligation to [rape] patients to provide high quality service, but the next superintendent may not.”**

assessment at one state hospital in Durban, KwaZulu-Natal found just under half (49%) were seen either by a hospital social worker (45.5%) or an external agency referred to by the hospital (3%) in the three-month period studied (October to December 2004). However, this service was largely restricted to a single intake interview, provided on the day of initial presentation in 21.6% of cases; between two days and one week after initial presentation in 20% of cases; a further 10.5% being seen between one week and one month later; and 7.5% more than a month later. All children attended to by an external agency such as a NGO were seen more than a month after initial presentation. Children presenting after hours and children living in informal settlements were significantly less likely to receive counselling and social work services.

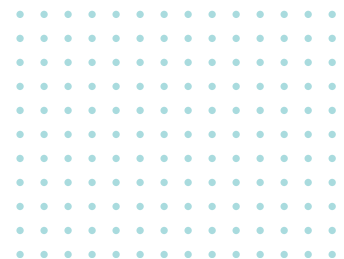
According to Collings (2009) the findings are suggestive of unintegrated professional engagement with children and their caregivers, compounded by the absence of safeguards to prevent systems of referral from failing - including procedures to re-establish contact with children's caregivers when children did not arrive for

appointments. Also absent was reciprocal communication between hospital services and external agencies confirming whether or not children had received follow-up services (*ibid*: 144). Mathews et al's small-scale study in the Western Cape (2013) suggests similarly-limited access to services. In this study a number of children received only a single session of debriefing and were not referred to specialised services. Structural and institutional barriers also limited children's use of these services.

Given the serious nature of rape's psychological effects these weaknesses in both intake and follow-up services for rape victims are concerning.

### **Addressing the mental health consequences of rape**

In South Africa only experiences of political torture match or exceed the severity of rape's psychological effects (Kaminer et al, 2008) - yet little local research has been undertaken to explore rape's psychological impact (Kaminer and Eagle, 2010; Kiguwa and Langa, 2011; Macleod and Howell,



**In South Africa only experiences of political torture match or exceed the severity of rape's psychological effects – yet little local research has been undertaken to explore rape's psychological impact.**

2013). With notable exceptions (Payne and Edwards, 2009; Padmanabhanunni and Edwards, 2014; Padmanabhanunni and Edwards, 2015) there is also a dearth of evidence for interventions effective in ameliorating its psychological impact.

Experiences of rape have been associated with alcohol and substance abuse and dependence; eating disorders; psychosis; and mood and anxiety disorders, including post-traumatic stress disorder (PTSD). Although the last is by no means the only approach to conceptualising the psychological effects of trauma, nor even the only consequence of trauma, PTSD has become the dominant approach to describing and understanding rape's effects.

Post-traumatic stress is characterised by the following cluster of reactions: the presence of intrusive symptoms associated with the event (such as nightmares and flashbacks); persistent avoidance of stimuli associated with the event; negative alterations in cognition and mood associated with the event; and marked alterations in arousal and reactivity associated with the event. The persistence and intensity of these symptoms may lead victims to organise their lives around the trauma, altering their habits, activities and relationships in the attempt to avoid reminders of the attack. While these reactions are generally at their worst in the first month following the assault, they tend to decline in severity over time. It is when they persist for longer than four weeks that a diagnosis of PTSD may result.

Not all survivors develop PTSD. Some experience only one or two reactions very intensely, while the onset of reactions may be delayed for others. Reactions may also subside – only to peak again at a later stage. An experience of rape, therefore, does not affect victims identically, as local data suggests. While the national South African Stress and Health survey recorded PTSD symptomology in 6% of women who identified as having been raped (Kaminer

et al, 2008), a Gauteng-based study identified symptoms of PTSD among 15.4% of women either sexually or physically abused by their partners and 28.1% of women raped by non-partners (Machisa et al, 2010). One quarter of women (25%) raped by non-partners and 19.1% of women either sexually or physically abused by their partners reported attempting suicide (*ibid*).

National data detailing the psychological impact of child sexual abuse would not appear to be available. One small qualitative study of 30 children aged between 8 and 17 and their care-givers found 67.7% of the sample to display symptoms indicative of full PTSD four weeks post-rape, while 29.3% exhibited partial symptoms. Anxiety of a clinically significant degree was identified in 45.2% of the children, and high scores of depression in 35.5%. By weeks 16 to 20 depressive symptoms had declined to 13.3%, anxiety to 23.3% and full-symptom PTSD to 43.3% (Mathews, Abrahams and Jewkes, 2013). Forced first intercourse has also been associated with increased risk of physical and/or sexual partner violence (Dunkle et al, 2004), as well as teenage pregnancy (Jewkes et al, 2001).

Because individuals' responses to traumatic events fluctuate and change over time, helping interventions need to be flexible and adapted to the particular stage of trauma they are experiencing. Much of the literature discerns three stages, with the first, or immediate, stage chiefly focused on crisis intervention, establishing the victim's safety and providing practical, stabilising assistance. Only once this has been achieved can second stage interventions begin, which typically focus on retelling the story of what happened and identifying the personal meaning attached to these events. The third stage focuses on integrating the traumatic event into someone's overall life narrative, as well as enabling them to establish new directions

An experience of rape does not affect victims identically.





Because individuals' responses to traumatic events fluctuate and change over time, helping interventions need to be flexible and adapted to the particular stage of trauma they are experiencing.

and connections in their lives (Herman, 1992; Edwards, 2009).

Critical Incident Stress Debriefing (CISD), or psychological debriefing, was initially widely used in the immediate, or acute, stage of trauma. First used in group settings, it was later expanded to include individuals and intended to be applied within the first 72 hours of a traumatic incident. Participants were typically required to provide a full narrative account of their experience, coupling this with identification of the emotional reactions evoked. These responses were normalised and participants encouraged to seek further assistance (Kaminer and Eagle, 2010). Despite its popularity, no research exists supporting the efficacy of CISD or psychological debriefing, which in some instances may even worsen PTSD symptoms over the long-term (Rose et al, 2002). This perhaps, is due to CISD being applied during the first stage of trauma, rather than the second (Edwards, 2009). What is currently recommended in both the immediate and acute stages of trauma is psychological first aid (PFA), which can be utilised by professionals and lay counsellors alike (Allen et al, 2010). The goal of PFA is to encourage people's ability to cope and function adaptively in the short and long-term by restoring their sense of safety, as well as providing various forms of practical assistance.

Second and third stage treatment interventions associated with decreased symptoms of PTSD in rape survivors include cognitive and behavioural interventions such as Cognitive Processing Therapy, Prolonged Exposure Therapy, Stress Inoculation Therapy and Eye Movement Desensitisation and Reprocessing (Regehr et al, 2013). However, because these are therapeutic interventions restricted to clinicians they fall outside the scope of lay counsellors' practice. Many of the

guidelines for trauma-related interventions are also largely applicable to clinicians only<sup>2</sup>, with the result that little exists guiding community-based services to rape survivors either locally or internationally. What is widely used in South Africa is the Wits trauma model which consists in the following five components: telling/retelling the story; normalising symptoms; addressing self-blame or survivor guilt (restoring self-respect); encouraging mastery; and facilitating creation of meaning (Kaminer and Eagle, 2010; Edwards, 2009). This model is also suited to survivors no longer experiencing the first stage of trauma. Other approaches to addressing PTSD are also being developed in South Africa (eg Edwards, 2009) but these too are suited to clinicians.

Trauma interventions not only need to be matched to the stages of trauma but must also be developmentally appropriate. Services to children need to accommodate both younger children, as well as adolescents. While adolescents are at greater risk of being raped than younger children (Jewkes and Abrahams, 2002; Vetten et al, 2008), they may experience particular difficulties in being believed and therefore face significant barriers to reporting and accessing services. Other groups of rape victims may also face barriers to reporting and accessing services. It is unknown, for example, how frequently lesbians' experiences of rape are recorded in official SAPS statistics, even though the issue attracts a good deal of public attention.<sup>3</sup> There is also very little guidance to either counsellors or clinicians around addressing heterosexism in trauma work with sexual minorities (Padmanabhanunni and Edwards, 2014).

Although an entire chapter of the Sexual Offences and Related Matters Amendment Act (SOA) of 2007 is devoted to criminalising sexual offences against

2 See Forbes et al, 2010 for a summary.

3 The only study that appears to have been completed to date was undertaken with a convenience sample of 591 women largely recruited by community-based organisations in Botswana, Namibia, South Africa and Zimbabwe, found 31.1% to have had an experience of forced sex - 14.9% by men only, 6.6% by women only and 9.6% by both men and women (Sandfort et al, 2013).

people with intellectual disabilities, there is also no information available from the police as to how many of these crimes are being brought to their attention. While a Gauteng-based study of rape reported in 2003 showed 41 (or 1.9%) of victims in the study to have some form of disability (Vetten et al, 2008), these figures fell below the prevalence of disability in Gauteng, calculated as affecting 3.8% of the female population in the province by the 2001 Census. It is impossible to know whether these figures reflect under-recording of disability on official documents; under-reporting of rape by victims with disabilities; or a lower vulnerability to rape amongst disabled people. Again, with notable exceptions (eg. Dickman et al, 2006), there is little to guide trauma work with survivors with intellectual disabilities.

When local research does focus on community-based services it is largely within the context of their ability to assist rape survivors adhere to post-exposure prophylaxis (PEP) to prevent

HIV infection (Vetten and Haffejee, 2005; Christofides et al, 2005; Abrahams and Jewkes, 2010; Kim et al, 2010; Abrahams et al, 2010; Roland et al, 2011; Rohrs, 2011; Arend et al, 2013). Predictably, the recommendations emerging from these studies largely focus on supporting victims to complete their regimen of PEP. And while the DSD has issued *Guidelines for Services to Victims of Sexual Offences* (2010), these largely apply to social workers in the department's employ and are of limited applicability to community-based services reliant on lay counsellors.

Thus while women may value counselling services (Christofides et al, 2005; Maw, 2013), there is very little to guide evidence-based practice in this regard at community level outside of supporting adherence to PEP. Indeed, counselling services must encompass far more, given that some victims will report after the 72-hour window in which PEP must be initiated has expired, while yet another group will already be HIV-positive at the time of the rape (Vetten and




**Trauma interventions not only need to be matched to the stages of trauma but must also be developmentally-appropriate.**

Haffejee, 2005) - both circumstances which render adherence to PEP moot.

Most rape survivors also do not report the incident to the police. Interviews conducted in Gauteng in 2010 by Gender Links and the Medical Research Council found that almost one in 12 women had been raped in 2009. However, only one in 13 of women raped by a non-partner reported the matter, while a scant one in 25 of women raped by their partners reported the matter to the police (Machisa et al., 2010). This study is not the first to show how extensively under-reported rape can be, an

earlier, national study finding that only one in nine women who had been raped and also had physical force used against them subsequently reporting the attack to the police (Jewkes and Abrahams, 2002). These findings make it clear that the majority of rape victims never seek assistance from the criminal justice system - and also point to the exclusions inherent in a model of post-rape care predicated upon victims' recourse to these institutions.

Against this backdrop the report now turns to examining the emotional support services provided by NGOs based in the TCCs.



**Interviews conducted in Gauteng in 2010 found that almost one in 12 women had been raped in 2009.**

# Findings

The purpose of this study was to describe the range of emotional support services provided to rape survivors by NGOs based in TCCs, as well as identify factors shaping these services. This section of the report now details these services, as well as two key themes organisations repeatedly emphasised: the funding of their services; and the relationships between the various institutions located within the TCC, as well as the effect of these on post-rape care.

## Methods

By February 2014 there were 51 TCCs<sup>4</sup> of variable functionality distributed across South Africa, with a further four sites being built by the NGO the Foundation for Professional Development on behalf of the NPA. While both these new sites, as well as the existing sites, were slated to engage the services of NGOs in 2015, this study focused on the 27 organisations providing services to 39 TCCs on or before 31 December 2014.

As preparations for the study began in December 2013 one organisation's services

were terminated by the NPA, while a second organisation, unable to maintain the TCC service due to lack of funding, handed it over to a different organisation in early 2014. Both of these organisations were interviewed to understand the reasons for their withdrawal from the TCC. A few months into the study a third organisation ceased operating altogether. While a number of efforts were made to locate this organisation's previous employees these proved unsuccessful and the organisation could not be included in the study. Thus the final number of organisations interviewed for the study was 29.

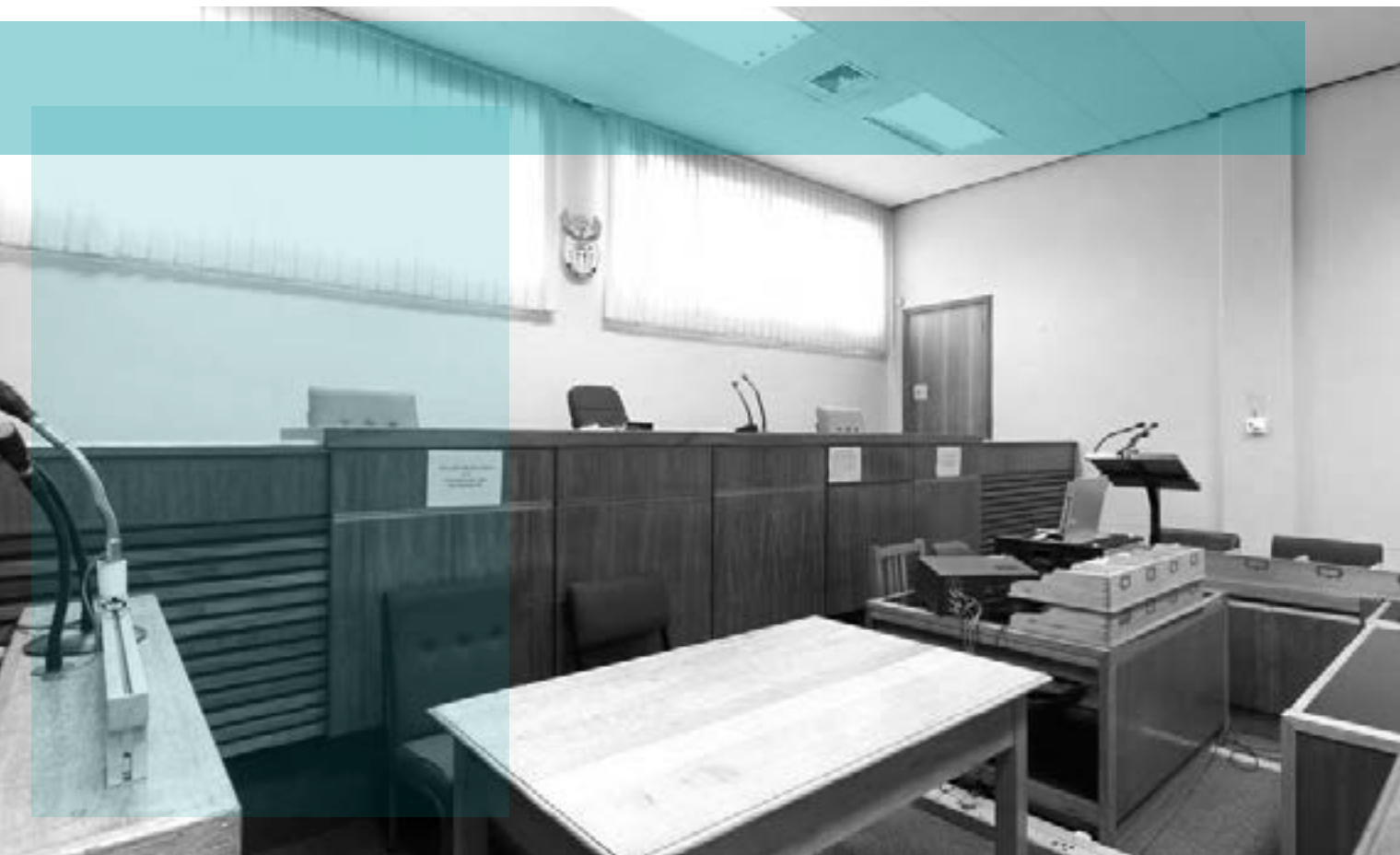
An initial consultation around the study was conducted with a group of organisations in November 2013 to identify key issues for the research. This was followed by a second presentation to a larger group of organisations in February 2014. Once ethics approval for the study had been obtained from the University of the Witwatersrand<sup>5</sup> study participant information sheets were distributed to all organisations inviting their participation in

**Table 2: Number of TCCs including NGOs, by province**

Province	No. of TCCs	No. of TCCs with NGOs
Eastern Cape	8	6
KwaZulu-Natal	7	7
Gauteng	7	6
Limpopo	6	4
Mpumalanga	5	2
Western Cape	5	5
North West	5	5
Northern Cape	4 (+ 1 entirely inoperative)	2
Free State	4	3
<b>TOTALS</b>	<b>51 (52)</b>	<b>39</b>

4 Although a 52nd site has been established at Kakamas in the Northern Cape it was not operational when the study began.

5 Ethics clearance certificate H14/05/15.



the study and followed up with a telephone call confirming the organisation's participation. The subsequent interviews were either conducted in person (where cost permitted) or via telephone by the study author. In each instance either the director or the programme manager overseeing rape services was interviewed. On occasion, up to three different people in the organisation were interviewed to ensure that information about the service was complete. In this way a total of 40 interviews was yielded.

Data were gathered between May 2014 and April 2015 through a combination of in-depth interviews and participant observation. The interview schedule comprised both closed and open-ended questions and focused on three broad areas: the organisation's work overall; their post-rape services both within the TCC as well as other sites; and factors shaping the

provision of post-rape services, including the resources available to organisations. In addition, the author was contracted by the Networking HIV, AIDS Community of South Africa (NACOSA) to run three workshops between May and December 2014 aimed at mapping current practice within TCC settings and developing a set of guidelines for the provision of post-rape services in the acute stage of trauma. This added a dimension of participant observation to the study.

In developing the study and its instruments, the author also drew on her history as a volunteer providing counselling and para-legal assistance to rape survivors, as well as her experience working with NGOs and government departments around the design and implementation of health and criminal justice services.

# Description of services provided by NGOs

Five of the organisations in the sample bring a history of feminist activism around sexual offences to their work with rape survivors and also pioneered specialised services in this regard, ranging from lay counselling, to court support. Not all continue to define themselves as feminist today, while at least seven other organisations define themselves as either child rights' or human rights' activists, organising demonstrations at court in support of survivors and/or supporting efforts at policy reform and implementation. The remaining organisations are more closely focused on their services than activism. Organisations in this sample were therefore a mix of the specialist and generalist, comprising those solely dedicated to combatting rape, as well as those which addressed issues of community well-being generally. A number of organisations also took both rape and HIV/AIDS as their focus either by providing general pre- and post-test counselling for HIV, sometimes coupled with testing for

the virus, or, less frequently, by supporting rape survivors adhere to PEP. In some instances these HIV-focused activities were new and introduced as a result of the NACOSA grant from the Global Fund for AIDS, TB and Malaria which required particular objectives around HIV/AIDS to be met.

Organisations offered post-rape care to rape survivors and, in the case of child victims, their families too. Their interventions took a range of forms: support in the immediate aftermath of rape; assistance with adhering to PEP to prevent HIV infection; individual, group or family counselling and support in the short, medium and long-term; preparation for testifying in court, as well as accompaniment to court; and writing reports for court, as well as providing expert testimony. Other activities included training about rape for a range of community structures, often coupled with

**Table 3: Number of organisational services, by site**

Site of service	No. of organisations providing such service (n=27)	Total no. of sites
Court	6	15
Police station	8	31
Shelter	10	11
Non-TCC health facility	10	22
TCC	27	39
Offices and satellites	27	65

programmes and campaigns intended to raise awareness around the problem.

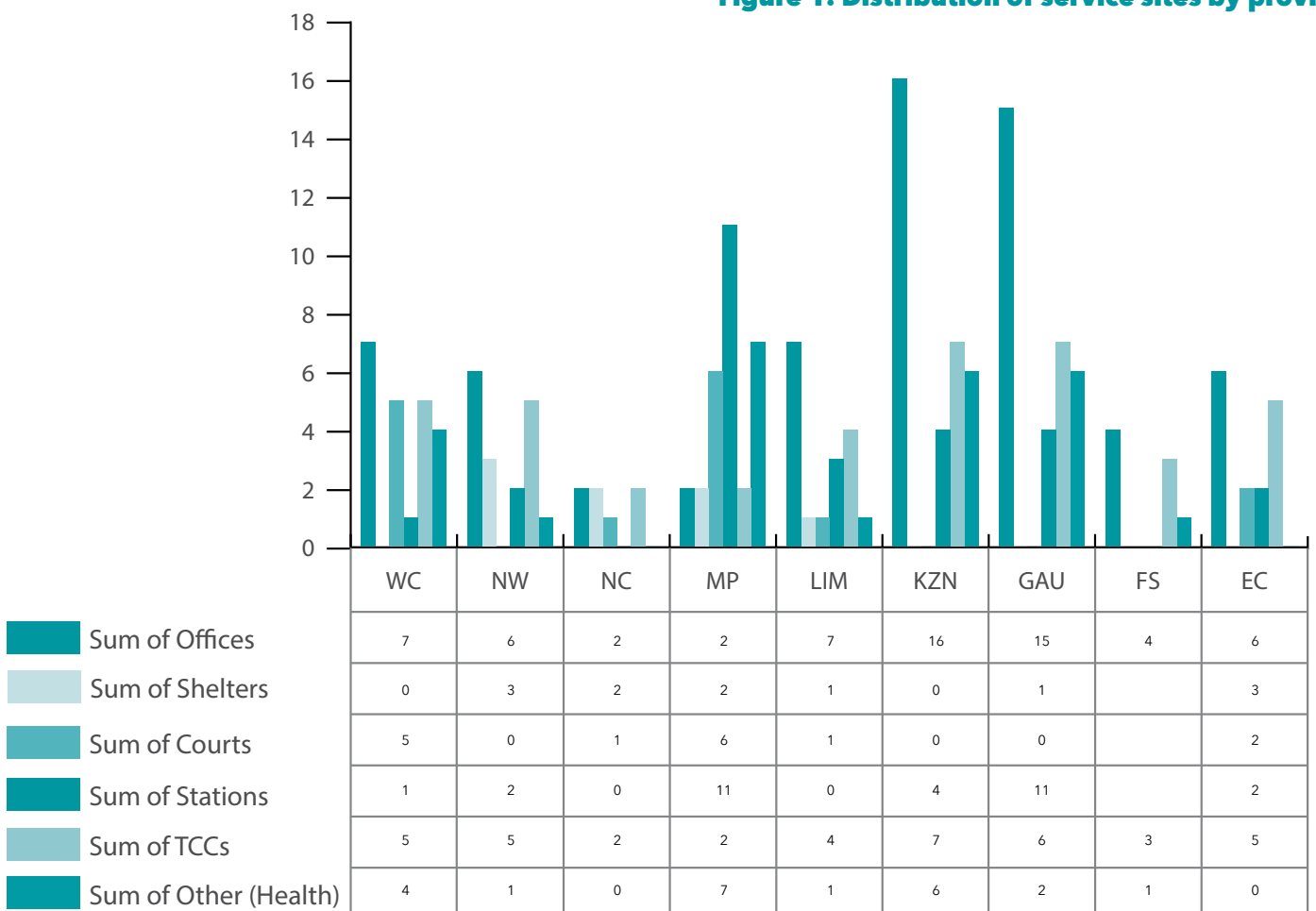
Services were provided from a variety of sites in addition to the TCC and included police stations, health facilities, court buildings and organisations' offices. Table 3 sets out the range of sites from which organisations provided services, as well as the number of such sites in total. Court services dedicated to assisting women apply for protection orders in terms of the Domestic Violence Act of 1998 were not included in this table and nor were offices dealing with child abuse generally, or foster care services. Shelters were included within this count of services when organisations noted they were also being utilised, on occasion, to house rape survivors. The combined reach of these 27 organisations is significant, accounting for at least 183 different service points to rape

survivors. In some instances these offices were satellites and so the service was not available every day.

Services at 24 TCCs (or 69.2%) were provided by two national organisations through their provincial offices. Eight organisations were housed in two or more TCCs, with one organisation managing five sites and two organisations four sites each. While most sites accommodated one organisation only, seven sites housed both an adult and children's organisation.

These services were not evenly distributed across the country as figure 1 shows. The Free State had the most limited range of services and therefore provided the fewest service points to rape survivors - although there may have been other organisations not linked to the TCCs providing such services. Where court-based services were

**Figure 1: Distribution of service sites by province**



chiefly concentrated in Western Cape and Mpumalanga, police station-based services predominated in Gauteng as well as Mpumalanga. Mpumalanga, Western Cape and KwaZulu-Natal were the three provinces where organisations made the most use of clinics or other hospitals outside of the TCCs to provide services.

The location of a service affected its scope and content, with services based at police stations, TCCs or health facilities inevitably exclusively focused on assisting rape survivors in the immediate aftermath of the attack. By contrast, services offered from organisations' offices, or the courts, were largely focused on assisting rape survivors for whom the attack was not as recent. State and NGO services thus saw slightly different populations of rape survivors, with state facilities attending to large numbers of victims who had been raped very recently, while organisations with office-based services were also seeing women seeking help with historical experiences of rape, who had typically not reported the attack at the time it occurred.

Personnel providing post-rape care included counsellors and community workers, auxiliary social workers, social workers and psychologists. Overall, the bulk of acute stage care was being provided by lay counsellors (some of whom were qualified as auxiliary social workers), not least because some organisations could not afford to employ social workers. When social workers were available, it was largely to supervise the lay counsellors, provide psycho-social care to children and attend to those adults who required lengthier periods of counselling.


Almost three-quarters of organisations (19 or 70.4%) reported that their counsellors were capable of assisting victims for between three to 12 sessions. Organisation C's lay counsellors, many of whom had been working in this capacity for more than 10 years, had also become capable of running support groups for survivors under the supervision of a psychologist. In

the case of children's services office-based counselling was provided by social workers on an unlimited basis.

Three organisations' TCC counsellors did not appear to have had any particular training around providing emotional support to rape survivors. The remainder had been trained in basic counselling skills, typically over a five-day period by social workers. Given that almost two-thirds of TCC services were provided by two organisations' provincial offices, much of this training and practice was relatively standardised, being rooted in the humanist psychology of Carl Rogers and the skilled helper model developed by Gerard Egan. The latter framework is widely used internationally and the book now in its 10<sup>th</sup> edition. With a strong focus on empowerment, Egan's model has two main goals: helping people solve their problems and develop opportunities (Egan, 2013). Two organisations not part of these two national structures described their approach as being informed by the principles of feminist empowerment, with one also explicitly influenced by Judith Herman's conceptualisation of trauma (see Herman, 1992). Another three organisations were faith-based and drew on Christian teachings in the provision of their services. Overall, practice was strongly informed by social work as a discipline and could be described as pragmatic and incremental, being modified by reflection and learning, as well as reading, or hearing about, other organisations' endeavours.

Psychologists were a rarity in these post-rape services. In addition to organisation C (whose director was a psychologist), organisation D had access to a psychologist on a part-time voluntary basis, while organisation E was also able to refer to a psychologist working in the agency to which they were affiliated. Organisation F worked closely with the psychology department of the local university, which also made psychology students

The bulk of acute stage care was being provided by lay counsellors because some organisations could not afford to employ social workers.

A person is sitting on a light-colored couch, holding a white tissue in their hands. The image is partially obscured by a teal overlay that contains text. In the background, there is a book with a female symbol and the text 'Rape Crisis' visible. The overall scene suggests a moment of emotional support or care.

**The centres must attempt to mediate both the interests of the criminal justice system, as well as the public health system, with the inclusion of NGOs adding, in many instances, yet another layer of complication.**

available for counselling. In addition to organisation F, only two other organisations made extensive use of students in the provisions of services. Only two universities were actively involved with the work of organisations in this sample, with a third beginning to develop an interest.

Because of its relationship with the local university's psychology department, organisation F's TCC service was the most heavily influenced by current psychological thinking around trauma. After the medico-legal examination had been completed organisation F's social worker typically assessed the rape survivor's risk of developing PTSD (being the only organisation to do so) and referred accordingly. The protocol guiding psycho-social services offered at this particular TCC was also explicit in outlining which therapeutic models and approaches were to be applied to rape survivors.

The minimal influence of different forms of psychological theory and practice upon these organisations, especially in relation to trauma, provides further illustration of the discipline's limited engagement with rape, as noted at the outset of the report. The minimal involvement of psychologists in community-based rape services is also an artefact of DSD's funding approach. According to the psychologist based in organisation C, it is extremely difficult to obtain funding from DSD for any professional other than a social worker. Psychologists are far more likely to be employed by the DoH.

## The TCC service

The TCC model is a creature of the NPA and located within a health facility. This design and management by a prosecutorial function of what is essentially a health service guarantees an inherent tension within the care centre component of the TCC model. The centres must therefore, attempt to mediate both the interests of the criminal justice system, as well as the public

health system, with the inclusion of NGOs adding, in many instances, yet another layer of complication.

With notable exceptions most organisations were initially not clear as to what precisely it was they were to do within the TCC. During the first NACOSA workshop organisations compiled a list of all the terms that had been applied to their work within the TCC at one time or another:

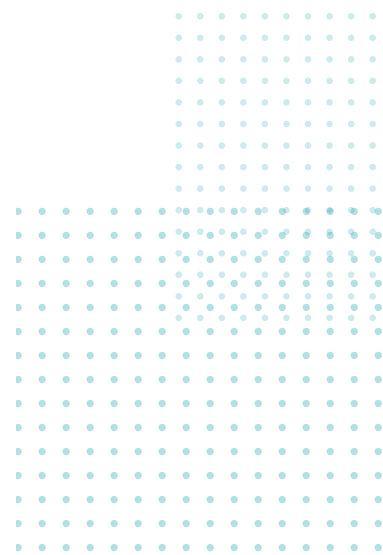
*containment, protection, empowerment, counselling, intervention, crisis counselling, psycho-social counselling, trauma debriefing, therapy, long term counselling, crisis intervention, lay counselling, referral, assessment and inquiries (NACOSA 2013: 3).*

While some terms overlap, subtle distinctions also exist between each. Health workers, criminal justice personnel and NGOs also utilise them to mean different things. Containment and debriefing were however, the two most common descriptions of their services, with containment described as comforting and calming someone down and explaining the procedures to be followed in the TCC. For those organisations who were debriefing, this comprised asking the victim to recount her experience – an activity that appeared to have a great deal in common with the CISD or psychological debriefing described earlier.

If organisations themselves were not entirely clear as to their role, then neither were the NPA and health staff based in the TCC. Indeed, defining and controlling the content and nature of NGO services constituted an important arena of struggle within the TCCs.

At some facilities the NGO worker was initially understood to be a nurse's auxiliary and expected to take patients' blood pressure and carry out other tasks identified by the nursing staff. When NGO workers declined to do so, relationships frequently soured with health personnel.

With notable exceptions most organisations were initially not clear as to what precisely it was they were to do within the TCC, and neither were the NPA and health staff based in the TCC.



Most organisations experienced difficulty in following up survivors after the initial report and forensic examination.

At the same time health workers unhappy with the facility's treatment of rape survivors also formed covert alliances with the NGO and passed on information that they hoped the NGO would take up and act on. Still other organisations reported being treated as the equivalent of a "family personal assistant" and instructed by the doctors on how survivors were to be assisted. Indeed, at one site health staff had simply taken over the NGO service, determining the roster of counsellors, the training they were to receive and their management. This appropriation of the NGO's staff included the counsellors being told to remove their belongings from the organisation's office and to place them in the health workers' offices instead. At a different site it was the NPA's site co-ordinator who had commandeered the service, instructing the NGO to stop running its rape survivor support groups and to reduce the number of their follow-up counselling sessions to three. At the time of the interview she was also seeking to replace the NGO on the basis that they did not want to undertake rapid HIV testing of rape survivors.

This insistence on NGOs performing rapid testing for HIV is an example of downward task-shifting and while resisted by some organisations on the grounds that they were not health workers (and therefore not competent to perform such a task), five organisations had taken on this role. A more common example of task-shifting was pre- and post-test counselling for HIV, with 11 organisations performing this function. In one province the NPA deemed all counsellors not qualified as auxiliary social workers to be incapable of providing any form of emotional support and confined their practice to providing pre- and post-test counselling alone.

Three slightly different roles for lay counsellors had thus become evident in the TCC: an HIV counsellor, a post-rape counsellor, and a victim's advocate. What distinguished the victim's advocate from the post-rape

counsellor was the degree of activism evident in their support to the victim. Unlike post-rape counsellors, victim's advocates also saw it as their role to actively ensure that the victim was well-treated and all procedures correctly followed and, when this did not occur, to take up the matter immediately. This role had been most developed by organisation A which, unlike the other organisations in the study, had not adapted their service on the entry of the NPA into the health facility. This was also the only service to use a "buddy" system.

Organisation A, which was based in a rural area, had inaugurated their service at the local hospital and police station in 2000. Over the years the service had become one in which the advocate would be present from the moment of reporting at the police station, to the forensic examination at the health facility. It was this particular advocate's responsibility to support the victim's adherence to PEP, with the organisation providing survivors with both bus tickets enabling their periodic return to the health facility, as well as e-pap (a nutritional support porridge) to ensure survivors took their medication with meals. The advocate also routinely followed up on criminal justice system procedures, monitoring bail proceedings as well as the police investigation and challenging criminal justice personnel when they thought matters were not being attended to as they should be. Advocates were also involved in monitoring court proceedings. Organisation A's service was thus far more strongly focused on the criminal justice system and PEP, than on counselling.

Only one other organisation provided as comprehensive a follow-up service to victims as organisation A. Organisation B, based in a different rural province, had stationed its volunteers at a number of police stations throughout the province, as well as health facilities and courts. Victims would thus be assisted at the police station, as well as the hospital - although by a different counsellor. The counsellor based

at the health facility was also responsible for regularly visiting the survivor (with her permission) to follow up on adherence to PEP, as well as update her on the progress of the police investigation. Court preparation and support were also offered once cases reached the trial stage.

The remaining organisations all experienced difficulty in following up survivors after the initial report and forensic examination, with none able to calculate what proportion of survivors returned for counselling either to their organisation (if they provided such a service), or to social workers employed by either the DoH or DSD. This had much to do with the form and location of follow-up services.

Within the TCC organisations' follow-up of rape survivors took three different forms. One (on the NPA's instruction) restricted lay counsellors' contact with victims to the immediate aftermath of the rape alone, with this group of counsellors discouraged from any further contact with survivors. This approach applied to all services to adults in one province, but only some services in other provinces. Where this model was

adopted, follow-up counselling was either provided by DoH social workers based at the health facility, another NGO, or DSD social workers. A second model saw some services making follow-up contact with survivors in order to encourage their adherence to PEP, as well as provide some rudimentary emotional support. Generally they too referred survivors to DoH social workers based at the health facility, another NGO, or DSD social workers for medium or long-term assistance. A third form of intervention saw organisations offering lay counselling from their offices.

However, at one TCC where DSD social workers provided all assistance to adults and the NGO assisted children, there was no form of service to adults for over a year when the social workers went on strike, according to one informant. Follow-up services provided by DoH social workers at other health facilities were also not always available, either because these were general social workers with a range of responsibilities (and thus very limited time), or because DoH staff refused to provide such services on the grounds that they were not paid to do so by the NPA.





At least **1 in 4**  
organisations  
experienced serious  
stressors between  
2012 and 2014

These were not the only factors affecting follow-up services. In some instances the geographical area served by the TCC was very large, with its furthest reaches up to three hours' drive away. If employed, some survivors could not afford the time off work to make regular trips to the TCC and, if unemployed, did not possess the means for such travel. Instead, unemployed victims were often reliant on the police to bring them to the TCC - which was not always feasible. For small stations based on the peripheries of a TCC's jurisdiction, dispatching their only vehicle to the TCC for a minimum of six hours was simply not an option, including at the time of reporting - which meant that victims falling within the far-flung corners of any particular TCC were often not transported to the facility. A few TCCs had also gained a reputation for poor service, with the police either choosing to take victims to another facility, or victims themselves asking to be taken to a different TCC. Because the preferred facility was further away from the victim's residence, this again introduced problems of distance, transport and cost. While most organisations tried to address these problems by referring survivors to their closest clinic to ensure PEP follow-up, there was often no local counselling service.

A further factor complicating follow-up was the availability of after-hours' health services at the TCC. Where after-hours services were only available from casualty (and doctors hard to locate) some stations did not bother to bring the victim for examination until the following day. By then, some victims no longer wished to pursue the matter. In other instances the victim would be brought to the facility and examined by the doctor. Doctors however, appeared to consider rapid testing a nurse's responsibility and so would provide the survivor with a three day starter pack of PEP only and instruct her to return the following day for an HIV test. Some did not and, where no counsellor was available, would be lost to follow-up.

Finally, the pain and distress of remembering the rape, potentially coupled with the reappearance of post-traumatic stress symptoms, also did not make counselling a particularly appealing option to some victims. It was the observation of one director that if women returned for follow-up counselling to the organisation where she was based, it was usually only about three months after the rape.

## Funding

The post-rape services in this study are fragile and at least one in four organisations had experienced serious stressors between 2012 and 2014. As the research was being designed, an organisation's services were terminated by the NPA following a strike by their counsellors over the R500 per month stipend they were paid for their work. The organisation was still in a precarious position when interviewed a year later. All staff had been informed that they would not be paid that month and perhaps for some months to come unless a donor provided bridging finance. A second organisation ceased operating altogether within the first five months of the NACOSA project, while a third was still recovering from the effects of having retrenched all but one

member of staff in 2012. Also during the course of the study, a fourth organisation discontinued its services at two hospitals and three police stations when further funding for these services could not be obtained. As the research began a fifth organisation was recovering from the worst financial year in its 26 year history and the retrenchment of 22 members of staff, while the entire staff complement of a sixth organisation had had their salaries cut for a seven month-period. A seventh had had to approach a donor for emergency funding when it became apparent that much of the TCC and its allied services were not going to continue. An eighth NGO, which had been funding the TCC service from its reserves and the Expanded Public Works Programme (EPWP), could no longer sustain this arrangement and handed the TCC service over to another organisation.

Only one organisation did not receive funding from NACOSA for their TCC service. Theirs was an after-hours service only provided by a pool of counsellors who were on call, rather than being stationed at the

TCC. The remaining 26 services were either funded entirely by NACOSA, or through a combination of NACOSA and DSD, or other funding. Eleven organisations (40.7%) were solely dependent on the NACOSA grant, with another two receiving additional funding from a source other than DSD. The remaining 13 organisations received some DSD funding which was combined with the NACOSA grant. In theory, DSD should have been funding all services.

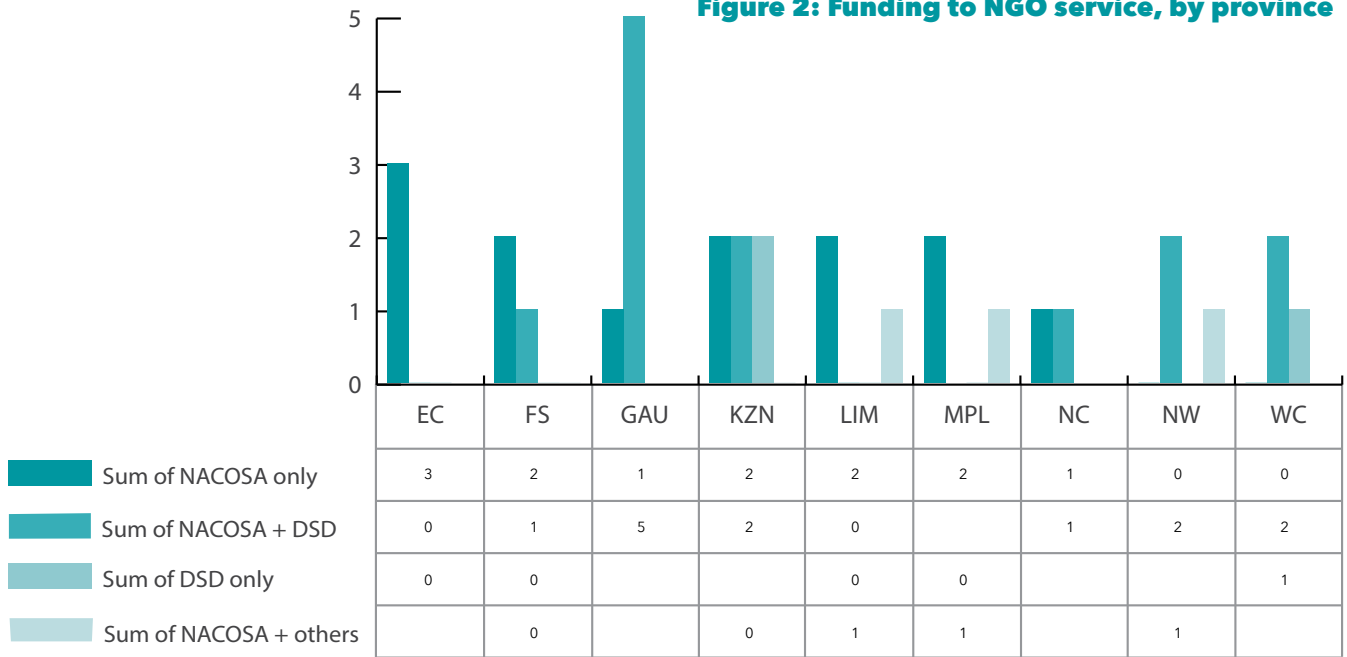
In 2010, when the costs of increasing the number of TCCs from 17 to 80 was being actively explored, the United Nations Children’s Emergency Fund (UNICEF) commissioned a report examining the cost-effectiveness of the TCC model. This calculated the operational, personnel and capital costs of a single TCC as amounting to approximately R4.6 million per centre (Dladla and Gabriels, 2010). It is worth reproducing their tabulation of personnel costs in detail, but noting that these figures were supplied by only one TCC – Manenberg in the Western Cape – so do not represent the average cost of all TCCs.

**Table 4: Personnel costs for a TCC**

Job Category	Department	No of posts	FTE	Remuneration p.a.	Actual cost
Clinical forensic practitioner (Dr)	Health	1	1	490 000	490 000
Pool of doctors	Health	1		873 685	873 685
Operational manager: nursing	Health	1	0.4	227 148	90 859
Forensic nurse	Health	1	1	267 150	267 150
Staff nurse	Health	1	0.6	86 805	52 083
Nursing services (over week-ends)	Health			93 684	93 684
Site co-ordinator	NPA	1	1	216 468	216 468
Victim Assistance officer	NPA	1	1	150 000	150 000
Case manager	NPA	1	1	478 577	478 577
Counsellors (Rape Crisis)	DSD	4	1	224 000	896 000
Cleaner	Health	1	0.5	51 000	25 500
<b>TOTAL</b>				<b>R3 158 517</b>	<b>R2 962 006</b>

Source: Dladla and Gabriels 2010: 82

**Figure 2: Funding to NGO service, by province**



In terms of this table, the salary budgeted for the counsellors is commensurate with that of a social worker, rather than a lay counsellor, and is a cost allocated to DSD. But as the study authors observed: “Mostly the services delivered are not budgeted for by the department on the basis of where the services are delivered” (Dladla and Gabriels 2010: 79). In other words, DSD was likely to be reluctant about paying for services provided from a facility managed by DoH.

The amounts proposed here were most certainly not being paid to organisations based in the TCCs, with no organisation’s TCC service entirely comprised of social workers. Most services were provided by lay counsellors, who were sometimes qualified as auxiliary social workers. Payment to these lay counsellors ranged from a minimum of R500 per month, to R6 000 per month, reflecting the inconsistent approach across provinces by DSD to the funding of these services.

To illustrate: the Western Cape’s Department of Social Development calculates the quantum of funding to be

awarded to any organisation on the number of rape victims it assists. This formula however, assumes that each survivor will only need to be seen once. Help to the survivor who requires more than one session of counselling is therefore unfunded – so guaranteeing a service that discourages follow-up assistance. While other provinces fund posts, this is dependent on the location of the service. Thus in some provinces the DSD would not fund services provided from a police station, arguing that because the service was based on police premises, this made it the police’s responsibility to fund. In a different province DSD was reportedly insisting that the NGO provide services from at least four police stations before it applied for funding.

Funding approaches could also be inconsistent within provinces, DSD choosing to fund three of an organisation’s TCC services but not its fourth, all of which were based in the same province. The organisation had received no explanation from the department for this decision. Funding could also summarily be brought to an end. Organisation M, with more than a decade’s service in the TCC, had been given weeks’ notice that it

would no longer be funded, as the DSD now wanted to support a different selection of organisations – none of which proposed providing services at the TCC. Retrenchments and cutbacks in the service loomed for M.

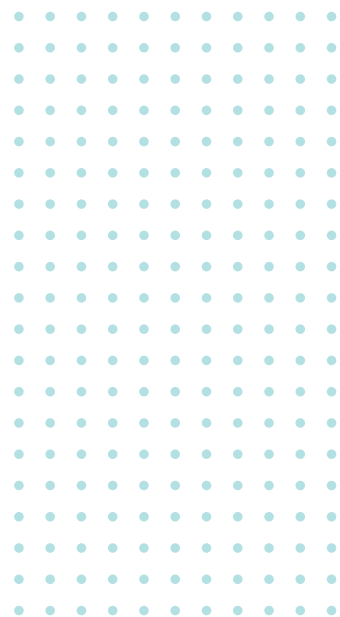
DSD and DoH also disagreed on who was to fund TCC services. Because counselling was seen to be a DSD service, DoH argued that DSD should fund NGOs. To DSD the fact of NGOs' location within a health setting made their funding DoH's responsibility. In other provinces DSD was funding these services on the basis that the content and nature of the service made it DSD's responsibility, regardless of the service setting. Still another organisation reported being told by DSD that the department was merely there to support the NPA – not fund its projects. Three organisations had resorted to the EPWP in an attempt to obtain financial support of their counsellors, one unsuccessfully. At the same time, it should be noted that the DSD contribution towards TCC counsellors was low, ranging from R500 per month, to R2 500 per month, with only one of the 13 organisations awarded DSD funds receiving more than R3 000 per month. Indeed, when the DSD paid a sum of R1 500 per month or less for a counsellor's services, they were effectively paying organisations less than the Ministerial determination for EPWP wages, set at R71 per day in 2013 (Vetten, 2015).

As figure 2 illustrates, DSD did not fund NGOs' TCC services in three provinces, with this number set to increase to four provinces when Free State DSD ceased supporting the only organisation it subsidised in 2015. Like Eastern Cape, this would make Free State entirely dependent upon NACOSA funding for the TCC service.

Between 2008 and 2012 organisations had been able to rely on funding provided by USAID in support of the TCCs. When this USAID contract with the NPA ended in

September 2012, so did the funding associated with it, leading five organisations entirely reliant upon USAID funds to withdraw their services from the TCCs. When a new five-year contract for \$10 million over a five year period was signed between the NPA and USAID no funding was allocated towards existing NGO counselling services. The bulk of these funds were allocated towards activities publicising the TCCs, research and building four new TCCs. An amount of R6.5 million was made available to the organisations entering the four new TCCs.<sup>6</sup> NACOSA stepped into the breach in late 2013 and began, once again, supporting organisations based in the TCCs. However, this funding, like that provided by the Western Cape DSD, is also calculated by the number of rape survivors seen.<sup>7</sup> Consequently, when fewer rape survivors were attended to at the TCC than estimated, organisations received a correspondingly reduced funding tranche – even though counsellors had still worked their shifts at the TCC.

These uncertainties in funding contributed to very diverse approaches to the payment of lay counsellors, which also demonstrate the highly ambiguous use of the term 'volunteer' in South Africa. Only one of the 27 organisations engaged the services of counsellors who were already in full-time employment elsewhere and this was to provide the after-hours' TCC service alone. Rather than being based at the TCC they worked on a call-out system and were paid accordingly. At most other TCCs volunteering had become a precarious livelihood strategy providing counsellors with their only source of income. Referring to this category of worker as a 'volunteer' was thus a misnomer, not only on the part of the organisation, but also by the DSD. For example, in one organisation the volunteers worked 10 twelve-hour shifts per month, equal to 120 hours, or three weeks of work per month, with DSD only



6 Personal communication, Ria Schoeman Gender-based violence programme specialist, Foundation for Professional Development, August 2015.

7 Personal communication, Sharon Kouta Gender-based violence programme specialist, NACOSA, March 2014.

**Hostile  
relationships  
undermine  
the entire  
notion of  
a one-stop  
centre.**

providing a stipend of R500 per month towards these volunteers' travel costs. It was this payment which resulted in the volunteers going on strike and the organisation's services being terminated by the NPA. In another organisation volunteers were also working 12-hour shifts but only being paid the NACOSA fee per rape survivor assisted - R412. Thus counsellors might work a 12-hour shift, see no rape survivors and go home having earned no money. In a few other organisations DSD funding tranches had either arrived late, or organisations had run out of funds to support the TCC service. Counsellors had nonetheless continued working without pay, sometimes even sleeping at the TCC because they wished the service to continue but had no funds for transport from their homes to the TCC.

Important consequences flowed both from designating this category of worker a 'volunteer,' as well as paying them poorly, irrespective of whether they were termed 'counsellors' or 'volunteers.' All counsellors earned less than the social workers, nurses, doctors and NPA staff based in the TCC. Many organisations thus had the impression that their counsellors, because the lowest-paid category of worker, enjoyed the least status and authority in the TCC, and were also considered low-skilled. This, many reported, was a key contributor to the confusion around their role in the TCC, as well as the low value placed on their contribution.

## Relationships within the TCCs

The status and skills of the counsellors comprised one element of the everyday micro-politics playing out between the different agencies located within the TCC. Indeed, in many instances TCCs emerged as contested spaces where power struggles played out between NPA and DoH, DSD and DoH, NGOs and NPA, NGOs and DoH and NGOs and DSD, with these battles locating agencies in hierarchical relationships to one another.

As already noted by the RTI audit, health facilities' degree of co-operation with and support to the TCC, as well as its integration into the hospital, varied across sites. This observation still applied at the time of the study. At its worst, this had resulted in a physical fight between the NPA site co-ordinator and a health worker, leading the entire complement of health staff to remove themselves and all the hospital equipment from the TCC to another site. After four months of negotiations, and the replacement of the site co-ordinator, the service resumed. Elsewhere, the entire hospital had relocated to a new, smaller facility, in the process relegating the organisation to a small back office some distance away from where the forensic examination was conducted. Unless police officers and health workers remembered the detour past the organisation's offices, the service was forgotten. While these two examples are extreme, organisations offered a range of examples suggesting that some health facilities saw them as interlopers, with the staff of at least two health facilities bluntly stating to the organisation's manager that the organisation was not wanted and its services not needed.

Other forms of disrespect were more subtle and typically revolved around the use of space in the TCC. Even though space was available some organisations were only provided with one office, despite having requested more. This made counselling very difficult as only one person could be assisted at a time if her confidentiality was to be maintained. All other staff would have to sit in the reception or go outside. Debriefing and supervision of counsellors was also made very difficult under these circumstances. At another site, health personnel would routinely walk in and out of counselling sessions, even when 'do not disturb' signs had been put up on the door. At other sites, as mentioned previously, nurses were not particularly helpful to counsellors once they discovered that counsellors were not nurses' aides.

Some sites were entirely driven by doctors who had determined both the flow of processes in the TCC, as well as the time allocated to each step. Counsellors were provided with only 15 minutes in which to assist survivors. At other sites the counsellor had been made the last person to see the victim before she left the TCC. Given that it is the counsellor's role to explain the TCC processes to the survivor, as well as accompany her through these, this effectively rendered the counsellor redundant. As a result the content and scope of TCC services varied widely, with those organisations based in more than one TCC observing that not one functioned like the other.

Some organisations managed these tensions by demonstrating "flexibility", or seeing themselves primarily as "assisting" because they were "on others' territory". What this meant in practice was accommodating, rather than contesting, health workers' practices and rules. However, this approach could also raise a particular dilemma for organisations, which organisation J captured as follows: how, as counsellors, could they enable rape victims to develop a more empowered approach to their lives, if they, as counsellors, could not practise this approach in their own lives?

At other sites it was the relationship between the NPA and NGO which was less than collegial, especially those sites which

had originally been NGO services prior to the NPA's arrival.

Poor relationships largely seemed the result of a poorly-handled transition from a NGO service to a TCC. At two sites respondents reported arriving at work one day to be met by NPA staff and the announcement "This is now our TCC." At a third site the service had been moved to a new facility less accessible to the community, which had also resulted in the termination of particular services. Community protests outside the facility had not changed these decisions.

Conversely, it was sometimes the NGO which was later added to the service and the government staff not prepared for their arrival. This reduced one DSD social worker to tears when she interpreted the NGO's arrival to mean that she had been dismissed. While the arrival of the NGO did not meet with such dramatic results at other sites, DoH and DSD social workers nonetheless felt their jobs were under threat and were unwelcoming of the organisation. These relationships do not seem to have improved with time and the effect of these various hostilities, whether covert or overt, was to undermine the entire notion of a one-stop centre. For while agencies shared a working space, this did not mean they shared information about survivors, or their follow-up, and nor did they actively cooperate to improve services. As organisations pointed out, where there was limited





**What seemed to be particularly essential was regular meetings within the TCC to explain each agency's purpose and function, with the process of entry needing to be particularly carefully managed (taking up to one year at one site).**

compliance with the NPA's protocol for TCC services, the quality of those services became highly susceptible to the personalities managing the TCCs and the quality of relationships between each institution.

In sum, organisations' relationships with either the DoH or NPA existed on a spectrum, with the end-points summed-up by two interviewees' characterisations of the TCC as either "it sucks", or "it's a wonderful service." Approximately one-third of organisations could be located on the "it sucks" end. While the relationships of a further 14 could be categorised as either neutral or good, it was the service which did not function as intended, either because it was not available on a 24/7 basis, or lacked human and material resources (such as social workers for follow-up services, or telephones with which to contact survivors and make follow-up appointments). More

than half (15) of organisations commented on the gaps in services from TCCs which were not 24-hour and reverted to casualty after-hours (sometimes to a completely different health facility). Rape survivors seen after-hours still waited hours to be seen by staff, who were not always trained in the forensic examination of rape survivors, and did not necessarily consider rape a priority.

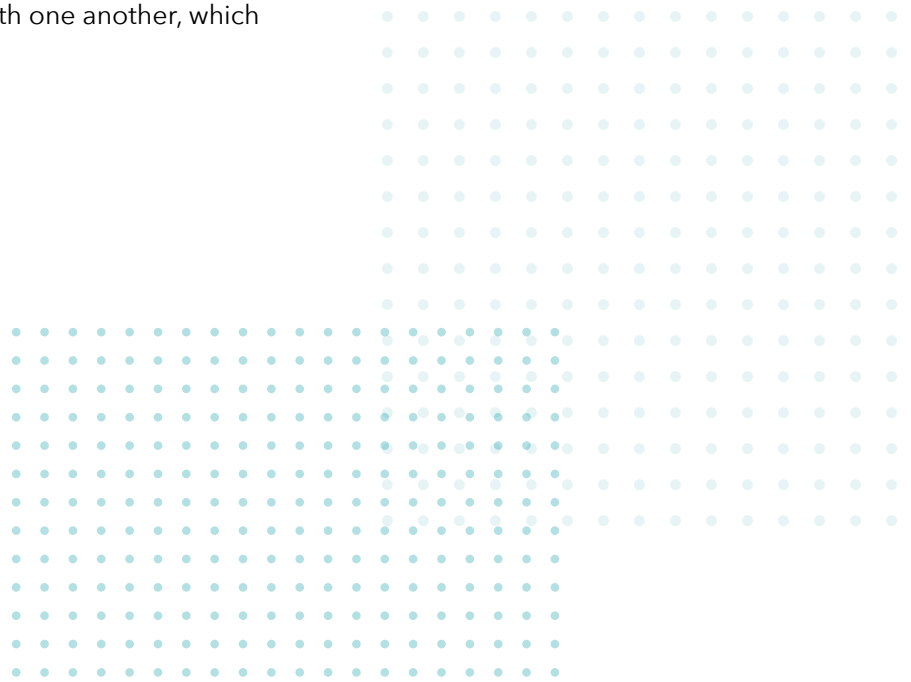
The ideal appeared to be the experience of five organisations where relationships were both good and the minimum components of the service appeared to be in place. These were the TCCs located on the opposite end of the spectrum: "it's a wonderful service." It was also clear that the presence of the NGO was valued by at least four sites, DSD requesting an organisation's return to the facility after they had been replaced by another organisation, and the DoH and/or DSD stepping in to fund an organisation on

the point of withdrawing from the TCC due to the loss of funding.

Organisations based at more than one TCC also had very different experiences at each site and had drawn some conclusions as to what facilitated good working relationships. These seemed the result of a combination of factors, including the length of time the TCC had been in existence and the number of changes to core management staff over the years. Long-established TCCs involving people with a history of working together were generally less conflictual than newer sites, or those marked by high staff turnover. What seemed to be particularly essential was regular meetings within the TCC to explain each agency's purpose and function, with the process of entry needing to be particularly carefully managed (taking up to one year at one site). Indeed, maintaining relationships was as core to the work of a TCC, as was the provision of quality services to rape victims. Where this was recognised, and there was a willingness to address conflict, TCC sites appeared genuinely able to work together, frankly raising issues of less-than-optimal performance with one another, which

generally led to an improvement in problems. When this point was reached, it was concern for the rape survivor, rather than defence and ownership of territory, which appeared to drive how a TCC functioned. These were the sites where rape survivors who returned for follow-up counselling often expressed their appreciation to the organisation of the service they had received from all agencies within the TCC.

Personalities were also important to the functioning of the TCC, particularly that of the NPA site co-ordinator. One interviewee, whose organisation worked in two TCCs, commented how, at the one TCC, the site co-ordinator had gone out of her way to include all parties in its working and management. It therefore felt more collaborative than the site where all roles were tightly regimented. At another site, indifferent attention to the TCC had been transformed when a senior staff member's daughter was raped and the shortcomings in the service exposed. Finally, in two instances NGO managers had previously worked in government departments before joining the NGO and this had helped build trust between parties.

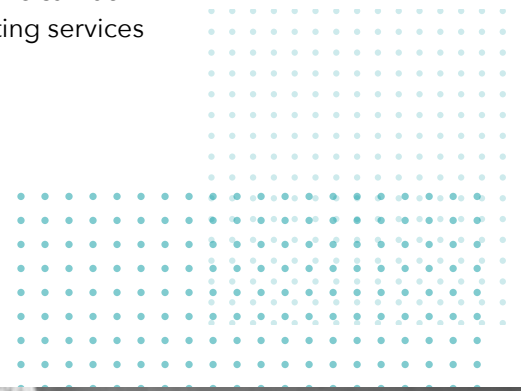


# Concluding recommendations

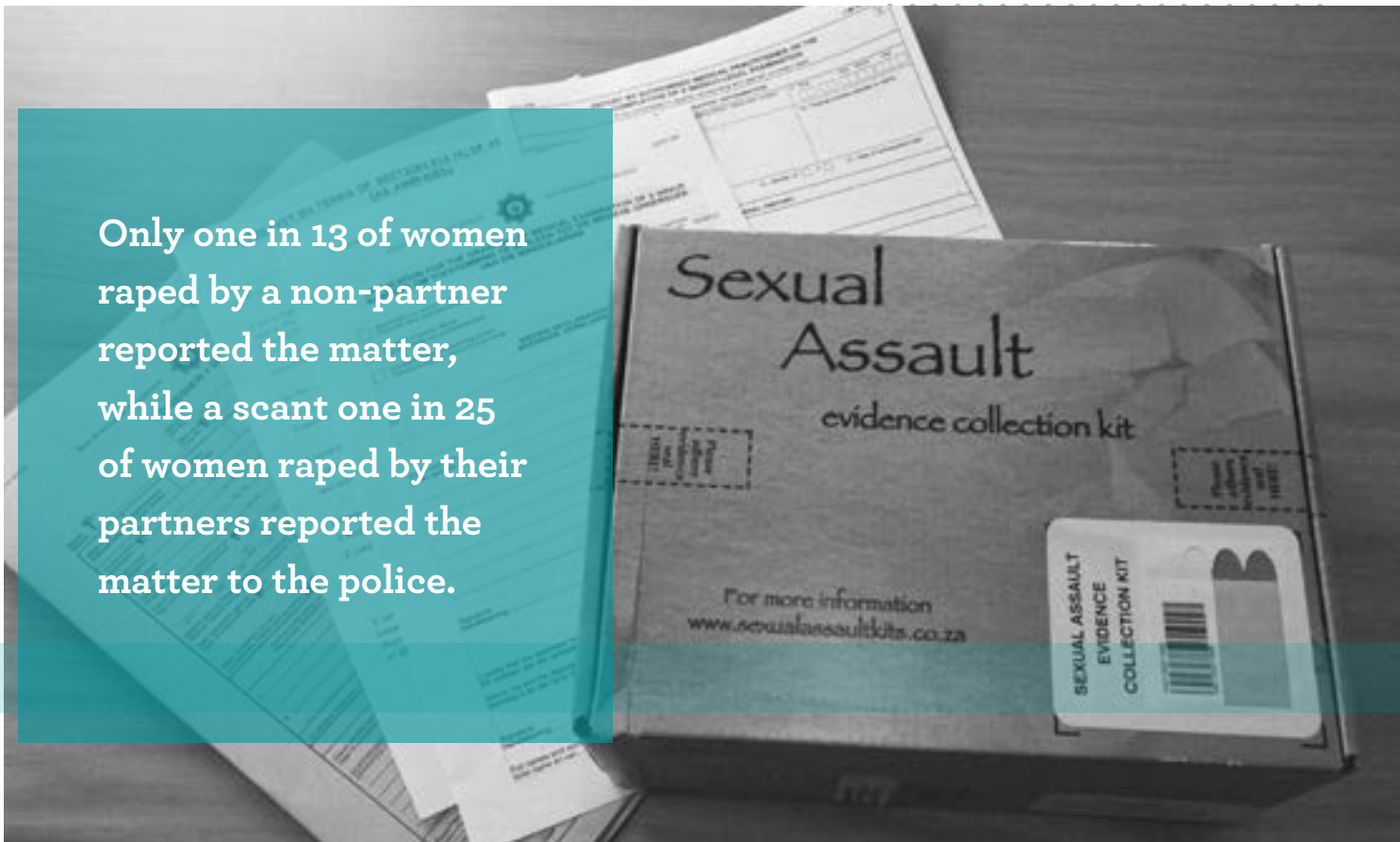
---

In theory, a one-stop centre is intended to reduce disjointed and uncoordinated services to rape survivors by locating all these services under one roof. However, as this study suggests, the mere fact of locating a range of agencies within one space does not automatically result in those agencies working together. In fact, such arrangements may generate a new challenge: reconciling competing interests and reducing conflict. Further, services may be described as 'one stop' only at the moment of reporting, with follow-up care continuing to be fragmented, as well as disjointed.

Indeed, emotional support services in the TCCs are treated as after-thoughts in many facilities. This is reflected in the inadequate funding for the service; the amount of space given to the service, as well as its physical location; and where in the TCC process the counsellor is located. A number of recommendations can be proposed to strengthen existing services and these are set out below.



**Only one in 13 of women raped by a non-partner reported the matter, while a scant one in 25 of women raped by their partners reported the matter to the police.**



# Recommendations for:

## 1 Community-based service providers:

Funding currently determines the nature, scope and extent of post-rape care in South Africa – rather than the nature, scope and extent of post-rape care determining the funding required by services. This situation must be reversed by establishing guidelines around the minimum core content of services to rape survivors during the acute stage of trauma, as well as over the medium to long-term. Determining this content is complicated by the absence of research in this area. Key research priorities therefore include identifying the key components of community-based services to rape survivors; investigation of the effects of these various interventions on rape survivors and the identification of evidence-based practice for this level of service; and exploration of rape survivors' perceptions and experiences of each intervention. These priorities would also need to acknowledge the diversity of rape survivors and ensure these varied needs are also considered.

Nonetheless, what can be promoted at this point are the guidelines collectively developed by 32 organisations under the auspices of NACOSA during 2014. This document, which draws on the principles of PFA, details the provision of acute stage post-rape care at either station or health facility level and lays a foundation for shared, standardised practice around emotional support to survivors, as well as training and debriefing for counsellors.

Organisations could also consider building on this process by forming a national body to act as a mechanism for self-regulation, as well as the setting of service standards for different forms of post-rape care as the data become available. Such a body could play a key role in funding negotiations with DSD by ensuring that services are at all times receiving the financial support necessary to providing good psycho-social support to rape survivors.

## 2 National Prosecuting Authority:

To strengthen the emotional support component of the TCC service it is recommended that organisations and the NPA meet to discuss incorporating the NACOSA acute stage post-rape care guidelines within the TCC protocol. If counsellors' roles are clearly prescribed and organisations enabled to manage this component of the TCC service, it may reduce the likelihood of NPA staff seeking to control or define what constitutes emotional support. It is also essential that the NPA ensure adequate funding to psycho-social services in future.

The study reinforces the observation of the RTI audit that there are significant variations to the TCC model, some of which impact negatively upon the quality of post-rape care. The NPA may wish to consider investigating how these variations may be reduced and whether or not different models may be required for areas where cost, transport and distance are barriers to accessing post-rape care.

## 3 Department of Social Development:

It is essential that DSD both standardise their funding practices nationally to ensure equitable funding of organisations' staff both within, as well as between provinces, and take a more generous approach to subsidising post-rape care. In pursuing a strategy of under-funding they are promoting self-exploitation and high staff turnover within organisations, as well as placing organisations in a position where they potentially violate labour legislation.

The psychological effects of rape are not identical to those of other traumas, as South African research finds. Indeed, subsuming post-rape care within generic victim empowerment guidelines, as DSD policy currently does, may well be doing a disservice to rape survivors. It is recommended

that organisations also engage with the DSD around adopting the acute stage guidelines and any others developed subsequently. The existence of such protocols will enable DSD to ensure that funding is commensurate with the desired standard of service.

#### **4** Department of Health:

Once the TCC protocol better recognises the scope and importance of organisations' contribution to the TCC model, this may result in counsellors being treated more respectfully. That said, there may need to be urgent intervention at those few sites where interviewees became visibly distressed while recounting their experiences with health staff - described as "bullying" by one. Further, there is evidence in this study of task-shifting from health workers to counsellors specifically in relation to pre- and post-test counselling, HIV testing and PEP follow-up. Given this, DoH must also consider funding NGOs' acute stage services to rape survivors.

#### **5** Donors:

In recent years there has been a move by donors away from funding post-rape care on the expectation that this support should come from the state. Before withdrawing support from such services it is recommended that donors ensure that this is actually the case. In addition, even if they choose not to support direct services, it is recommended that donors consider funding the research questions identified earlier, the training and development of counsellors and opportunities for organisations to develop their practice, as well as potentially form a self-regulating body.



**The mere fact  
of locating a  
range of agencies  
within one  
space does not  
automatically  
result in those  
agencies working  
together.**

# References

---

- Abrahams N, Jewkes R, Lombard C, Mathews S, Campbell J and Meel, B. (2010). 'Impact of telephonic psycho-social support on adherence to post-exposure prophylaxis (PEP) after rape', *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 22(10): 1173-1181.
- Abrahams N and Jewkes R. (2010). 'Barriers to post exposure prophylaxis (PEP) completion after rape: A South African qualitative study' *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care*, 12(5): 471-484.
- Allen B, Brymer MJ, Steinberg AM, Vernberg EM, Jacobs A, Speier AH and Pynoos RS. (2010). 'Perceptions of psychological first aid among providers responding to Hurricanes Gustav and Ike' *Journal of Traumatic Stress*, 23(4): 509-513.
- Arend E, Maw A, de Swardt C, Denny LA and Roland M. (2013). 'South African Sexual Assault Survivors' Experiences of Post-Exposure Prophylaxis and Individualised Nursing Care: A Qualitative Study' *Journal of the Association of Nurses in AIDS Care*, 24(2): 154-165.
- Artz, L., Smythe, D. and Leggett, T. 2004. *Reflections on Integrated Rape Case Management*. University of Cape Town: South Africa.
- Braam T and Makgalo M. (2009). *National Audit of Multi-disciplinary Services in South Africa Dealing with Sexual Offences. Volume 1: Final Consolidated report*. Report submitted by RTI International.
- Christofides NJ, Muirhead D, Jewkes RK, Penn-Kekana L and Conco DN. (2005a). 'Women's experiences of and preferences for services after rape in South Africa: interview study', *BMJ* DOI: 10.1136/bmj.38664.482060.55.
- Christofides NJ, Jewkes R, Webster N, Penn-Kekana L, Abrahams N. and Martin L. (2005b) "Other patients are really in need of medical attention" - the quality of health services for rape survivors in South Africa' *Bulletin of the World Health Organisation*, 83(7): 495-502.
- Collings SJ. (2009). 'Where the streets have no names: factors associated with the provision of counselling and social work services for child rape services in KwaZulu-Natal, South Arica' *Journal of Child and Adolescent Mental Health*, 21(2): 139-146.
- Coomaraswamy, R. (1997). *Report on the mission of the Special Rapporteur to South Africa on the issue of rape in the community (11 - 18 October 1996)*. United Nations Economic and Social Council Report E/CN.4/1997/47/Add.3
- Department of Social Development. (2010). *Guidelines for Services to Victims of Sexual Offences*. Pretoria: Department of Social Development.
- Dickman B, Roux A, Manson S, Douglas G and Shabalala N. (2006). 'How could she possibly manage in court?' An intervention programme assisting complainants with intellectual disabilities in sexual assault cases in the Western Cape' in Brian Watermeyer, Leslie Swartz, Theresa Lorenzo, Marguerite Schneider, Mark Priestley (eds) *Disability and Social Change in South Africa*. Cape Town: HSRC Press.

Dladla Y and Gabriels H. (2010). *Final Research Report Cost-effectiveness Study Thuthuzela Care Centres (TCC)*. Report prepared for UNICEF by YD Consulting.

Dunkle K, Jewkes R, Brown H, Yoshihama M, Gray G, McIntyre J and Harlow S. (2004). 'Prevalence and Patterns of Gender-based Violence and Revictimization among Women Attending Antenatal Clinics in Soweto, South Africa' *American Journal of Epidemiology* 160(3): 230-239.

Edwards DJA. (2009). 'Treating Posttraumatic Stress Disorder in South Africa: An Integrative Model Grounded in Case-Based Research' *Journal of Psychology in Africa* 19(2): 189-198.

Egan G. (10th edition, 2013). *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping*. Belmont: Brooks/Cole.

Forbes D, Creamer M, Bisson JI, Cohen JA, Crow BE, Foa EB, Friedman MJ, Keane TM, Kudler HS and Ursano RJ. (2010). 'A Guide to Guidelines for the Treatment of PTSD and Related Conditions' *Journal of Traumatic Stress* 23(5): 537-552.

Gevers A and Abrahams N. (2014). *Capacity Assessment of Mental Health Services for Rape Victims in Acute Health-Care Settings: A rapid appraisal of services in the Western Cape Province*. Cape Town: Medical Research Council.

Govender, P. (2007). *Love and Courage A Story of Insubordination*. Auckland Park: Jacana Media.

Herman JL. (1992). *Trauma and Recovery*. London: Pandora Press.

Human Rights Watch. (1995). *South Africa: The State Response to Domestic Violence and Rape*. [Online]. Available at: <http://www.hrw.org/reports/1995/Safricawm-02.htm> [Site accessed 1 March 2015]

Human Rights Watch. (1997). *Violence against women and the medico-legal system*. [Online]. Available at: <http://www.hrw.org/legacy/reports/1997/safrica/> [Site accessed 1 March 2015].

Jewkes R, Vundule C, Maforah F and Jordaan E. (2001). 'Relationship dynamics and teenage pregnancy in South Africa', *Social Science and Medicine* 52: 733-744.

Jewkes, R. and Abrahams N. (2002). 'The epidemiology of rape and sexual coercion in South Africa: an overview.' *Social Science and Medicine*, 55(7): 1231-1244.

Kaganas, F and Murray, C. (1991). 'Law Reform and the Family: The New South African Rape-in-Marriage Legislation.' *Journal of Law and Society* 18(3): 287-302.

Kaminer D, Grimsrud A, Myer L, Stein DJ and Williams DR. (2008). 'Risk for post-traumatic stress disorder associated with different forms of interpersonal violence in South Africa.' *Social Science and Medicine* 67: 1589 - 1595.

Kaminer D and Eagle G. (2010). *Traumatic Stress in South Africa*. Johannesburg: Wits University Press.

Kiguwa P and Langa M. (2011). 'South African psychology and gender: An analysis of the SAJP and PINS journals 1994-2009' in A Rutherford, R Capdevila, V Undurti and I. Palmary (eds) *Handbook of International Feminisms: perspectives on psychology, women, culture and rights*. New York: Springer.

Kim J, Askew I, Muvhango L, Dwane N, Abramsky T, Jan S, Ntlemo E, Chege J and Watts C. (2009). 'Comprehensive care and HIV prophylaxis after sexual assault in rural South Africa: the Refentse intervention study' *BMJ* 338: b515 DOI: 10.1136/bmj.b515

Machisa M, Jewkes R, Lowe Morna C and Rama K. (2010). *The War at Home - GBV Indicators Project*. Cyrildene: Gender Links.

Macleod C and Howell S. (2013). 'Reflecting on South African Psychology: Published research, 'relevance', and social issues' in *South African Journal of Psychology* 43(2): 222-237.

Mafani P. (2014). *Thuthuzela Care Centre Model*. Presentation to NACOSA meeting, 27 February 2014.

Mathews, S, Abrahams, N and Jewkes, R. (2013). 'Exploring Mental Health Adjustment of Children Post Sexual Assault in South Africa' *Journal of Child Sexual Abuse* 22(6): 639-657.

Maw A. (2013). *The Psychological Impact of Rape: A Longitudinal Study of Adult Female Survivors in the Western Cape, South Africa*. Thesis submitted in fulfilment of a PhD degree in the Department of Psychology, University of Cape Town.

NACOSA. (2014). *The state of post-rape care in South Africa: Current practices and challenges Workshop report 12 - 13 May*. Report in possession of the author.

National Prosecuting Authority. (n.d.) *The Thuthuzela Care Centres*. [Online]. Available at: <http://www.npa.gov.za/UploadedFiles/THUTHUZELA%20Brochure%20New.pdf> [Site accessed 5 January 2015]

National Prosecuting Authority. (2010). *October 2010 Performance Information Report (draft)*. [Online]. Available at: <http://www.npa.gov.za/ReadContent506.aspx> [Site accessed 5 January 2015]

Nkabinde TC, Ross A, Reid S and Nkwanyana NM. (2013). 'Internship training adequately prepares South African medical graduates for community service - with exceptions', *South African Medical Journal*, 103(12): 930-934.

Padmanabhanunni A and Edwards D. (2013). 'Victimisation in the Lives of Lesbian-Identified Women in South Africa: Implications for Clinical Assessment and Treatment' *Journal of Psychology in Africa* 23(3): 385-392.

Padmanabhanunni A and Edwards D. (2014). 'A Phenomenological Case Study of the Therapeutic Impact of Imagery: Rescripting Memories of a Rape and Episodes of Childhood Abuse and Neglect' *Indo-Pacific Journal of Phenomenology*, 14(1): 1-16.

Padmanabhanunni A and Edwards D. (2015). 'Rape Survivors' Experiences of the *Silent Protest*: Implications for Promoting Healing and Resilience' *Qualitative Health Research*, February 25: 1-12, doi:10.1177/1049732315573201.

Payne C and Edwards D. (2009). 'What services and supports are needed to enable trauma survivors to rebuild their lives? Implications of a systematic case study of cognitive therapy with a township adolescent girl with PTSD following rape' *Child Abuse Research in South Africa*, 10(1): 27-40.

Regehr C, Alaggia R, Dennis J, Pitts A and Saini M. (2013). *Interventions to reduce distress in adult victims of sexual violence and rape*. Campbell Systematic Review 3. DOI: 10.4073/csr.2013.3

Research Triangle Institute. (2007). *Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault Care*. USAID report prepared for the SOCA Unit.

Rohrs, S. (2011). "I feel for rape survivors, but I don't have the time, I'm always running." Cape Town: Gender, Health and Justice Research Unit, University of Cape Town.

Roland M, Myer L, Martin LJ, Maw A, Batra P, Arend E, Coates TJ and Denny, L. (2011). 'Preventing Human Immunodeficiency Virus Infection Among Sexual Assault Survivors in Cape Town, South Africa: An Observational Study', *Journal of AIDS Behaviour* 16(4): 990-998.

Rose SC, Bisson J, Churchill R and Wessely S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD000560. DOI: 10.1002/14651858.CD000560.

Russell, D. (1989). *Lives of Courage: Women for a New South Africa*. New York: Basic Books.

Sandfort TGM, Baumann LRM, Matebeni Z, Reddy V and Southey-Swartz I. (2013). 'Forced Sexual Experiences as Risk Factor for Self-Reported HIV Infection among Southern African Lesbian and Bisexual Women' *PLoS ONE*, 8(1): e53552. doi:10.1371/journal.pone.0053552

Simon B. (2000). Every 26 seconds *CBS News* [Online]. 1 February. Available from: <http://www.cbsnews.com/news/every-26-seconds/> [Site accessed 27 May 2015].

Smith C. (2001). *Proud of Me*. Johannesburg: Penguin Books

Smith P and Mafani P. (2013). *Thuthuzela Care Centre Model*. Presentation to the 8th Annual Prosecutors' Association Conference 2013, Cape Verde, Praia. [Online]. Available at: [http://www.africaprosecutorsassociation.com/pdf/8conference/smith\\_and\\_mafani\\_tcc\\_sa\\_presentation\\_oct\\_2013.pdf](http://www.africaprosecutorsassociation.com/pdf/8conference/smith_and_mafani_tcc_sa_presentation_oct_2013.pdf) [Site accessed 17 February 2015]

South African Police Service. (2009). *Annual Report 2008/09*. Pretoria: SAPS.

South African Police Service. (2010). *Crime Statistics: April 2009 - March 2010 Per Province: Per Stations*. Available from: <http://www.saps.gov.za/statistics/reports/crimestats/2010/province.htm>

South African Police Service. (2013). *An Analysis of the National Crime Statistics 2012/13*. Pretoria: South African Police Service.

UN Women. (2011). *Progress of the World's Women 2011 - 2012: In Pursuit of Justice*. [Online]. Available at: <http://www.unwomen.org/~media/headquarters/attachments/sections/library/publications/2011/progressoftheworldswomen-2011-en.pdf> [Site accessed 5 February 2015].

van Zyl, M. (1991). 'Invitation to Debate: Towards an explanation of violence against women.' *Agenda* 11: 66-77.

Vetten L and Haffejee S. (2005). *Factors affecting Adherence to Post-exposure Prophylaxis in the Aftermath of Sexual Assault: Key Findings from Seven Sites in Gauteng Province*. Report prepared for the Gauteng Department of Health.

Vetten L, Jewkes R, Fuller R, Christofides N, Loots L and Dunseith O. (2008). *Tracking Justice: The attrition of rape cases through the criminal justice system in Gauteng*. Johannesburg: Tshwaranang Legal Advocacy Centre, South African Medical Research Council and the Centre for the Study of Violence and Reconciliation

Vetten, L, Le, T, Leisegang, A. and Haken S. (2010). *The Right and Real: A Shadow Report Analysing Selected Government Departments' Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act*. Johannesburg: Tshwaranang Legal Advocacy Centre.

Vetten L. (2014). *Evaluation Synthesis - Violence Against Women And Child Sexual Abuse*. Report prepared for the Gauteng Planning Commission, Office of the Premier Gauteng Provincial Government

Vetten L. (2015). *Who cares? Post-rape services and the Expanded Public Works Programme in South Africa*. Cape Town: the Heinrich Boell Stiftung.

Vogelman, L. (1990). *The Sexual Face of Violence: rapists on rape*. Johannesburg: Raven Press LTD.

# About the project partners

---



[www.shukumisa.org.za](http://www.shukumisa.org.za)  
[coordinator@shukumisa.org.za](mailto:coordinator@shukumisa.org.za)  
021 447 1467

## The Shukumisa Campaign

The Shukumisa Campaign was launched in 2008 by members of the National Working Group on Sexual Offences (NWGSO). The NWGSO was originally formed in 2004 to advocate around the proposed Sexual Offences Bill. When the Criminal Law [Sexual Offences and Related Matters] Amendment Act no. 32 of 2007 (Sexual Offences Act) was passed in late 2007, the NWGSO turned its focus to the implementation of the Sexual Offences Act and reformulated itself as the Shukumisa Campaign.

The Shukumisa Campaign aims to stir and shake up public and political will to develop and implement policies and strengthen laws related to sexual offences in South Africa. It periodically carries out monitoring at police stations, health facilities and courts to determine the extent to which government departments and service providers are meeting their commitments to providing services to victims of sexual offences.

The Shukumisa Campaign is made up of 47 organisations from all nine provinces and is governed by a steering committee comprising of 10 organisations. The Shukumisa Campaign coordinator is housed at the Rape Crisis Cape Town Trust (RCCTT) and is based at their office in Cape Town.

The Shukumisa Campaign has a vision of a South Africa with well crafted, well implemented sexual offences legislation and a strong criminal justice system that supports rape survivor's access to justice and provides a clear deterrent to rapists.

In 2013 Shukumisa and Action Aid South Africa (AASA) signed an agreement to collaborate on the Young Urban Women (YUW) Programme. Shukumisa is a strategic advisory partner supporting on advocacy strategies for YUW to better articulate their needs and lobby around Sexual Reproductive Health Rights (SRHR) and decent work. The implementing partner organisations Shukumisa works with are Afrika Tikun in Johannesburg and Wellness Foundation in Cape Town.

---

## YUW Programme

The Young Urban Women Programme (YUW) is a multi-country programme implemented by ActionAid South Africa in urban areas across South Africa, Ghana and India. It seeks to enable young women's economic participation and ensure the realisation of their sexual and reproductive health rights. In South Africa, the YUW programme is implemented in Johannesburg and Cape Town and is targeted at working with 1000 young women between the ages of 14 - 25 years old. One of ActionAid's five strategic objectives is to "Ensure that women and girls can break the cycle of poverty and violence, build economic alternative and claim control over their bodies". This TCC research report provides useful information in as far as provision of emergency care services are available for young women in their communities. This is a continued area of advocacy for young women who presently find access to public health service on SRHR and information unavailable at local health facilities. The evidence from this report provides substantive evidence for the advocacy they will work on to make emergency services available and appropriate for all women but particularly young women who require adolescent friendly and appropriate services. We believe that this is a groundbreaking piece of work as it sheds light on the state's response to emergency services nationwide.



ActionAid South Africa  
[www.actionaid.org/south-africa](http://www.actionaid.org/south-africa)  
[info.za@actionaid.org](mailto:info.za@actionaid.org)  
011 731 4566



[www.shukumisa.org.za](http://www.shukumisa.org.za)  
[coordinator@shukumisa.org.za](mailto:coordinator@shukumisa.org.za)  
021 447 1467

Locating a range of agencies within one space does not automatically result in those agencies working together. In fact, such arrangements may generate a new challenge: reconciling competing interests and reducing conflict. Further, services may be described as 'one stop' only at the moment of reporting, with follow-up care continuing to be fragmented, as well as disjointed. Indeed, emotional support services in the TCCs are treated as after-thoughts in many facilities. This is reflected in the inadequate funding for the service; the amount of space given to the service, as well as its physical location; and where in the TCC process the counsellor is located.