



**A Critical Assessment
of the Role of NGOs
in the Delivery of Services to Sexual
Gender Based Violence Survivors
at Thuthuzela Care Centres**

March 2017



Acknowledgments

A special thank you goes to the organisations that formed part of a task team to provide advice and assistance to the Shukumisa TCC Monitoring Project, namely Thohoyandou Victim Empowerment Programme (TVEP), Justice and Women (JAW), Rape Crisis Cape Town Trust (RCCTT), Ekupholeni Mental Health and Trauma Centre (EMHTC), Lifeline Durban, Greater Rape Intervention Programme (GRIP) and the Networking HIV, AIDS Community of South Africa (NACOSA).

Thank you as well to the consultants who came on board at very short notice to assist with the completion of the project, Bongwiwe Ndondo, Vicci Tallis and Bulelwa Mshumpela.

This report would not have been possible without the organisations who gave so generously of their time and participated willingly in the interviews and the consultative forum that formed part of the project. Thank you to all!

Lastly, this report is made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the Presidents Emergency Plan for AIDS Relief. The contents are the responsibility of FPD and do necessarily reflect the views of USAID or the United States Government”

The report was compiled by Bongwiwe Ndondo with the assistance of Aniela Batschari (Shukumisa Coordinator). Finalising the report was a collaborative effort including the other consultants and the organisations who participated in the interviews and the consultative forum.



Contact Details:

The Shukumisa Coalition c/o The Rape Crisis Cape Town Trust, 23 Trill Rd, Cape Town

Tel: 021-447 1467 / Cell: 082-546 4261

Email: shukumisacampaign@gmail.com / Website: www.shukumisa.org.za

Table of Contents

Executive summary.....	5
List of Abbreviations	10
Definition of Terms.....	11
1.0 INTRODUCTION.....	13
1.1 The Shukumisa Coalition.....	13
1.2 The TCC Monitoring Project	13
2.0 BACKGROUND	14
2.1 Definition of Sexual Violence	14
2.3 Sexual gender based violence: Statistics, reporting and the law	15
2.4 Services available to sexual assault victims.....	17
<i>Psychosocial support: The Role of DSD.....</i>	<i>17</i>
<i>Investigative and prosecutorial services: The role of the criminal justice system (SAPS, NPA and DoJ).....</i>	<i>18</i>
<i>Medico-forensic services: The role of the Department of Health (DoH).....</i>	<i>19</i>
2.5 The Thuthuzela Care Centres.....	20
2.6 Psychosocial support for survivors of sexual gender based violence	22
3.0 METHODOLOGY	23
3.1 The purpose of the research study	23
3.2 Research objectives	23
3.3 Data Collection.....	23
3.4 Description of respondents.....	24
4.0 RESULTS/FINDINGS – In-depth Interviews	25
4.1 Nature of psychosocial services offered by NGOs in the TCCs.....	25
<i>Containment counselling.....</i>	<i>25</i>
<i>Emotional counselling.....</i>	<i>25</i>
<i>Pre and post-test HIV counselling.....</i>	<i>26</i>
<i>Adherence counselling.....</i>	<i>26</i>
<i>Follow up therapy.....</i>	<i>26</i>
<i>Group therapy.....</i>	<i>26</i>
<i>Community outreach.....</i>	<i>26</i>
4.2 Funding of NGO TCC work.....	27
<i>Funding for psychosocial services in TCC is often fraught with inadequacy and uncertainty.....</i>	<i>27</i>
4.3 Extent of sexual gender based violence in South Africa.....	28
4.4 Drivers of sexual gender based violence (socio-cultural and systemic factors) 28	
<i>Culture of interpersonal violence</i>	<i>28</i>
<i>Patriarchy and gender inequality.....</i>	<i>29</i>
<i>An ineffective and unresponsive criminal justice system</i>	<i>29</i>
<i>Fragmented and ineffective programmes.....</i>	<i>30</i>
<i>Alcohol and substance abuse.....</i>	<i>30</i>
<i>Harmful cultural and religious beliefs.....</i>	<i>30</i>
<i>Poverty.....</i>	<i>30</i>
4.5 Barriers to reporting sexual gender based violence.....	30
<i>Most people do not know their rights.....</i>	<i>30</i>
<i>There is poor knowledge of the TCCs and perceived poor quality services</i>	<i>31</i>
<i>Protection of perpetrators.....</i>	<i>32</i>
<i>Logistical challenges</i>	<i>32</i>

<i>Denial on the part of parents</i>	32
4.6 Perceived efficacy of the TCC model	33
<i>TCC is conceptually a great model, it is patient focussed and minimises secondary victimisation</i>	33
4.7 Challenges faced in the TCC	33
<i>Long waiting times</i>	34
<i>Inadequate working space and other infrastructure</i>	34
<i>Inadequate resourcing</i>	35
<i>Poor stakeholder relationships:</i>	35
<i>Lack of accountability</i>	36
<i>Administrative challenges</i>	37
4.8 Perceived quality of services	37
4.9 Policy gaps and lack of harmonisation.....	38
5.0 RESULTS/FINDINGS – Consultative Workshop	41
5.1 Theme 1: Funding and sustainability of TCC.....	41
<i>Funding is inadequate</i>	41
<i>Government should take responsibility and provide the funding</i>	41
<i>Foreign funding, often used by NGOs as supplementary funding has a lot of short comings</i>	41
<i>Funding for TCC should cover 24/7 services</i>	41
<i>CARA funding should be made more accessible to NGOs</i>	42
<i>The NGO rationalisation process is threatening the survival of NGOs and compromising support for sexual assault victims</i>	42
<i>Inequity in the salaries for social workers is detrimental to patient care</i>	42
5.2 Theme 2: Relationships and Partnerships	43
<i>There are poor relationships between various stakeholders in TCCs, and in particular between the DOH and NGOs</i>	43
<i>Some TCC staff are not always on site</i>	43
<i>There is poor accountability in how TCCs are managed</i>	43
5.3 Theme 3: Service Delivery at TCCs	44
<i>Efficacy of the TCC model</i>	44
<i>Limited space and long waiting times</i>	44
<i>Poor access to TCCs</i>	44
<i>Outdated protocols and protocols not followed</i>	44
5.4 Theme 4: Policies and Protocols	44
<i>Different interpretation and gaps in knowledge about policies amongst NGO staff</i>	44
6.0 SUCCESSES AND CHALLENGES	46
6.1 Successes	46
6.2 Challenges.....	47
7.0 RECOMMENDATIONS	48
8.0 CONCLUSION	50
9.0 WAY FORWARD	50
10.0 REFERENCES	52
Annex 1	53

Executive summary

BACKGROUND

The Sexual Offences and the Domestic Violence Acts are the pillars of South Africa's legislative response to sexual gender based violence. In spite of these progressive policies, South Africa continues to experience unprecedented levels of sexual gender based violence. Several reasons have been cited for this, including socio-cultural drivers and systemic failures in the implementation of these policies.

One of the innovations of the Department of Justice, who are the custodians of the Sexual Offences Act (SOA) is the Thuthuzela Care Centres (TCCs). These are one stop shop facilities that provide medical and forensic services, psychosocial counselling and prosecutorial services to victims of sexual gender based violence. The intention is to offer an integrated service from emergency trauma care to preparation for court, ideally reducing the overall length of time in finalising cases and improving conviction rates. The psychosocial services are offered by NGOs who work within the TCCs. Although without them it would not be possible to offer 24-hour services to victims, they do not currently form an integral and essential part of the TCC Blue Print or model and therefore are required to source their own funding to enable them to deliver these essential services.

METHODOLOGY

In 2017, the Shukumisa Coalition commissioned a study to understand the role played by the NGOs in TCCs and the challenges that they face. Qualitative data was collected from 19 NGOs key informants through a structured questionnaire and a consultative forum. The results showed a myriad of successes and innovative practices instituted by the NGOs to advance the well-being of, and restore justice to SGBV survivors. However, numerous challenges were also cited, relating to both conceptual, operational and institutional arrangements in the TCCs.

FINDINGS

Extent of SGBV and systemic under reporting

The NGOs reflected on the shocking incidences of SGBV that they saw in the TCCs and expressed concern about under reporting which they understood to be due to a number of factors, including a lack of faith in the criminal justice system, poor knowledge of the TCCs, limited access to transport due to high fees charged, perceived poor quality of services and the protection of perpetrators for fear of further victimisation or because they are bread winners.

Efficacy of the TCC model

Some of the NGO participants felt that the TCC model was conceptually sound but in its current form lacked operational robustness. The model has not been hugely successful in securing convictions and the NPA statistics masked the true picture. They also argued that it was not ideal for the NPA to lead the partnership at site level because they were not well placed to oversee a trauma centre.

There was a feeling that having the NPA at the realm, whose interest is to catch the perpetrators and bring them to trial - goes against the spirit and ethos of the TCCs which is to support and provide care to a victim of trauma.

The NGO participants also complained about poor accountability at site level. As a result – TCCs were not delivering on their mandate to offer victim centred care and increasing the rate of prosecutions. They argued that the NPA was failing to hold everyone accountable for their work because they lacked the authority over other government departments. They suggested that for the model to work better – an independent – non-government body needs to be the site manager and hold all the government departments accountable for their responsibilities. Concern was also expressed that the successful implementation of the model is largely dependent on the personality and capacity of TCC staff members.

Quality and standardisation of services offered by NGOs

Although most of the NGO participants were comfortable with the services offered in TCCs, they also expressed concern regarding protocols not being followed, and a lack of bench marking to ensure a standardised range and quality of services.

Funding and sustainability of NGO services in TCCs

Most NGOs were funded by the DSD and/or the Global Fund. It was clear that the funding provided by DSD was inadequate and did not cover services 24/7. As a result NGOs sought supplementary funding from foreign donors which made the model unsustainable. Most of the funding was short term which severely limits their ability to sustain quality services and retain experienced staff.

There was a reflection on the need to improve the mechanisms used to disburse CARA funding – making it more accessible to NGOs through an efficient grant making process. Other concerns around funding included the need to standardise subsidies for social workers across provinces and between government and the NGO sector. Lastly, the NGO rationalisation process was seen to threaten the delivery of quality services to SGBV victims.

Challenges faced by NGOs

NGOs cited several challenges to performing their duties. These included long waiting times, inadequate infrastructure, space, resourcing, poor stakeholder relationships and administrative issues. The majority of these challenges stem from the lack of respect afforded to them by other stakeholders, which in turn is a direct result of the failure of the TCC model to recognise and accommodate the importance of their involvement.

Policy implementation gaps

Whilst the DVA and the SOA are seen to be sound and progressive pieces of legislation in dealing with SGBV in South Africa, they are by no means comprehensive and several implementation gaps were cited; all of these being worsened by an overall lack of accountability in enforcing the legislation. These included police turning away victims of intimate partner violence, a narrow interpretation of exposure to HIV, defined primarily by physical penetration, unjustifiable denial of consent to HIV testing of minors by parents and inconsistencies and lack of harmonisation of various government department policies relating to SGBV.

RECOMMENDATIONS

Several recommendations were made, which included the following:

Recommendation 1

The Department of Social Development needs to take more responsibility and accountability for the provision of psychosocial services to victims of sexual gender based violence through addressing gaps in the current legislation and putting in place a sustainable funding model for NGOs and TCCs in general.

- a) The SOA should be revised to make psychosocial support imperative for SGBV survivors. This will ensure that any service delivery models, such as the TCCs include the role of NGOs in their blue print.
- b) The TCC blue print should be revised to support a 24/7 services, without which more than 60% of the victims of reporting to TCCs would not receive a full range of timely service. To this end, all government departments involved in resourcing the TCC should align their plans and budgets and should include the costs of multi-agency stakeholder platforms, engagements and routine collaborative processes
- c) DSD should provide funding for NGOs on a long term contractual basis and take greater ownership of the role played by NGOs through defining and funding core essential services for SGBV victims and debriefing services for care givers. Funding for SGBV care should be ring-fenced. This is in line with the National Policy Framework which mandates DSD to provide a funding framework and support for NGOs contracted to provide services to victims of sexual offences.
- d) An independent capable body should be set up to manage the disbursement of the CARA funding. They should be held accountable for efficiency and reporting.
- e) There is a need to undertake a study on various sources of funding for TCC and determine what proportion is foreign funding. Knowing what government's contribution is will help assess the sustainability of the TCC model and measure governments own commitment to addressing SGBV and achieving gender equity.

Recommendation 2

The TCC model has to be revised to ensure greater effectiveness, improved operational efficiency and better patient outcomes

- a) DSD should provide clarity on what are considered 'essential' services for sexual assault victims to ensure uniform offering at all TCCs and ability for stakeholders to hold each other accountable
- b) The government should contract the services of an independent non-governmental body to run the TCCs based on an agreed framework and standard of delivery. The current model does not allow for accountability monitoring because it is inherently difficult for a government department to hold another to account.
- c) There should be a costed operational model for TCCs, which should include all services offered and resources required based on the conceptual model.

This will help bench mark the quality of services, measure funding gaps and be the basis for advocating for additional resources.

- d) In light of the limited number of TCCs – 55 country-wide – government should set up satellite TCCs and cheaper SGBV trauma management models to provide services closer to communities in order to increase access.
- e) An integrated training programme should be offered to all TCC staff, as part of capacity building and team building. This training should include roles and responsibility of different stakeholders working in the TCCs and soft skills for relationship management and managing conflict. It should also include the principals of some of the divisional units.
- f) The services offered in TCCs should be standardised through valid protocols and guidelines.
- g) Shukumisa should track the percentage of cases prosecuted of the total reported and understand reasons for non-prosecution.
- h) Survivors must be informed of their rights including the right to complain if they did not get the services they have a right to access and they must be informed of the correct complaints mechanisms and processes.

Recommendation 3

NGOs working in TCCs need to exercise greater agency in managing site level stakeholder relationships and understanding of policies and protocols

- a) NGOs should lobby government, civil society organisations and academic institutions, and use coalitions such as Shukumisa to develop easy to use resources, tools and algorithms to help them at site level with the interpretation and implementation of policies.
- b) All TCCs should have signed and up-to-date protocols, which are the basis for the relationship between the different stakeholders as well as standards for service delivery

Recommendation 4

Government needs to do more to address the scourge of SGBV through prevention and addressing both the acute and long term needs of victims

- a) There is a need to increase evidence based social behaviour change campaigns targeting the general public to deal with barriers to reporting sexual gender based violence. DSD should provide funding to scale up best practice models.
- b) Government should do more to market the TCCs and create an awareness of their services amongst the general population. There must be increased visibility of signage to the TCCs including the rights of survivors and complaint processes.
- c) Government should fast-track the development, implementation and monitoring of a National Strategic Plan for SGBV. This NSP should provide guidance on what services should be made available to perpetrators where applicable.
- d) TCC personnel should strengthen their strategic partnerships with supporting facilities such as safe houses, shelters and economic empowerment initiatives in order to offer more comprehensive care and ongoing support to survivors.

- e) The DSD, as the support department responsible for psychosocial support in TCCs has to take greater ownership and advocate for the welfare of the NGOs and the sanctity of the social work professions and counselling services offered in the TCCs.

CONCLUSION

Psychosocial support is crucial in the care for victims of SGBV. In spite of this, the SOA does not give enough credence to it, only mandating the DSD to contribute to the National Policy Framework and manage the National Register of Sexual Offenders. Many of the imperatives relating to psychosocial care for SGBV victims were excluded in the final draft of the policy. As a result, many gaps remain in the delivery and standardisation of psychosocial care for victims of SGBV.

The TCC model is conceptually a very good model and has huge potential in offering comprehensive services to SGBV victims and significantly reducing secondary trauma. In spite of huge efforts by NGOs to offer quality services to victims, their work remains outside the scope of the TCC blue print. As a result of this, they are not wholly funded by government. In the face of the growing epidemic of SGBV, it is time for government to accept their obligation to ensure the financial sustainability of TCCs, and in particular the psychosocial.

NGOs should lobby government to develop a legislative framework to allow for the establishment of TCCs as a formal part of the criminal justice system.

List of Abbreviations

CJS	Criminal Justice System
CSO	Civil Society Organisation
CSP	Civilian Secretariat for Police
DJCD	Department of Justice and Constitutional Development
DoH	Department of Health
DSD	Department of Social Development
DVA	Domestic Violence Act
FCS	Family Violence, Child Protection and Sexual Offences
FPD	Foundation for Professional Development
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
NACOSA	Networking HIV/AIDS Community of South Africa
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
NPF	National Policy Framework
NRSO	National Register for Sex Offenders
PEP	Post Exposure Prophylaxis
POWA	People Opposing Women Abuse
PSS	Psychosocial Support
SAPS	South African Police Service
SGBV	Sexual Gender Based Violence
SOA	Sexual Offences and Related Matters Amendment Act, 2007
SOC	Sexual Offences Courts
SOCA	Special Offences and Community Affairs
STATSA	Statistics South Africa
STI	Sexually Transmitted Infections
TCC	Thuthuzela Care Centres
USAID	United States Agency for International Development
VEP	Victim Empowerment Programme
VOCS	Victims of Crime Survey
WHO	World Health Organisation

Definition of Terms

TCC - Thuthuzela Care Centres are one-stop facilities for rape survivors. They are unique in that they offer all services (counselling, physical exams, and law enforcement) under one roof. This makes it logistically easier for survivors to report a rape, and helps to lessen the amount of secondary trauma a survivor experiences.

NGOs – these are non-governmental organisations that are involved in service provision in the TCC.

SGBV – Sexual gender based violence describes sexual violence that occurs with a gender and power dimension, often with an intimate partner.

SOA – The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007; also referred to as the Sexual Offences Act) is an act of the Parliament of South Africa that reformed and codified the law relating to sex offences. It repealed various common law crimes (including rape and indecent assault) and replaced them with statutory crimes defined on a gender-neutral basis. It expanded the definition of rape, previously limited to vaginal sex, to include all non-consensual penetration; and it equalised the age of consent for heterosexual and homosexual sex at 16. The act provides various services to the victims of sexual offences, including free post-exposure prophylaxis for HIV, and the ability to obtain a court order to compel HIV testing of the alleged offender. It also created the National Register for Sex Offenders, which records the details of those convicted of sexual offences against children or people who are mentally disabled.

NRSO – A register of sexual offenders mandated by the Sexual Offences Act, kept by the Department of Justice.

CARA – Criminal Assets Recovery Account which by legislation can be used to research or prevent crime related social harm.

J88 - an official form issued by the Department of Justice which documents the medico-legal examination that the healthcare practitioner performs on a victim and highlights findings that are potentially relevant for legal purposes. A key document recording medical evidence that may be needed in order to obtain a conviction in an assault case. It is written evidence of the medical indications that a rape may have taken place.

IPV - intimate partner violence describes physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner. An intimate partner can be characterized by the following: regular contact, ongoing physical contact or sexual behaviour, identity as a couple and knowledge about each other's lives.

Child – any person under the age of 18 years' old.

HIV – This term is used to refer to the virus which causes AIDS. The expression HIV and AIDS is not generally used because it can cause confusion. Most people with HIV do not have AIDS.

Key populations - populations that are key to the HIV epidemic and key to the response. UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

Living with a disability – includes people who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

Parents and caregivers – this term takes into account that not all children are cared for by their biological parents. Caregivers might be extended family members, friends, neighbours, legal guardians or others.

Ukuthwala – traditional Nguni culture of forced marriages

Sexual and reproductive health and rights - rights of a person's sexual and reproductive life. These rights are closely linked with other human rights.

Sexual offences - crimes committed without the consent or permission of one of the people involved in the sexual act. The court must decide if either gave consent to the sexual act.

Consent - voluntary or unforced agreement. This means that the victim must freely, willingly and deliberately agree to the sexual act; and must be able to understand what she is consenting to.

Victim – someone who has experienced sexual violation and seeking clinical or psychological care at a facility.

Survivor – someone who experienced sexual assault and is outside of a clinical setting.

1.0 INTRODUCTION

1.1 The Shukumisa Coalition

Shukumisa is a coalition of over 60 non-governmental organisations and individual members across the country who share the vision of a South Africa where adults and children are free from sexual violence. Shukumisa's mission is to ensure that South Africa takes the problem of sexual violence seriously, as evidenced by well crafted, well implemented legislation derived from broad-based public participation processes.

The coalition aims to stir and shake up public and political will to develop and implement policies and strengthen laws related to sexual violence 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 quality services to victims of sexual gender based violence.

1.2 The TCC Monitoring Project

This study forms part of the TCC Monitoring Project based on a partnership between Shukumisa and the Soul City Institute for Social Justice funded by the Foundation for Professional Development (FPD) through the United States Agency for International Development (USAID).

The TCC Monitoring Project emanated from a report that Shukumisa published in 2015, *"It sucks/It's a wonderful service": Post-rape care and the micro-politics of institutions*. The study, conducted by Lisa Vetten, sought to describe the range of emotional support services provided to rape survivors by NGOs based in TCCs, and identify factors shaping these services. The study found that 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, and the effect of these on post-rape care.

This project was initially meant to carry out monitoring of TCCs through Shukumisa member organisations to expand the findings of above mentioned study. However the scope of the project was revised slightly after a TCC Compliance Audit and Gap analysis report was released by FPD and had covered aspects of the original scope.

Eventually a team of six Shukumisa member organisations providing advice and assistance on how to implement the project decided the study should conduct interviews with Shukumisa members and other organisations working with or within TCCs, followed by a consultative forum to verify the findings and deliberate on the role played by NGOs. The aim was to establish how the role of NGOs in TCCs can be optimised and to contribute towards improved collaboration at TCCs and services to survivors of sexual violence. The final outcome is a report with recommendations to be shared with Shukumisa members and the broader public and to feed into the next five year strategic plan of USAID.

2.0 BACKGROUND

“I have never been free of the fear of rape. From a very early age I, like most women, have thought of rape as a part of my natural environment—something to be feared and prayed against like fire or lightning. I never asked why men raped; I simply thought it one of the many mysteries of human nature.” Susan Griffin 1971.

2.1 Definition of Sexual Violence

In South Africa, the Sexual Offences and Related Matters Amendment Act 32 (SOA) enacted in 2007 provides the guiding definition for sexual violence and the framework for its response⁷. The promulgation of the SOA gave way to a broader interpretation of sexual violence, which includes rape, compelled rape, sexual assault, incest, bestiality, sexual exploitation and grooming of children and mentally disabled persons and exposure to pornography (Box 1). In the act, the definition of rape, previously confined to vaginal penetration, includes oral, anal or vaginal penetration of a person with a genital organ or any object. Two key elements of sexual offences in the Act are the **intention of the perpetrator** to commit the offence and the **absence of consent** from the complainant⁷. However, one has to note that sexual violence is defined through a legal lens and not a medical one. This makes it up to the courts - using medical and other forensic evidence - to decide if an incident fits the definition of sexual violence.

In this report, sexual gender based violence is used as a broad term to include all forms of sexual violation but excludes sexual grooming, compelled masturbation and exposure to pornography for which there is still very little data.

Box 1

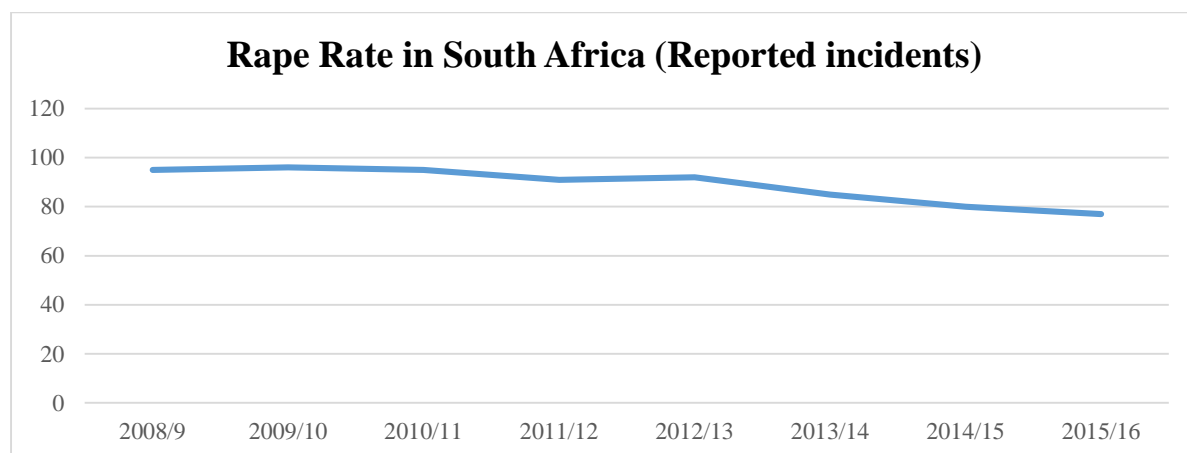
Acts of sexual violence based on SOA

- *Rape and compelled rape.*
- *Sexual assault, compelled sexual assault and compelled self-sexual assault.*
- *Incest, bestiality and sexual acts with a corpse.*
- *Sexual exploitation and grooming of children and persons who are mentally disabled.*
- *Compelling or causing children to witness sexual offences, sexual acts or self-masturbation.*
- *Exposure or display of pornography, or child pornography, to persons who are mentally disabled and using people with mental disabilities for pornographic purposes, or benefiting therefrom.*
- *Exposure or display of pornography, or child pornography, to children and using children for pornographic purposes, or benefiting therefrom.*
- *Performing or benefiting from the services of adult sex work.*

2.2 Extent and nature of sexual violence in South Africa

South Africa is signatory to numerous international agreements such as the Convention on the Elimination of all Forms of Discrimination Against Women and the African Charter of the Rights and Welfare of the Child. These are aimed at promoting the rights of women and children in general, and in particular, protecting them against violence and discrimination. The country also boasts a progressive constitution, legislation and policies that deal with sexual gender based violence (SGBV). However, in spite of this, SGBV remains unacceptably pervasive, resulting in systematic violation of the rights of women and children. These acts are an extreme manifestation of the gender inequality women face in other areas of life.

Although Figure 1 shows a decline in the reported rape rate¹ over the last 5 years, the numbers remain very high when compared to other countries in the region⁶. In addition, these numbers often do not tell the complete story. Many cases of rape go unreported and thus undocumented. A 2011 Gauteng study found that when raped by a current or former intimate partner, only one in 25 women reported the offence⁸.



Percentage of people reporting rape per 100 000². STATSA 2016

2.3 Sexual gender based violence: Statistics, reporting and the law

Although sexual gender based violence is governed by the Sexual Offences and Domestic Violence Acts, its implementation is located in several different laws, making it difficult to get a comprehensive overview of the nature and extent of reported sexual violation in South Africa¹⁵. The various categories include femicide, rape, intimate partner violence and sexual harassment. Intimate partner violence is by far the more commonly occurring type of sexual assault and is dealt with through both acts, but mainly the Domestic Violence Act. Rape and femicide are considered more extreme crimes, and dealt with through the SOA; whilst sexual harassment attracts a more lenient sentence, and in a work environment could be dealt with in terms of labour law and the institutions' disciplinary codes¹⁵.

¹ This rate is based on only those cases that get reported

² Only captures those cases that get recorded by the SAPS. There is evidence that not all cases that get reported get recorded by SAPS

The South African Police Service (SAPS) releases quarterly statistics on SGBV crimes. Because this data is aggregated, it is difficult to know which of the sexual offences was committed. This makes it impossible to track the number of rapes being reported annually and equally impossible to assess how many of the new crimes introduced through the SOA are reported and recorded by the police¹⁵. These figures are also often surrounded by controversy because they do not capture the total picture. Several studies show extensive underreporting of sexual assault^{6,11,17}. Because of various social and cultural norms around sexual relations between men and women, many people do not identify certain acts of sexual violence as crime. For instance, many victims of marital rape may not describe their experiences as sexual assault – even though what they have experienced would fit its legal definition⁴. In most instances, women tend to live with the crime or seek family resolution. A qualitative study conducted by the Soul City Institute for Social Justice in 2012 reported a range of barriers to accessing sexual assault services. These are shown in Box 2.

A study conducted in Gauteng in 2010 by Gender Links and the Medical Research Council found that only 1 in 13 women raped by a non-partner (stranger or family member known to victim) reported the matter⁹. Although this is still low, it represents a better chance of reporting than if it is an intimate partner (1 in 25). The national Victims of Crime Survey (VOCS) results further showed that the proportion of rape victims who reported incidences of sexual violence to the police decreased by 21% between 2011 and 2014¹². This

Box 2
Barriers to victims of sexual assault accessing services

- Lack of information about where to go
- Services are inadequate and are not user orientated
- Lack of confidentiality due to inadequately trained providers
- Fear perpetrator will harm the victim
- Financial dependence on the perpetrator
- Lack of trust in the police
- Fear of victim blaming by the community and the police
- Inefficient, ineffective and cumbersome justice system
- Corrupt police officers
- Bribery and withdrawal of case
- Stigma and shame

underreporting is worsened by the fact that “domestic violence” is sometimes recorded as common assault or assault with gross bodily harm (GBH) or, at its most extreme, as murder or attempted murder¹⁰.

Currently the statistics released by the SAPS do not provide any information about the relationship between the perpetrator and victim. Despite the general belief that women get raped by strangers, research shows that women are two to four times more likely to be raped by someone known to them⁶. Although police are required by law to record cases of domestic violence in a register at police stations and have victim friendly rooms available, compliance is very low. The Civilian

Secretariat for Police found that between

October 2013 and March 2014, only 1.4% of police stations inspected (two out of 145) were fully compliant with the Domestic Violence Act¹². Sadly, unlike the Sexual Offences Act which obligates training of the SAPS in the act, training around domestic violence is not compulsory in terms of the Domestic Violence Act⁸.

Another compounding factor is the currently used measure of performance of the police. According to performance targets, the police are expected to reduce violent crime by between 4% and 7% per year¹⁵. This creates a profound disincentive for police to record all violent crimes reported to them. There is anecdotal evidence that some station commissioners 'negotiate settlements' between the perpetrator and the victim so as to keep the station's statistics low. All these factors point to the absence of an accurate picture of the extent of the problem of SGBV facing the country. Other limitations of sexual assault statistics include that:

- They do not provide a reasonable age disaggregation (only distinguishes child and adult victims);
- They do not give information on the deliberate and selective rape of vulnerable groups such as mentally disabled people, lesbians and other gender non-conforming women and sex workers and,
- They do not give any information on the sexual violation of men; whether by women or other men.

2.4 Services available to sexual assault victims

The Domestic Violence and Sexual Offences Acts provide the blue print for services that sexual assault victims are constitutionally entitled to. The DVA spells out the victim's entitlements to protection from any further harm (physical, sexual, emotional/psychological and economic abuse) whilst the Sexual Offences Act is explicit about the package of services that sexual assault victims should receive. The custodian for these laws are the South African Police Services (SAPS), the Department of Justice and Constitutional Development (DoJ), the Department of Health (DoH) and the Department of Social Development (DSD). Working together these departments are mandated to ensure that they minimise secondary victimisation to the complainant, provide the necessary clinical and psychological care and ensure access to justice⁸.

Psychosocial support: The Role of DSD

The role of the DSD in relation to SGBV relates mainly to psychosocial support, a factor that this report deals with in detail in later sections. It is worth noting that although the DVA pronounces a very prominent role for DSD in psychosocial support, the department is assigned a minimal role in the implementation of the Sexual Offences Act⁷. This role is not what had been envisaged originally in the bill drafted by the South African Law Reform Commission, which had included clauses legislating medical care, treatment and counselling to all survivors who sustained physical, psychological or other injuries as a result of the sexual offence. These services were also to be extended to victims' family members. Also proposed were modest measures to protect both adult and child victims from the excesses of the adversarial trial process, including the provision of support persons at court. The bulk of these psychosocial services would have been the responsibility of the DSD. All these provisions were excised from the Bill by Cabinet on the grounds that they were too costly to the government⁸. This has resulted in downstream problems, as various models for victim support have placed a peripheral role to both short and long term psychosocial care to the victim and their families.

The DSD's limited responsibility has been challenged by various institutions including parliament; which identified a need to compel a psychosocial contribution from the DSD. As a result, the national policy framework, although it is not legally binding, assigns the following responsibilities to DSD:

- Coordinate the implementation of the victim empowerment programme (VEP) which guides services to victims of violence as a whole;
- Provide specialist services for victims of sexual offences;
- Issue instructions, policies, and guidelines in terms of victims of sexual offences;
- Provide access to appropriate psychosocial services, including clinical psychologists, social workers, clinical social workers, assessments, and victim impact reports and,
- Provide a funding framework and support for NGOs contracted to provide services to victims of sexual offences.

These responsibilities are of particular significance in this report as they relate to the responsibility to provide psychosocial care within the multidisciplinary model of a TCC.

Investigative and prosecutorial services: The role of the criminal justice system (SAPS, NPA and DoJ)

While the DoJ may have few obligations in terms of the DVA, the SOA places a significant responsibility to this department, making it the chief custodian of the legislation.

The investigation and prosecution of sexual assault crimes is guided primarily by the provisions of the SOA. The first point of contact is the police service, which is tasked with ensuring that they provide, in a non-judgmental manner, the option for the victim to pursue a criminal case. The introduction of the Family Violence Child Protection and Sexual Offences (FCS) units within the police services is seen as an important response to the scourge of SGBV.⁸ These units are run by specially trained staff who offer specialised services that deal with sexual violence with all its complexities and nuances. Because the vast majority of domestic violence complaints do not end up as criminal charges, an adequate policing response to the problem would have to include the receiving and handling of complaints - and not only their investigation. This element is lacking and the performance measures used in SAPS further create a disincentive to record all the crimes.

The NPA is also a critical part of the services offered by the criminal justice system. Their role is to ensure the timeous prosecution of cases. In 2002, a Blueprint for Sexual Offences Courts (SOC) was developed by the Sexual Offences and Community Affairs (SOCA) Unit within the NPA aimed at fast tracking sexual assault cases^{7,8}. An ill-conceived moratorium on specialised courts saw their closure from an estimated 67 in 2005 to about 40 in 2010. Subsequently, pressure from parliament and the United Nations Committee on the Convention on the Elimination of Discrimination against Women resulted in a change in the policy direction⁵.

These courts are in line with the ethos of the objectives of the SOA which seek to afford complainants of sexual offences the maximum and least traumatising protection.

A research study found that they (courts) were successful in the establishment of a victim-centred criminal justice system, reduction of secondary victimisation, improvement of skills of court personnel, reduction of the cycle time in the finalisation of sexual offences cases, and have generally contributed to the efficient prosecution and adjudication of cases. However, it is difficult to routinely assess these gains as they relate to rape⁵. The NPA publishes conviction rates with broad categories of sexual offences. Because this is aggregated data, it does not provide a conviction rate for rape thus making it impossible to estimate what percentage of rape cases end in a conviction. It should also be noted that these conviction figures are based on the number of cases (less than 5%) that reach court; no mention is made of the ±95% attrition rate.

By far the most significant contribution of the NPA to the fight against SGBV is the establishment of the Thuthuzela Care Centres (TCCs). These provide trauma management to victims of SGBV. Some have argued that having them run by the NPA diverts their attention and resources away from the NPA's primary role which is to effect successful convictions. The TCC are dealt with in more detail in section 1.5.

Medico-forensic services: The role of the Department of Health (DoH)

The SOA makes provision for sexual assault victims to receive medico-forensic services. This is the DoH's role. The forensic investigation of the patient includes physical examination, which is a key component of evidence gathering. However, the implementation of law and policy is often hampered by misunderstandings of the law, including negative social norms, myths and stereotypes about rape. Previously, survivors were required to demonstrate that they had indeed been violated – physical injury used as a measure of such violation¹⁴. Although the current act does not require this of victims, indeed, it is still a social expectation that a victim who resisted the sexual advance must have something to show for the resistance. This attitude considerably worsens the plight of victims of sexual offences, and thus deters reporting, and compromises the victim responsiveness of the criminal justice system.

The examination and evidence collection are time sensitive, with a general cut-off of 120 hours since the time of the alleged incident for the evidence collection, and 72 hours for the provision of post exposure prophylaxis (PEP) against HIV^{14,15}. A detailed management of sexual assault victims is presented in Box 3.

Box 3a

Step by step medical and psychosocial assessment of a sexual assault survivor

Step 1. Offer containment counselling if available. Prepare the patient and obtain informed consent to proceed with the examination and evidence collection (SAP 308 form and consent form inside the evidence collection kit to be signed by the complainant/guardian, investigating officer and clinician).

Step 2. Take a detailed history, following the information requested on the J88 form, and add clinical notes in the hospital folder.

Step 3. Conduct a medical examination and collect evidence (guided by the details of the sexual offence) in the presence of a chaperone, who is preferably of the same sex as the survivor (more details on evidence collection are given below). If available and applicable, arrange or perform photographic recording of injuries.

Box 3b

Step 4. Carefully document findings in an objective and understandable manner on the J88 form, and sign and complete the Affidavit 212 form. Take care to describe the injuries, using accurate wound terminology.

Step 5. Perform relevant medical tests.

Step 6. Provide necessary medical treatment.

Step 7. Arrange follow-up visits at the appropriate healthcare facility, as indicated, at 1 week, 6 weeks and 3 months.

Step 8. Offer the survivor a comfort pack (if available) and bath/shower if facilities are available.

Step 9. Hand over the completed medico-legal documentation (original) to the investigating officer and keep copies in the survivor's file, in a secure location.

2.5 The Thuthuzela Care Centres

The SOCA unit's star project is unquestionably the TCCs which, like the SAPS' FCS Units, is the most consistent and well documented intervention in the problem of violence against women. Parliamentary Portfolio Committee Report. 2010.

Thuthuzela Care Centres (TCCs) were started in 2000 by the National Prosecuting Authority - in collaboration with the Departments of Health, Social Development, Justice and Constitutional Affairs, and the South Africa Police Services - to provide comprehensive services to sexual assault survivors. They are specialised centres - often an extension to a hospital - that provide medical and forensic services, psychosocial counselling, case management and referrals, and police services in one site. This "one stop shop" approach lies at the heart of the model, as it enables an integrated service from emergency care to preparation for court, ideally reducing the overall length of time in finalizing cases and improving conviction rates. In the conceptual model, TCCs offer a 24-hour service 7 days a week and are linked to a sexual offences court.

However, in practice, these TCCs are staffed during office hours, with some TCCs reportedly seeing only 25% of their clients during this time, and the remaining 75% present outside office hours and receive a skeleton service and only if an NGO is funded to provide it.

In the model, the TCCs services are aimed at:

- Providing containment, crisis management and psychosocial care and support to the victim;
- Providing a comprehensive history-taking and medico-legal examination;
- Increasing access to prophylaxis and treatment for pregnancy and sexually-transmitted infections, including HIV;
- Providing a bath/shower, refreshments and a change of clothing;
- Providing access to transportation home (or to a place of safety), referrals and follow-up support and,
- Expediting case turnaround times and prosecution success rates.

It is worth noting that only the last function relates to the NPA and yet they are the lead in the partnership and are responsible for the strategic and operational management of the TCCs.

Currently there are 55 TCCs country wide, the majority situated in communities with relatively high incidences of rape and sexual assault. Given that there are 413 secondary and tertiary hospitals in South Africa, it goes without say that at 13%, the coverage is low and most victims have to contend with fragmented care offered between police stations, the hospital and community based NGOs. The provincial distribution of TCCs and hospitals is shown in Table 1 below:

Province	Number of TCCs	Number of secondary and tertiary hospitals
Eastern Cape	9	94
Free State	4	73
Gauteng	7	28
KwaZulu Natal	8	73
Limpopo	7	47
Mpumalanga	5	27
North West	5	26
Northern Cape	4	27
Western Cape	6	58
Total	55	413

In the TCC blue print, site staff should include a case manager, victim assistance officer and site coordinator, non-governmental organisation (NGO) or DSD counsellors, trained detectives and officers competent to take statements and either SAPS or emergency medical service personnel able to transport victims. The success of the model depends on multi-stakeholder cooperation, the availability of equipment and supplies, adequate staffing and a patient-centred culture. In spite of the blueprint, not all TCCs meet these specification.

A study commissioned by the Foundation for Professional Development (FPD) in 2016 reported that only 28% of the TCCs had a SAPS officer stationed on site and 46% had a case manager³.

In spite of this, evidence to date suggests that TCCs have improved the process of reporting and prosecuting crimes of sexual violence by increasing coordination and cooperation across the medical and legal sectors^{5,8}. However, they have also been criticised for creating a strain on local resources as they provide highly specialised services to a small subset of the population^{5,8}. The model has further been criticised for allowing the NPA – whose prosecutorial role in a crisis management setting is not as critical as that of medical and psychosocial care – to take the overall lead.

2.6 Psychosocial support for survivors of sexual gender based violence

Sexual trauma in adulthood is associated with short-term and long-term psychological consequences. Short-term effects include shock, fear, anxiety, confusion, and withdrawal. Many sexual assault survivors experience a reduction in symptoms within a few months, whereas some women experience distress for years^{1,13}. Long-term outcomes include posttraumatic stress disorder, depression, eating disorders, sexual dysfunction, alcohol and illicit drug use. Risks of developing mental health problems are related to assault severity, other negative life experiences and perceptions of lack of control¹³.

Health services play a crucial role in clinical management and psychosocial support of survivors of sexual assault. This role extends from managing acute distress to assist them in avoiding additional exposure to violence. In order to deliver on this role, the health and social services have to work cooperatively and complementarily¹⁴.

The TCC model recognises this and places an important role on psychosocial support. This support is provided by NGOs working in SGBV, women's and children's health rights. These NGOs are often given space and roles within the TCC. A study by Lisa Vetten reported a myriad of challenges and opportunities for improving patient care in TCCs. It reported strained multi-sectoral stakeholder relationships¹⁶. In light of those findings, this study explores in more detail, the role played by these NGOs, their interface with the other services and the challenges that they face. This assessment seeks to help NGOs improve the quality and responsiveness of their services to victims of sexual violence.

3.0 METHODOLOGY

3.1 The purpose of the research study

In 2017 Shukumisa commissioned a study to assess the role of NGOs providing psychosocial services at TCC. Its overall objective was **to critically assess the role played by NGOs in the delivery of services by the TCCs**. The focus was on how to improve collaboration at the TCCs to ensure that quality services are delivered to survivors of sexual violence.

3.2 Research objectives

The study engaged NGOs working in TCCs to assess the following (inter alia)

- The role(s) played by the various NGOs?
- How this role could be enhanced?
- The value NGOs brought to the TCCs (NGO perspective)?
- What challenges NGOs faced? How these could be addressed.
- The amount of time the NGOs spent engaging directly within TCCs?
- The interface of NGOs with survivors of sexual assault and the nature of those interactions and,
- Important partnerships and how to enhance them.

3.3 Data Collection

Data was collected between February and March 2017 from 19 NGOs working in TCCs through in-depth interviews with key informants and a consultative workshop. The sample represented 35% of TCCs purposefully selected based on the following criteria:

- Shukumisa membership (100% selection)
- Geographic spread to ensure proportionality
- TCC in hospital/community setting
- Rural/urban provinces and setting
- NGO working within or outside TCC
- Patient throughput in TCC

In-depth Interviews

The initial part consisted in depth interviews with selected representatives of the NGOs. Almost 60% of the interviews were conducted face to face, the remainder telephonically. The respondents were NGO management and some site based social workers. The data was transcribed verbatim and analysed thematically.

Consultative workshop

The second part, was a 2-day consultative workshop that was held with 17 of the 19 organisations that participated in the first phase. The workshop was aimed at enriching the findings from the interview process through focused engagements with NGO representatives and other relevant stakeholders.

The workshop format was very interactive, with group sessions, plenary reflections and presentations of other relevant research studies.

Although the results from the two processes are presented separately, it must be noted that most of the findings from the in-depth interviews were reiterated and validated in the workshop. The workshop was key in that it enriched the findings, ventilated some of the intricate issues facing NGOs and analysing them within the context of other operational research studies conducted within TCCs. It also discussed implications of the findings on site level efficiency, effectiveness and quality patient care. Additionally, it made key recommendations and action points for NGOs, government departments and other stakeholders. For ease of reading, the two processes are presented separately in the findings.

3.4 Description of respondents

The 19 NGOs that participated in the study were mostly organisations working within a specific locale, district or province, and only two had a national footprint. All of the respondents offered services in at least one or more TCCs; two of them with a specific focus on minor sexual assault victims. The actual services were varied and are shown in Table 2 below.

Table 2: Profile of services offered by NGOs interviewed

Service offered	Number of NGOs
Psychosocial support	18
HIV testing services	4
Community outreach services	9
Spiritual counselling	1
Offering clothing, meals and toiletries to the homeless	1
Victim empowerment programmes which included access to legal services, safety shelters	3
Child adoption services	1
Youth vocational skills training	3
Legal advice and court support	6
Training to community based workers, door to door skills to identify GBV	3
School based programs offering information and education to youth	4
Advocacy work with various service providers such as police stations to ensure victims receive the necessary care and support	13
Safety shelters	3

4.0 RESULTS/FINDINGS – In-depth Interviews

4.1 Nature of psychosocial services offered by NGOs in the TCCs

All the organisations that participated in the study offered psychosocial support to all victims presenting at the TCCs. The majority of the cases were sexual assault victims; others included physical and emotional abuse. There was no uniformity in who saw the victim first, and most of the respondents felt that they should be the first professional to engage the client. The psychosocial support varied between TCCs, and was offered by a mix of trained lay counsellors, social auxiliary workers and social workers. In some TCCs, the medical staff also had a responsibility to counsel the victim in preparation for and during medico-forensic examinations whilst in others all these services were provided by the NGO. Trauma counselling and containment was the key service offered at the point of contact – after which the clients were usually referred to other forms of psychosocial support. The funding for the follow up counselling was rarely (if ever) provided by the Department of Social Development – necessitating NGOs to seek supplementary funding from other sources for this.

Containment counselling

Containment counselling was offered by the first respondent within the psychosocial support team. This person dealt with crisis management through calming the victim down and assuring them of their safety. Containment counselling also included giving the client information about the TCC services, the processes that will be followed and their rights in relation to accessing services and laying criminal charges. This was seen as a crucial step in stabilising the client and comforting them. It was also seen as the first step in healing the victim. In some TCCs this was the first contact with the patient, whilst in others, the victim saw the police first.

“Containment is about crisis management and educating them about how TCC's function and their rights within the TCC.”

Emotional counselling

During the course of accessing medico-legal services in the TCC, the victim was often referred for professional counselling. In some instances, the victim requested the lay counsellors to sit in during the forensic examinations, and in one they even replaced the nurse by assisting the doctor. This request from the victims was seen as testament to a trust relationship that is built during containment counselling. The counsellors also dealt with any specific issues that arose, such as refusal to be seen by a male practitioner, especially the doctor whose work often includes vaginal examination, which some felt could further traumatise a rape victim.

Other standard questions were also sometimes seen as intimidating – as they delve into the client's sexual history, making some clients feel disrespected and further victimised. The counsellor thus played a critical role in preparing and helping the client through these phases. This was viewed as victim empowering and the first step to the victim regaining their power.

“When one has been raped the power has been taken away from them by the rapist and therefore should know their options and decide what to do next. The survivor should be on a process of regaining their power.”

Pre and post-test HIV counselling

In some of the TCCs, HIV counselling was offered by the lay counsellors.

“...our staff is also trained to do HIV tests so they also test them for HIV. Of course they counsel them, they do pre-test counselling then they test them then they do post-test counselling.”

Adherence counselling

In addition to the counselling outlined above, lay counsellors also offered adherence counselling for survivors on PEP. This included further explaining why PEP is important, information about implications for not completing the course, information about side effects and offering follow up adherence support through home visits and support groups.

“We also offer adherence which is where we offer support to victims who are under PEP medication.”

Follow up therapy

Most respondents said it was routine for follow up therapy to be scheduled with the social workers, often the day after the reporting of the incident. Most organisations offered at least four sessions as a minimum, after which others could be prescribed on a needs basis. The follow up counselling was aimed at strengthening coping skills and supporting reintegration into society.

“...social workers who provide therapy and provide it every step of the way. They first start by providing six mandatory sessions with the survivor and after the six sessions are over, the survivor can then choose if they would like to continue therapy or not.”

“In terms of the psycho-social part offer therapy services which takes form in 3 sessions. As we offer services, the child is required to attend 3 sessions but the children can still continue to require the services during the prosecution and court phase.”

Group therapy

Some of the NGOs offered group therapy where similar cases were combined and a support group formed. The focus of these was to share coping mechanisms and offer peer support.

“...do group work facilities because other children cope well in a group and are with other children. Also in group work they are imparted with life skills and we speak about boundaries and self-care and safety skills.”

“We also have support groups where the victim can share their challenges based on the outcomes of their cases. Some medications have side effects, and when they are in a group they can share their coping mechanisms when it comes to medication.”

Community outreach

Other psychosocial services offered were included within community outreach services. These targeted high risk families and included family counselling - especially where a child had been victimised.

“...auxiliary workers and youth workers who do outreach work. They go to the communities and educate the masses on what sexual violence is, what traumatic rape syndrome...”

“...if there is a need for the child to be removed especially if the abuse happened within the family then we work with the courts to do statutory and remove the child from that environment. We ensure that the child is protected then we go to courts with them as well.”

4.2 Funding of NGO TCC work

Funding for psychosocial services in TCC is often fraught with inadequacy and uncertainty

The NGO work in the TCCs was funded mainly by DSD and a Global Fund grant managed by various principal recipients. Other funders included the private sector, USAID and Elton John Foundation. The annual funding ranged from one hundred thousand Rand to over two million Rand constituting between 7% and 60% of total organisational budgets. Most organisations were utilising their supplementary funding (from foreign donors and private sector) to ensure that they continued to provide psychosocial services after hours and on weekends.

Because the majority of their clients were seen outside office hours – this put a huge strain on their budgets and human resources. Most of the organisations reported a decline in funding in spite of the increase in the scourge of SGBV. Most of the Global Fund funded organisations had funding up to 2019 and expressed uncertainty about the future work in TCCs should the funding not be renewed. They expressed a need for government to step in and take over the funding, citing that foreign funders’ strategies were not always aligned with those of the country and they often only committed for short periods. In addition, some of the external funders were more concerned with clinical indicators such as the number of people tested for HIV, and there was little or no importance attached to the psychosocial indicators. They also expressed concern about the low funding given to administration, without which the organisations could not operate effectively. The instability in funding raised several concerns including staff attrition and a failure to deliver holistic programmes that dealt with social drivers and interlinking issues.

“Funders come in and they determine the agenda...”

“...funding in general for violence against women is dwindling because we mostly rely on government.”

“International donors only fund projects rather than service delivery. Since SA has been declared a middle income country, it is said that our government has sufficient funds to actually fund direct services. Which is partly true because SA signs conventions to eliminate violence against women and girls.”

“...the biggest thing is that nobody is ready to fund administration and that is where the struggle is. And if you don’t have administration then how can you run an organisation?”

“...it’s either there for a year or two years then it dries up.... you don’t get funding or a donor who says we will support the work for a good five years then you know you have a break and you can concentrate on other things like improving the service”

“... because of the funding not being always available, staff members know they need to be looking for greener pastures so you train them ...then a year later or 6 months later that staff member has left the organization now the NGO needs more funds to train new people to take on the work.”

“...people resigning from NGO's and they especially move to government, and when they are within government they no longer provide those psycho-social services and support even though their skills are in psycho-social services. In government they become social workers who do mostly administrative work.”

4.3 Extent of sexual gender based violence in South Africa

All organisations interviewed felt that the scourge of SGBV was grave and on the increase. They reflected on the number of cases that they saw in the TCCs, all of them showing an increasing trend. Some organisations cast aspersions on the crime statistics released by the SAPS every year, suggesting that the figures represented an underestimate even of those cases that made it to the police stations. They cited that some complainants were turned down at police stations without reporting due to a lack of understanding and inconsistent application of the DVA by the police.

This is consistent with the literature which shows that only up to 60% of the cases reported are taken on by the police, and that police performance indicators potentially disincentivise them to report violent crime. They also felt that not enough was being done in response to SGBV in the country.

“And that is only looking at the direct services we provide at TCC's and the women who actually come in to report, what about those who do not report?”

“I can safely say with authority that sexual violence is a huge problem...”

“...extremely horrendous. I mean the fact that people, a grandfather can go and rape his grandchildren, you know. What has gone wrong with our society?”

“We are doing a lot to combat sexual violence but as much as we are trying the scourge of sexual violence in the country is on the increase.”

“I don't feel as a country we are doing enough to protect the victims or survivors of gender based violence, I know the Act is there but I don't feel that justice is actually being done.”

4.4 Drivers of sexual gender based violence (socio-cultural and systemic factors)

Culture of interpersonal violence

Some respondents saw SGBV as a microcosm of the high levels of violence in the country. They reflected how violence, including interpersonal violence was normalised, as a result of anger in the general population.

“...frustration I think there a lot of anger issues in communities and people are displaying their anger in the wrong way.”

“...we are an angry nation in SA and we tend to take out the anger on the weak and vulnerable.”

“...backgrounds of people and the circumstances that they grew up in contributes to sexual violence. Sometimes you find that through counselling some of these perpetrators you find that they were abused and hence see no value in respecting women.”

Patriarchy and gender inequality

Patriarchy and gender inequality were commonly cited as a driver of sexual violence in South Africa. This manifested in women and girls seen as subordinate to men – and boys socialised to demand anything they wanted from girls. As a result of this socialisation, women did not understand intimate partner violence as sexual assault and sexual violence was normalised in marriage and relationships.

“...we live in a patriarchal society, and we live in a society that is violent where men believe that if I want something and I cannot get it through consent and I can just forcefully get it and I know I can get away with it.”

“...power and control is number 1...”

“Socialization it’s another issue because we are seeing quite a number of rapes that involve children and you can see maybe the child is 12 and he has raped a 5-year-old or 4-year-old...”

An ineffective and unresponsive criminal justice system

Most respondents expressed how failure in the criminal justice system was a driver of sexual assault. Most people had no confidence in the criminal justice system and thus did not report the incidences or in cases where they did, opted not to open a criminal case. They cited how alleged perpetrators were detained briefly and returned to the community with the risk of further victimising the survivor. There was a general feeling that perpetrators got away with the crime either through low prosecution rates or corruption within the police service. This ineptitude in the system was seen to fuel SGBV.

“Perpetrators and rapists will continue raping and abusers will continue abusing because they know they will get away with it.”

“...the conviction rate is very very low and for me if the conviction rate is very low in a way you are sending a message to the perpetrators to say you can do this and get away with it, because it either takes 2 years till people get realized or punished, but even when they go to court the chances of them being convicted are very very low which sends wrong messages to people.”

“People do not have confidence in the criminal justice system... you hear a victim says what is the use of them reporting the violence because I will see him walking around tomorrow again.”

“...we had 2010 and the turnaround time with crime in that period was phenomenal so why can’t that same level be put on issues of rape, assault against children.”

“A case takes two to three years to be concluded but one of the goals of the TCC is to reduce that turnaround time even that of convictions. But that is not happening.”

In addition to this, they cited how the system was often not victim friendly, resulting in secondary victimisation. They also felt that laws were partially enforced. This secondary victimisation, sometimes witnessed by others resulted in people not reporting in fear of being humiliated by the police and other front line staff. They shared that most police stations did not offer visual and audio privacy to victims reporting; resulting in humiliation, loss of confidentiality and fear of being ridiculed.

“We also need to fix our justice system. We need a justice system that is friendly for women so that when something happens like sexual assault women can feel free to go to a police station and clinic and hospital to report. If we don’t minimise secondary victimisation, women will stay at home and choose not to report.”

Fragmented and ineffective programmes

Another factor mentioned was the fragmented programmes which were not adequately resourced. Some respondents felt that without a common agenda around SGBV, the programmes will continue to be weak, uncoordinated and with little impact. Because the programmes are ineffective, there is despondency within society in general.

“We need a plan ... for the next 5 years ...it should address violence against women and children, and this is how we are going to monitor the plan and this is budget and this is how we are going to implement the plan. Civil society and government should constantly monitor this plan and its effectiveness. Whatever is not working should be revised. Not having money to address violence against women and children shows that this problem is not taken seriously as it should by government and civil society.”

Alcohol and substance abuse

Alcohol was cited as a driver of sexual violence as many respondents shared how victims were often violated either at a drinking place, on their way home or by a partner who had just come from a drinking place. They also observed that in several cases, women were abused by men who tested positive for drugs and narcotics.

“You cannot separate GBV from substance abuse. Some of the cases that we receive, you find that the abusers were under the influence of substances especially alcohol.”

Harmful cultural and religious beliefs

There was also reflection on forced marriage, a culture that has been corrupted and permits men to abduct young girls and sexually violate them.

“...ukuthwala as well it’s a big issue because it does not only speak about rape but it speaks about intimate partner violence and domestic violence...it is my culture and I can do it so whereas the girls are being actually abducted for sexual purposes...”

Poverty

Some of the respondents felt that poverty and overcrowding increased the risk of SGBV. The fact that children slept in the same room as adults, exposing them to sexual activity was seen as potentially emulate the behaviour out of context.

“...poverty as well because they are sharing the same RDP house with parents and obviously they are seeing some activities that they shouldn’t be seeing and they are copying that type of behavior.”

4.5 Barriers to reporting sexual gender based violence

Most people do not know their rights

The respondents suggested that most women did not understand their constitutional right to be treated with fairness and dignity. In their homes, they tolerated violence and did not report it because they did not know the provisions of the law to protect them.

This is worsened by the fact that men felt the constitution favoured women and they often abused them as part of asserting themselves and establishing the traditional power balance in a relationship. Some respondents shared how many women did not know that they could report rape by a spousal partner. Rape and sexual assault were commonly understood to be forced sexual penetration by a stranger – and it was clear that there had not been enough public information about the new Sexual Offences Act, the revised definition of rape and the inclusion of other crimes.

“One major thing is that people do not know their rights. When they get to the TCC, they do not know anything.”

“We should also have clear ways of telling survivors their rights and what they have access to.”

There is poor knowledge of the TCCs and perceived poor quality services

Most of the respondents also felt that the TCCs were not known to the majority of people and that government had not done enough to market these centres. As a result, many women did not know about their existence. They felt that the TCCs were never adequately marketed and that efforts by some NGOs such as Soul City were insufficient and government should take over the responsibility.

“...people do not have that much knowledge in the work that TCCs do.”

“...the nurses at the local clinic don't have full information to refer either to TCC for the medical practitioner to examine, they will talk to the child and talk to the mother and give them Panado and say you can go home.”

“Marketing a TCC should be taken by government because it is a huge task that should be marketed daily so that survivors are aware that there is a TCC.”

There were some sentiments about poor quality of services offered in some TCCs. Respondents said that sometimes clients were not treated with dignity and sensitivity to their emotional state. This resulted in secondary victimisation as clients were treated with disbelief, blamed and even shamed for having been raped. In many of the facilities, often clients did not have a reporting mechanism. Most of the centres did not have a complaints protocol for dissatisfied clients.

In some instances, clients had to wait long periods for one or the other member of the TCCs to see them. This was particularly common with police and doctors, who fulfil other roles outside of the TCCs.

“What is preventing survivors from reporting and speaking out is how they are treated firstly by the first person that they tell about the offence like a friend or family but most of the time they are blamed for the assault. Questions like why were you out at night late, or were you drinking or why did you go to his house or why is that skirt too short are examples of blame. So survivors then prefer to not speak about it.”

“Sometimes victims need time and should not be traumatised by being forced to tell a social worker or the police immediately. When one has been raped the power has been taken away from them by the rapist and therefore should know their options and decide what to do next. The survivor should be on a process of regaining their power.”

“...if a person on radio who was assaulted is listening to another one who was assaulted and they hear how that person was treated by the police or maybe the courts, they won't feel comfortable enough to report.”

Protection of perpetrators

Another commonly cited reason for not accessing services, is the interference of family, in cases where the perpetrator is a family member. In such instances, families opted to resolve the matter internally, to avoid possible criminal prosecution of the perpetrator. This was particularly so in cases where the family member was a bread winner.

“Our cases get thrown out because the families themselves do not want to do consultation and they do not want to pursue the case because they want to protect the abuser who is a provider...”

“We know that they are being abused but they do not want to be tested by the health. Even the parents do not want their children to be tested.”

Logistical challenges

Some of the respondents cited logistical challenges in accessing care at the TCCs. Although most agreed that the location of the TCC in a hospital meant that the route was well serviced by public transport, they still felt that the cost of transport was prohibitive. Language and physical access to persons with a disability were also cited as a challenge.

“There is a challenge in regard to transport as transport is very expensive.”

“...setup is not accessible to people who are disabled.”

“There is even a language barrier.”

“...the Act also talks about gender appropriation and maybe if we hire men in some TCCs men who have been sexually abused will feel more comfortable.”

“challenges like SAPS for example. They just come and leave people there then pick them up late at night and there won't be transport anymore and the J88 forms will be filled in incorrectly.”

“SAPS will bring them if the case was reported at the nearest police station but when they have to come back for ongoing follow ups, for bloods and other things nobody wants to take responsibility for them so there is nobody for them.”

Denial on the part of parents

In cases involving children, some respondents felt that parents were sometimes in denial that their children had been abused. As a result, they would not report the case to the police and almost 'wish it away'.

“...denial they don't want to accept the child has been raped. It's either they find it very difficult to accept that the child has been raped...”

4.6 Perceived efficacy of the TCC model

TCC is conceptually a great model, it is patient focussed and minimises secondary victimisation

Some of the respondents expressed confidence in the TCC model and described it as a 'one stop shop' that eliminates transport barriers, reduces secondary victimisation, increases chances of prosecution and improved referrals and thus quality of care given to sexual assault victims. They also cited how being at one place meant that the staff were able to cover for each other and there was a cross pollination of skills. They also highlighted the need of 24-hour care, which they felt was responsive to client needs and instrumental in reducing trauma. However, the percentage of TCCs offering services 24/7 ranged from 25% in the Free State to 100% in the Western Cape¹⁸. They criticised government for failing to fund them to be operational for 24 hours and 7 days a week. It is estimated that over 60% of cases are reported outside of normal working hours and yet most 24/7 services are made possible by NGOs through supplementary funding by mostly foreign donors. It must be noted that the role of the TCCs was seen to be primarily for sexual assault victims, with some also welcoming victims of gender based violence who were not necessarily sexually assaulted. This is consistent with a recommendation by parliament for facilities to be made available to women reporting domestic violence too.

"The TCC model is an excellent model where different stakeholders can come together and provide a holistic service to the client."

"It is a good model and the (supplementary) funding allows 24-hour care which is good for the survivor."

"The TCC model is a very good model because it reduces secondary victimisation of survivors. Also in a TCC, all the services that a survivor requires are located under one building as sometimes survivors struggle with access and transport."

"...they (TCCs) play a major role in terms of whether we get an opportunity to convict these perpetrators because if their documents are all in order and the examinations were done timeously and all of these then we have more evidence that we can use against the perpetrator in court. ...if the survivor has been supported enough in terms of emotional support, that survivor is in a good position to actually tell the story in court without breaking down."

"...provides psychological and social support to survivors of violence."

"They do not necessarily exclude Gender Based Violence. If a woman comes in and says she has been assaulted, maybe domestic violence, she would still see a first responder, a nurse and social worker. The J88 form that we use for survivors is also useful if a woman seeks to file a restraining order. It is proof that she got medical examination."

4.7 Challenges faced in the TCC

The study reported several challenges in the way that the TCCs were operating and services offered. These challenges ranged from long waiting times to poor stakeholder relationships.

Long waiting times

Although the NGOs indicated that the psychosocial services were always present, they shared that sometimes patients had to wait a long time to be served. This was partly due to staff unavailability and also limited rooms to deliver the services simultaneously. This was potentially precarious in cases where clients presented towards the end of the 72 hours cut off period for receiving PEP.

“...we have one room for psycho-social support and at times that leads to survivors waiting a long time to see a social worker.”

“...survivors in order to access the service have to stay there for hours and hours just waiting for the doctor to arrive. Even when they are being brought by the police, the police just leave them there to fill in the J88 form and attend to other cases.”

“The other challenge is the turn-around time for clients... they sit a long time on the benches waiting to be seen. The norm says one should wait from 45mins to an hour but we are going overboard.”

“...you find there is a survivor that has arrived and the 72 hours is about to lapse in the next 2 hours and the doctor is busy with deliveries and---emergencies C section so the client will have to wait for 2 to 3 hours for the doctor to finish, so it does not feel like issues of the survivors are being prioritized.”

“We sometimes have to wait for a doctor who comes to report to a doctor who comes in at 7 till ten. Clients then have to wait until late to see a doctor and this counts as secondary victimisation.”

“SAPS have got an FCS Unit and most of them knock off at 4 o'clock and only have two people on standby. These two people are overworked and have multiple cases at one time. The victim then has to wait at the charge station without any help.”

Inadequate working space and other infrastructure

Most NGOs complained about inequitable sharing of working space. Because the TCC is often in a hospital setting, the allocation of space is done by the DoH. The NGOs complained that they were deliberately side-lined in the allocation of space, consistent with an allegation that they (DoH) viewed their services as peripheral. They shared experiences where DoH staff was seen to be territorial and petty in dealing with the welfare of other staff in the TCC. They also reported how the absence of space compromised patient confidentiality – as they had to pack files in a small unsecured space with no controlled access.

“It is an inequitable distribution of space. There is space but the space for DNA is huge but it isn't being used.”

“...consultation rooms are not enough and of course the entire container is too hot in summer when temperatures are sitting at 40 degrees and you go into that container it is so hot you can't actually breathe.”

“...office space is a challenge... the space does not belong to us. We are only being housed there by health... they take precedent and we have to be 'slotted' in...”

“I need privacy, I need to train student, I need to do counselling but our office space comes with a lot of disruptions and interruptions. We are really struggling.”

“...they are not allowed to use hospital phones; they are not allowed to use hospital photocopy machines.”

Inadequate resourcing

Generally, NGOs complained about the inadequate funding of TCC services which resulted in a deviation from the conceptual model. The poor resourcing particularly impacted staffing and ability to offer a 24/7 service. Most facilities operated with skeleton staff and sometimes volunteer services after official working hours. For instance, some cases could not be followed up into the community for adherence counselling and support due to a lack of funding. In most cases, victims were offered trauma counselling with insufficient follow up therapy – which they identified as crucial for court preparation.

“...coverage issue is also another problem as we are not open 24/7.”

“We are not adequately staffed. We then have to work long hours making sure that each and every file is in order and that we make follow up visits to families, making phone calls for follow up therapy and if you feel that a child is at risk you have to make home visits and make risk assessments and let courts know if the child has to be removed.”

“...you need about 10 people in order to have a nice shift and people will have time to write their reports and actually take breaks because what they are currently doing it is one person after another right through which is not healthy for the actual staff doing it because it is very traumatic work.”

“Even when they ask for leave, it is almost impossible to get leave because then the remaining one has to work 24 hours a day. We really are short of staff and need more.”

“...what funding is there to ensure that the survivor heals properly after the entire thing because it is not about going to TCC and getting medical care there is actually more to it and I don't think our Government is prioritizing it, it is not coming out clearly saying this is the plan, this is how we are going to support the survivor for a year or 2 years until they are emotionally strong. And I believe it will have a lot of impact on how they are presenting their evidence in court, if they were not fully supported and they were not actually emotionally well they will not be able to present the evidence in a convincing way for the perpetrator to be sentenced.”

Inadequate resourcing also impacted on care offered to care givers. Most NGOs could not afford debriefing services for their staff, who dealt with very traumatic cases on an on-going basis.

Poor stakeholder relationships:

Although some NGOs felt that the ‘one stop shop’ approach of the TCC enabled closer relationships and better referrals and improved patient care, others felt that the relationships with other stakeholders were often a bottleneck and barrier to realising this. There were clear tensions between NGOs and DoH and in some instances the NPA.

The DoH staff and in particular the nurses were seen to be very territorial and undermined and looked down upon the services offered by the NGOs. The NGOs complained that they were not seen as partners and made to feel as if their services were not important to the patient. They were sometimes denied access to patient records – making them feel less of professionals. Conversely, there is one NGO that operates their own 24/7 model within a TCC and has excellent relationships with the hospital staff, to the extent that doctors prefer to be assisted by the NGOs first responders rather than their own nurses.

“Each and every profession should respect each other. No one should dictate each other’s work as that is what health always does and wants to control everyone. It could be the issue of space as the TCCs are situated in their premises. They treat us as if we are not equal and that they are in charge.”

“...all 3 or 4 departments should have access to certain documents if they need them but they (DoH) try and bully the NGO... DSD says we want proof if you are saying 90 clients were seen this month can we have registers of those clients and of course the Department of Health is going to say they are confidential and private... (the NGO) gets reprimanded because they can’t pay you next round of funding because they could not verify the work that we have done.”

They reported a hierarchical culture within the TCC, which put doctors at the apex and everyone else had to structure their offering around them. They complained about a lack of respect for the social work profession and how the nurses often pushed the counsellors around, demanding them to perform menial tasks outside their scope of practice.

“...nurses feel that they run the show even though protocol is there.”

“...rather unfortunate that it was established in a hospital hence why DOH seems to be running the show.”

“The health feels like because it is their setting they are in charge and they can do whatever they want and that the rest of us have to be subservient...the health people are just nasty.”

“... (we are) told by either the nursing staff or somebody senior to do the work that nobody else wants to do like go and fetch urine from this client...”

A few NGOs complained about their relationship with the NPA. They said that the NPA micro managed their staff, undermined them and even threatened to send negative reports about them to their funders. They demanded to know who was funding them, for how much and questioned some of their decisions to hire or not hire staff. They accused the NPA of bullying the NGO staff into compiling their monthly reports for them.

“Another challenge is that of the NPA. The NPA is killing us. Maybe it is because they are ones that started the TCCs. They just do not adhere to the protocol. They intervene in things that do not need them. NPA wants to even know how much we get and what we actually buy with OUR money. They ask us personal things.”

“Sometimes you find that our staff are compiling reports for NPA. They are just intimidating us; we are working under pressure.”

“...they want to make our adherence officer work for them...when the adherence officer goes for training. Then they ask questions like where did she go and what is she doing. It is not her duty. They even want to know how much we are getting for refreshments.”

Lack of accountability

Some NGOs expressed that there was little accountability because each of the various professions saw themselves as independent from each other and accountable only to themselves. Part of the challenge was with one government department holding another accountable, especially if they had a junior ranking.

This is the case in the TCCs where the site manager – who is the administrative head - is often considered junior to doctors and case managers.

“It means if Health is not doing what it is supposed to do NPA or SAPS can’t really hold them accountable and for me that is a gap because we should have some levels of accountability in what can be done if one of us is not pulling their weight.”

Administrative challenges

Some of the respondents felt that site level operational meetings were held infrequently and were often ineffective in resolving challenges due to the presence of junior staff only. They advocated for more decision makers to be present in those meetings. They also questioned the absence of DSD representatives in those meetings, and felt that DSD was the government department that should be championing their cause in the TCCs.

“...we should have power holder or people who can make things happen to sit in those meetings because it does not make sense that junior people sit in and talk because it becomes more like a complaint forum where they will be saying we don’t have this but the following month they will be saying the same thing.”

“I would actually think there is a need for senior people within government departments like Health, DSD, SAPS to come and sit in those local implementation meetings.”

“...meetings to include real decisions makers.”

Some respondents also felt that the TCCs were administratively heavy.

4.8 Perceived quality of services

Generally, NGOs felt that the quality of services offered in the TCC was on the whole very good. Although some said that there was a protocol for managing patients which outlined roles and responsibilities – they also cited that often those protocols were either not signed or outdated. Others cited varying interpretation of protocols and roles and responsibilities due to a lack of common training.

“The only problem is that it hasn’t been updated. It should be updated every year but it is there and just needs to be reviewed.”

“in the original protocol, no provision is made for the first responder – this has changed but protocol has not been revised, thus causing confusion.”

“Now they (nurses) feel that the role of the first respondent should be scrapped as that is too many people to see for a survivor.”

“Every stakeholder that functions within the TCC is responsible for training its own members. Joint training is a way of addressing challenges. It important because then they are all taken through the same process at the same time and at the same level so that there is common understanding.”

In some cases, they felt that the protocol was not followed and if doctors were there, patients would be required to see the doctor before they received counselling. Similarly, if the police happened to be at the TCC when a victim presents, they would insist that they take a statement before the victim received counselling. All the respondents agreed that this compromised quality of care.

“When it was signed, it was said that the victim first comes to us then to the SAPS then to the doctor but now just as we start a session, you hear a knock on the door and it would be the doctor rushing the victim to come see them. Sometimes you find that the police are so rude and they want to take a statement before we even get the chance to contain and comfort the victim.”

“If maybe when the first respondent is calming the survivor and the nurse just takes over and then the survivor is now confused as to who to speak to.”

“The services that we render is not of that much quality. We tend to fail our clients along the way.”

Some NGOs also cited that the limited work spaces also compromised quality of care. Some respondents felt that the quality of their counselling and the comfort of the victim was compromised and the absence of filing cabinets compromised patient confidentiality.

“I need lock my files away and maintain confidentiality but I do not have room for that. I am unable to render effective services.”

Another observation by some of the respondents was that different organisations use different counselling models. This lack of harmonisation was seen to result in discrepancies in the quality of psychosocial support at the different TCCs.

“The counselling models that we use should be reviewed. So everyone should use a uniform model when it comes to their training. Nurses, youth workers, social workers should all use one training model.”

Late reporting of cases was also seen to compromise patient care. Some respondents cited how in the rural areas access to transport and failure to prioritise sexual abuse incidences often resulted in the victims receiving inadequate and substandard care.

“...children’s cases the whole thing of reporting late when most of the evidence that one would need to prove the perpetrator he is guilty like the semen and everything they report maybe 3 to 4 months later when that evidence is actually gone and because they are small they don’t remember the times they don’t remember the day so it becomes actually very difficult to move forward with the prosecution.”

4.9 Policy gaps and lack of harmonisation

The services offered by the TCC are based on the prescript of the Sexual Offences and the Domestic Violence Acts. These Acts are also linked to other acts such as the Children’s Act which is instrumental in how child sexual violation cases are treated. These Acts find meaning in various policies and guidelines such as the Victim Empowerment Policy and the National Policy Framework.

Some of the respondents identified areas in which the policies or their implementation was unclear. On analysis, it was found that some of the unclear areas related more to a lack of understanding of the policies than ambiguity in the policy itself. In light of this, these gaps have been highlighted with the intention to help practitioners develop tools and standard operating procedures that will assist them in performing their work.

The first such ambiguity related to the lack of clarity on whether TCCs should be seeing victims of gender based violence, who were not necessarily sexually assaulted. Whilst this is not spelt out in the policy itself, the guidelines refer to both victims.

However, in spite of this, there were some TCCs who saw only victims of sexual assault. In those that saw both, police took a statement, completed a J88 form in cases of physical injury and went on to offer legal advice around obtaining a protection order. The victim also received counselling and support and referral to a shelter were appropriate. This is consistent with the policy. It is important for practitioners to be trained in and additional tools made available to them at site level to guide such decision making.

“They do not necessarily exclude Gender Based Violence. If a woman comes in and says she has been assaulted, maybe domestic violence, she would still see a first responder, a nurse and social worker. The J88 form that we use for survivors is also useful if a woman seeks to file a restraining order. It is proof that she got medical examination.”

The SOA gives sexual assault survivors the right to open a criminal case with the police. In some TCCs, health staff required a criminal case to be opened before services could be rendered to the survivor. This contradicts the law and is again due to a wrong interpretation.

“DOH is saying that before a patient can access their services they need to open a case but the sexual offences act is against all that. Any adult is not compelled to open any case so their mandate does not make sense.”

In a few TCCs, respondents reported that police still turn away victims of sexual assault in a case where the alleged perpetrator is a husband or boyfriend. This in spite of intimate partner violence being the foundation of the DVA. This might be linked to either wrong interpretation of the law or the desire to reduce the number of violent crime cases reported (linked to the police’s measure of performance). Either way, this results in victims being humiliated and turned away with the consequence of them and others losing confidence in the criminal justice system.

“...our SAPS does not have knowledge about the TCCs and about the acts that govern domestic violence in SA. You find that they re-victimise our clients in front of people. If you tell them that you were raped by a boyfriend, they will tell you to go away and that a boyfriend cannot rape you in front of people at the police station.”

Some respondents also highlighted variations in the interpretation of the SOA and section 7 of the Children’s Act. The SOA stipulates that children under the age of 12 years cannot consent, and need the consent of their parents for accessing services, including forensic examination and HIV testing. The Children Act on the other hand refers to the ‘best interest of the child’. In some instances, parents/guardians refuse for the child to be tested – for reasons that are not necessarily to the benefit of the child.

For instance, one responder suggested that refusal is often linked to the mother suspecting that the child might already have been infected with HIV, often through vertical transmission. This refusal however, denies the child the right to PEP in the event that the mother’s suspicion is wrong – thus unconstitutionally exposing them to HIV infection.

“...loopholes was in terms of the testing of the minors. It says that children under the age of 12 must give written consent to receive testing from a guardian or a social worker. The loophole comes in the sense that there are parents who do not want their children to be tested as they are still minors, there is nothing that says that we can hold the parent accountable because they refused to let their child get tested for HIV. If she refuses, the Act does allow us to take that parent to court as we believe that the child might have been exposed to some fluids and it is in their best interests to test. (The contradiction is that the refusal of the parent is not always in the best interests of the child.)”

In such instances, the policy guidelines state that the matter is referred to the hospital CEO, who has the final decision making. In these instances, this option was not exercised.

Another grey area highlighted in the policy was that of interpretation of exposure to HIV. Currently the law states that any victim of sexual assault exposed to HIV should be offered an HIV test. In some instances, children upon examination did not show any signs of penetration, and this was interpreted to mean that the child had not been exposed to HIV and by implication there was no need for an HIV test. However, this is a narrow interpretation of exposure to HIV, as someone can come into contact with semen, blood and vaginal fluids without any penetration. This means that more needs to be done to ensure correct and consistent interpretation of the policies.

“... if the doctor finds that there was no penetration, for the patient to receive HTS the doctor would say that the patient has to have been exposed to blood and semen or any vaginal fluids. Sometimes when there are no signs of penetration, doctors tend to agree with the parents that the child should not be tested because everything is fine. But this minor might have been exposed to semen and blood of the perpetrator. I believe that this gap needs to be filled in.”

Some respondents cited a lack of consistency and harmonisation in guidelines and policies across various government departments involved in psychosocial support for women in general. This was found to be confusing.

“The whole issue of the minister of women, and the department of social development, and the department of health, and the things that are done there, everyone has their own little process...we need to look at that, in those spheres, there are definitely contradictions.”

5.0 RESULTS/FINDINGS – Consultative Workshop

The consultative workshop findings were not systematically analysed and have been presented as a reflection of the dialogue and consensus reached around possible solutions. Focused discussions happened in groups, constituted around broad thematic areas – where members were encouraged to participate where they felt they could contribute their expertise and experience most effectively. The group discussions were guided by a common framework:

1. Scale of the problem (explored and characterised the problem incl. its severity)
2. Possible solutions
3. Any recommendations

5.1 Theme 1: Funding and sustainability of TCC

Funding is inadequate

There was an overwhelming view that current funding for psychosocial in TCCs is inadequate and that NGOs were having to compromise the quality of care afforded to clients through cutting back staff and services. Although the funding gaps could not be determined – a later proposal to develop a costed operational model for TCCs would enable each TCC to accurately quantify the shortfalls.

Government should take responsibility and provide the funding

All the NGO participants argued that DSD had a responsibility to fund psychosocial services within the TCCs – in the same manner that DoH and DoJ were funding those functions that related to their departments.

They further argued that psychosocial support should be seen as a critical service and should thus have a dedicated funding stream and sustainable model. Currently, most NGOs have year-on-year funding which they have to reapply for with each business plan of the DSD. Because it is not guaranteed, they are unable to plan long term. They felt that DSD funding is offered as ‘a favour’ to NGOs – and often used to undermine their independence.

Foreign funding, often used by NGOs as supplementary funding has a lot of short comings

NGO participants also reflected on the shortcomings of relying on funding from foreign sources. They argued that this often came with preconditions, some of which undermined the country’s agenda for combatting SGBV. Global Fund grantees expressed concern about the ratio of the grant which went into administrative processes for the Principal Recipients (PRs). They felt that more should be done to regulate the split between administration and actual programming. They also felt that no more than 20% of NGO funding should be from foreign sources.

Funding for TCC should cover 24/7 services

In addition to current funding gap, NGO participants felt that government should ensure that all services are offered 24/7 and make funding available to achieve this. This would have implications for not just funding of psychosocial support, but all TCC services.

Currently, only NGO staff whose organisations have alternative supplementary funding are available 24/7. Other staff, such as doctors and nurses have to be drawn in from the hospital – which is already over stretched.

CARA funding should be made more accessible to NGOs

Money and assets that are proceeds of crime are confiscated by the Department of Justice. This money is put into a separate account known as the Criminal Assets Recovery Account (CARA) – which by legislation can be used to research or prevent crime related social harm. The DSD has in the past made some of this money available to NGOs working with sexual assault victims through a competitive grant making process. Whilst the participants welcomed this, they felt that the administration of the process was inefficient and resulted in long delays and poor accountability. They called for the fund to be administered by an independent body, with sufficient capacity. They felt that NGOs should be consulted in revising the administration of the fund, to ensure that their experiences and views are considered in the final disbursement modalities.

The NGO rationalisation process is threatening the survival of NGOs and compromising support for sexual assault victims

In 2015 the DSD undertook an NGO rationalisation process which was aimed at improving efficiency of their NGO funding model. The process looked at community services offered by NGOs and aimed to deal with any duplication which resulted in some NGOs being consolidated and others being asked to either close down or seek alternative funding sources. Whilst this process had good intention, the uncertainty caused in the NGO sector has resulted in loss of skills and compromised care. The NGOs felt that the process was not communicated well and did not have the necessary transparency. They argued that government has also used it to further cut their funding and that the service delivery gaps created have not been filled. NGO participants felt that government ought to commit more money to NGO offered psychosocial services.

Inequity in the salaries for social workers is detrimental to patient care

Currently government provides NGOs providing community based services a subsidy towards salaries for key staff such as social workers. However, this subsidy is less than what government pays its social workers, resulting in a net movement of social workers from the NGO sector to government. As a result of this, NGOs are only able to attract entry level social workers, who leave as soon as they can secure a government post. This attrition has implications for training and delivering a quality service.

In addition to this, the subsidy is not uniform across provinces – making it even more difficult to attract and retain social workers within the NGO sector in some provinces. The NGO participants called for a more equitable pay scale structure – as the services delivered by the NGO sector are done on behalf of the Department of Social Development. They feel it should be a 100% subsidy for the salaries of social workers based on the department's current salary scales and that this should be uniform across provinces.

5.2 Theme 2: Relationships and Partnerships

There are poor relationships between various stakeholders in TCCs, and in particular between the DOH and NGOs

The NGO participants shared how the poor working relations resulted in poor patients care.

They argued that there was little respect for the NGOs whose work was seen to be peripheral. In some sites, the nurses questioned why NGOs were required, given that all they do is 'comfort' patients – a function which they either saw as unimportant or that they could perform themselves. It was agreed that the source of the poor relationship emanated from the fact that NGOs were not included in the blue print of the TCCs and that they continued to be seen as an 'add on'. The poor relationships often manifested in the NGO not being allocated decent working space and being told what to do by the nurses. In some cases the NGO staff were seen to be inferior – for instance - some NGOs said that the NPA did not support the use of lay counsellors in the TCCs, as they were not regarded as a professional cadre and evidence that they presented could be inadmissible in court.

Some TCC staff are not always on site

In the conceptual model, the TCCs have all the necessary staff at the site (A site coordinator, a forensic nurse, a doctor, a case manager, victim assistance officer, non-governmental organisation (NGO) or DSD counsellors, trained police detectives and officers). However, the reality is that some officials such as the police and doctors operate from multiple sites and are often not available to see clients timeously. In some sites, the positions were not even filled. This was corroborated by the FPD study which showed high vacancy rates in some TCCs, particularly doctors and prosecutors. This resulted in long waiting times and compromised patient care.

There is poor accountability in how TCCs are managed

The NGO participants complained about poor accountability at site level. As a result – TCCs were not delivering on their mandate to offer victim centred care and increasing the rate of prosecutions.

They argued that the NPA was failing to hold everyone accountable for their work. They felt that this was because the NPA site managers were often seen to be junior to some of the other staff, such as doctors and prosecutors – making it difficult for them to hold them to account. They argued that it was inherently difficult for one government department to hold another accountable, observing that even in those TCCs that worked well, it was because of a committed site manager who went beyond the call of duty, arguing that any good model ought to be able to deliver even when employees did no more than they were expected. They suggested that for the model to work better – an independent – non-government body needs to be the site manager and hold all the government departments accountable for their responsibilities. It must be noted that currently the TCCs are not legislated, and the NPA argues that this has made it difficult to govern them. At the time of writing, the NPA was in the process of legislating them.

5.3 Theme 3: Service Delivery at TCCs

Efficacy of the TCC model

Some of the NGO participants cited that the TCC model had not been hugely successful in securing convictions, despite this being the main reason that they were set up. They argued that the NPA was selective in the cases that they took on – and that their measure of success was thus biased as it looked at successful convictions as a percentage of those prosecuted and not those that were reported. They felt that there was a need to relook at the denominator and consider an additional indicator measuring the percentage of cases reported that get prosecuted.

They also argued that it was not ideal for the NPA to lead the partnership at site level. The responsibility of the NPA is that of prosecution, and their main role in the TCCs is to expediting case turnaround times and increase prosecution success rates. Many of the respondents felt that the TCC was a trauma centre and that it did not make sense for it to be managed by the NPA whose role is prosecutorial. There was a feeling that having the NPA at the realm, whose primary interest is the judicial charge to catch the perpetrators and bring them to trial – is somewhat contrary to the minimisation of secondary harm and psychosocial restoration of the victim (the primary psychosocial purpose of the TCCs). They felt that the NPA should be acknowledged as this is their brain child, but that the model should not be rigid, but rather should be refined, taking on board lessons learnt.

Limited space and long waiting times

Most NGO participants cited logistical challenges at the TCCs, including limited space which resulted in poor working conditions for staff and poor privacy for clients. They also reported long waiting times due to inadequate staff on site.

Poor access to TCCs

They also shared that most clients were not able to honour follow up visits due to transport challenges and prohibitive costs. They relied on the police to transport them – and there was no dedicated budget to do this. In some instance patients had to wait long to be transported back home after receiving care.

Outdated protocols and protocols not followed

Some NGO participants felt that on site protocols were often out-dated and in many instances not followed. The custodian of these protocols is the site manager – from the NPA. They felt that there was a need to update the protocols annually and hold an integrated training for all staff at the TCCs including their managers. They also felt that site coordination meetings were a good platform to advocate protocol updating and that this would go a long way in standardising quality of care to clients.

5.4 Theme 4: Policies and Protocols

Different interpretation and gaps in knowledge about policies amongst NGO staff

There were several discussions about policy gaps which often pointed to a misunderstanding of some of the policies. Some of the controversial policies included:

- How and whether TCCs ought to see victims of GBV in cases where they had not been assaulted
- Dealing with parents refusal for minors to receive medical care including HIV testing
- Protecting the right of the victim not to open a criminal case – and yet still receive medical care and forensic examination (in case they change their minds at a later stage)
- Contradictions in the Children’s Act and the SOA around age of consent.

These discussions concluded that most of these issues had clear legislative guidelines which were not understood by some participants.

In order to close the implementation gaps, there was a need, not to review the policies, but rather to develop easy to use tools to help practitioners understand and interpret the policies. These could be SOPs, guidelines, matrices and algorithms.

Another challenge observed in the consultative workshop was the lack of guidance about what services could be made available to perpetrators who are known. Some NGOs felt that there was good cause in counselling the perpetrator, but that the limitation was that the TCC model did not allow for access or engagement with the perpetrator, for fear of interfering or compromising the court case.

6.0 SUCCESSES AND CHALLENGES

The NGOs that participated in the study had a lot to be proud of. They highlighted some of their successes and reflected how, in spite of all the challenges; they had remained committed to providing a quality service to the patient and ensuring that the victims are indeed transformed into survivors. The successes and challenges are shown below:

6.1 Successes

- ❖ One NGO had been offering volunteer services at the TCC for up to 3 years before they received any funding. This was a sign of dedication and commitment to the cause.
- ❖ The NGOs had had continuous uninterrupted presence in the TCCs. In spite of funding uncertainty – they would not cut staff, but rather scale back other services in order to ensure that patients are well taken care of.
- ❖ Many of the NGO reflected on the foot print they had in the community in which they worked, reflecting on the strong relationship, trust and reputation as advocates for women’s rights and the rights of survivors.
- ❖ Some NGOs saw the increase in the number of cases reported as an expression of confidence in the quality of their services.
- ❖ Most NGOs cited that they had been successful in securing funding for the TCCs amidst dwindling development funding and reluctance to fund South Africa as a middle income country.
- ❖ Some of the respondents felt that through the work that they did, they had successfully turned victims into survivors, enabling them to reintegrate into school, work and society.
- ❖ Most of the NGOs felt that the containment counselling helped manage trauma and that it formed the basis for a smooth experience within the TCC.
- ❖ Ability to advocate for the patient – amongst others in terms of language, and access to professional staff.
- ❖ Some NGOs felt that the psychosocial support, particularly around court preparation helped achieve quicker trial times and higher conviction rates in those cases that make it to court.
- ❖ NGOs were contributing to employment and poverty alleviation in the communities.
- ❖ NGOs had collaboratively developed norms and standards for rape survivors in acute stage of trauma. This is the first of its kind and attempts to benchmark services for sexual assault victims.
- ❖ Some innovative approaches have been developed such as the buddy system implemented by TVEP and described as a best practice model in Annex 1.

6.2 Challenges

The majority of the challenges faced by NGOs stemmed from the fact that psychosocial support for sexual assault victims is not adequately catered for in the SOA and as a result, NGOs have not been included in the TCC blueprint. It was their firm belief that addressing this issue will help solve the many challenges that they face in the TCCs which include:

- ❖ Inadequate resourcing of TCCs by government,
- ❖ Poor stakeholder relationships within the TCCs,
- ❖ Inadequate working space and infrastructure,
- ❖ A lack of accountability monitoring in the TCCs and many of the operational challenges relate to this,
- ❖ Poor long term support for survivors resulting in high case drop outs and low conviction rates, if cases received is used as an indicator.
- ❖ A lack of uniformity and standardisation of services across TCCs,
- ❖ Long waiting times due to staff unavailability and limited number of working spaces and,
- ❖ Policy implementation gaps resulting from a misunderstanding of policies by some NGOs and service providers.

7.0 RECOMMENDATIONS

Recommendation 1

The Department of Social Development needs to take more responsibility and accountability for the provision of psychosocial services to victims of sexual gender based violence through addressing gaps in the current legislation and putting in place a sustainable funding model for NGOs and TCCs in general.

- a) The SOA should be revised to make psychosocial support imperative for SGBV survivors. This will ensure that any service delivery models, such as the TCCs include the role of NGOs in their blue print.
- b) The TCC blue print should be revised to support a 24/7 services, without which more than 60% of the victims of reporting to TCCs would not receive a full range of timely service.
- c) DSD should provide funding for NGOs on a long term contractual basis and take greater ownership of the role played by NGOs through defining and funding core essential services for SGBV victims and debriefing services for care givers.
Funding for SGBV care should be ring-fenced. This is in line with the National Policy Framework which mandates DSD to provide a funding framework and support for NGOs contracted to provide services to victims of sexual offences.
- d) An independent capable body should be set up to manage the disbursement of the CARA funding. They should be held accountable for efficiency and reporting.
- e) There is a need to undertake a study on various sources of funding for TCC and determine what proportion is foreign funding. Knowing what government's contribution is will help assess the sustainability of the TCC model and measure governments own commitment to addressing SGBV and achieving gender equity.

Recommendation 2

The TCC model has to be revised to ensure greater effectiveness, improved operational efficiency and better patient outcomes

- a) DSD should provide clarity on what are considered 'essential' services for sexual assault victims to ensure uniform offering at all TCCs and ability for stakeholders to hold each other accountable
- b) The government should contract the services of an independent non-governmental body to run the TCCs based on an agreed framework and standard of delivery.
The current model does not allow for accountability monitoring because it is inherently difficult for a government department to hold another to account.
- c) There should be a costed operational model for TCCs, which should include all services offered and resources required based on the conceptual model. This will help bench mark the quality of services, measure funding gaps and be the basis for advocating for additional resources.
- d) In light of the limited number of TCCs – 55 country-wide - government should set up satellite TCCs and cheaper SGBV trauma management models to provide services closer to communities in order to increase access.

- e) Integrated training should be offered to TCC staff, with a focus on soft skills and team building
- f) The services offered in TCCs should be standardised through valid protocols and guidelines.
- g) Shukumisa should track the percentage of cases prosecuted of the total reported and understand reasons for non-prosecution.

Recommendation 3

NGOs working in TCCs need to exercise greater agency in managing site level stakeholder relationships and understanding of policies and protocols

- a) NGOs should lobby government, civil society organisations and academic institutions, and use coalitions such as Shukumisa to develop easy to use resources, tools and algorithms to help them at site level with the interpretation and implementation of policies.
- b) All TCCs should have signed and up-to-date protocols, which are the basis for the relationship between the different stakeholders.

Recommendation 4

Government needs to do more to address SGBV through addressing both the acute and long term needs of victims

- a) There is a need to increase evidence based social behaviour change campaigns targeting the general public to deal with barriers to reporting sexual gender based violence. DSD should provide funding to scale up best practice models.
- b) Government should do more to market the TCCs and create an awareness of their services amongst the general population. There must be increased visibility of signage to the TCCs including the rights of survivors and complaint processes.
- c) Government should fast track the development, implementation and monitoring of a National Strategic Plan for SGBV. This NSP should provide guidance on what services should be made available to perpetrators where applicable.
- d) TCC should strengthen strategic partnerships with supporting facilities such as safety homes/shelters and economic empowerment initiatives in order to offer more comprehensive care to survivors. Shelters should be made available to male victims too.
- e) The DSD, as the support department responsible for psychosocial support in TCCs has to take greater ownership and advocate for the welfare of the NGOs and the sanctity of the social work professions and counselling services offered in the TCCs.

8.0 CONCLUSION

Psychosocial support is crucial in the care for victims of SGBV. In spite of this, the SOA does not give enough credence to it, only mandating the DSD to contribute to the National Policy Framework and manage the National Register of Sexual Offenders. Many of the imperatives relating to psychosocial care for SGBV victims were excluded in the final draft of the policy. As a result, many gaps remain in the delivery and standardisation of psychosocial care for victims of SGBV.

The TCC model is conceptually a very good model and has huge potential in offering comprehensive services to SGBV victims and significantly reducing secondary trauma. In spite of huge efforts by NGOs to offer quality services to victims, their work remains outside the scope of the TCC blue print. As a result of this, they are not wholly funded by government. In the face of the growing epidemic of SGBV, it is time for government to accept their obligation to ensure the financial sustainability of TCCs, and in particular the psychosocial.

NGOs should lobby government to develop a legislative framework to allow for the establishment of TCCs as a formal part of the criminal justice system.

All TCCs should have signed and up-to-date protocols, which are the basis for the relationship between the different stakeholders as well as standards for service delivery

9.0 WAY FORWARD

There is an urgent need to take this project further as the level of frustration of participating NGOs is mounting. Many of the organisations took part in various studies and attended numerous meetings over the past few years to explore how to improve their role in successfully fighting sexual violence, yet the challenges seem to remain the same.

The role of the Shukumisa Coalition needs to be explored further as most NGOs do not have the capacity or expertise to act on the recommendations indicated in this report. Members of the Shukumisa Coalition should discuss and decide how best to take up advocacy action that is in the interest of NGOs providing services in a TCC environment.

The booklet *Guidelines and Standards for the Provision of Support to Rape Survivors in the Acute Stages of Trauma* published by NACOSA in 2015, should be considered when taking the recommendations of this report further.

This report should be viewed as a working document as organisations continue to be affected by the challenges mentioned in this report. From the time the interviews were conducted in February until the final version of the report in June 2017, organisations reported on the following:

- Challenges with SAPS:
 1. Clients are being turned away at SAPS stations
 - The SAPS official making the call on whether it is rape or not
 - The official deciding if there would be a doctor on duty at TCC or not
 - Telling the client/victim to get to the TCC themselves as there is no official transport or no FCS transport
 - Sending victims from pillar to post
 2. Crime kits not collected (sometimes for months)
 3. Clients/victims waiting to be taken home or brought to TCC
 4. At stakeholder meetings the SAPS are either not there at all or those present have no authority to make decisions
 5. Protocols that have never been signed

- Social Workers not completing relevant forms and for all cases that SAPS records and brings to TCC's the lack of proper documentation results in the case being dismissed for lack of reporting and evidence.

- NPA is no longer providing refreshments for staff or victims.

- NGOs at TCCs are threatened to discontinue their services because of funding cycles coming to an end.

10.0 REFERENCES

1. Christo des et al, 2006. "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.
2. CSVR Report. 2016. Gender Based Violence in South Africa: A brief review.
3. Foundation for Professional Development. 2016. TCC Compliance Audit Report.
4. Glick et al, 2000. Beyond prejudice as simple antipathy: hostile and benevolent sexism across cultures. *Journal of Personality and Social Psychology*, 79(5): 763–775.
5. Inter-ministerial Advisory Task Team on the Adjudication of Sexual Offences Matters. 2013. *Report on the establishment of sexual offences Courts*.
6. 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.
7. South African Government. The criminal law sexual offences Amendment Act 32 of 2007.
8. The Right and the Real. 2011. A Shadow Report Analysis of Selected Government Departments Implementation of the Domestic Violence Act and the Sexual Offences Act.
9. Machisa et al. 2010. The war at home – GBV indicators project. *Gender links* Report.
10. SAPS. An analysis of the National Crime Statistics.
11. Soul City Institute of Social Justice. 2014. Understanding gender policy and gender based violence in South Africa. A literature review.
12. Statistics South Africa. 2012. Victims of crime survey. *Statistical release P0341, Pretoria: Statistics South Africa*, 39.
13. Suffa et al, 2001. Evaluation of medico-legal services in Gauteng: implications for the development of best practices in the after-care of rape survivors, Unisa Institute for Social and Health Sciences and centre for Peace Action and MRC-Unisa Crime, Violence and Injury Lead Programme.
14. Tiemensma M. 2016. Current approaches to the management of adult survivors of sexual offences. *SAMJ* 106(11): 1071-1074.
15. Vetten L. 2014. Rape and Other Forms of Sexual Violence in South Africa. *Policy Brief* 72.
16. Vetten L. 2015. "It sucks/It's a wonderful service". Post rape care and the micro politics of institutions. *Wits Institute for Social and Economic Research*.
17. Vetten et al 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.
18. Foundation for Professional Development. 2016. Thuthuzela Care Centres Compliance Audit and Gap Analysis.

TVEP's BUDDY SYSTEM METHODOLOGY©

TVEP's Victim Advocacy (VA) Model is unique for a number of reasons, but primarily because it ensures on-going practical, emotional and para-legal support for each victim of SGBV, until after the case has been concluded – and longer if necessary – whilst mitigating traumatisation. An outline of the process follows; please note that the elements we believe can be implemented either fully or partially, irrespective of the existence of a dedicated trauma centre, have been italicised. We are of the opinion that a VEP operating near to any hospital could provide these services, so long as they and their Victim Advocates are appropriately trained and monitored:

- a. *In the Vhembe District, more than 90% of rape victims report first to their local police station. The first criteria following penetrative rape is for the victim to access post-exposure prophylactics (PEP), so as to inhibit the transfer of HIV from perpetrator to victim. The sooner the meds are taken, the more effective they are and if more than 72 hours have passed since the assault, they will not be prescribed at all. Our local SAPS are now aware of this and no longer delay the victim at the station, but transport her/him immediately to the nearest trauma centre.*
- b. *At the Trauma Centre, the first person that the victim (here-after known as the client) meets is a female Victim Advocate (VA) holistically trained to provide practical, emotional and para-legal support. After calling the doctor, the VA provides containment and pre-test counselling as PEP can only be prescribed to people who are not already HIV+. A nurse then conducts the HIV Rapid Test and the doctor examines the client and collects forensic examination, assisted by the VA. If the test proved negative, the client is immediately provided with a month's prescription of PEP, and takes the first dose. Anti-emetics are provided at the same time, with advice on how to use them, as this helps to ensure compliance. It is not reasonable to expect victims to return to the hospital if they feel sick; most will simply stop taking the PEP.*
- c. *After the examination, a police officer takes the client's statement in the presence of the VA who simultaneously enters the details onto to TVEP's intake form. The police statement and the J88 medico-legal document completed by the doctor are photocopied and retained with the intake form. This was hotly disputed initially by both the police and medical staff, but they were unable to stop us as the client provides signed consent for TVEP to access "all documentation pertaining to the case". These documents have often been requested by prosecutors when dockets have been misplaced, so that the case can still proceed in court.*
- d. *Once all formalities have been attended to, the client is provided with a care package consisting of soap, face cloth, toothbrush and paste, panties, a sanitary pad and body lotion, and offered a hot relaxing bath. If it is not safe for her/him to return home, accommodation is available within the centre for up to 4 weeks.*

- e. *The client is also given a Survivor's Rape Manual, which explains the process she has been through, what medications she has been given, what will happen regarding the criminal case (if one has been opened), the date of her counselling appointment and the name and cell number of her VA "buddy".*
- f. Counselling is provided by TVEP's Trauma Counsellor, registered with the SAHPC. Clients can attend as many sessions as they wish, and are referred to the hospital Psychologist when indicated. The Counsellor is skilled in debriefing children, and one of our trauma centres has a Play Therapy room equipped for this purpose. Family support and counselling is also provided, and support groups facilitated.
- g. *On the third day after the assault, the VA visits the client at home to encourage completion of the PEP medication, provide support and assess the home circumstances; in cases involving children there exists a possibility that other children in the extended household are also being abused but have not reported.*
- h. *When not on duty at a trauma centre, the VAs monitor the process of their client's cases through the police investigation and ensure counselling is provided when indicated; indigent clients are reimbursed for their transport to counselling appointments as poverty is rife in our district.*
- i. Whilst on duty at the trauma centre, the VA is supervised by the Trauma Centres Manager, but when following up on cases, she is supervised by one of three Legal Officers who form part of TVEP's Access to Justice Team. They are well informed on both police and court protocols, and ensure they are adhered to. Until TVEP's intervention, the scene of the crime was never secured or examined; the police relied exclusively on evidence collected from the body of the victim and many perpetrators were acquitted as a result. A common defence, for example, is that the sex was consensual; this can easily be countered if fingerprints prove that he entered the house through a window! Another innovation mobilised by TVEP is the use of tracker dogs; TVEP pointed out that the vast majority of perpetrators leave the scene of the crime on foot, so the K9 unit is now summonsed when indicated. To support this, communities are advised through TVEP's prevention campaigns not to disturb the scene of a crime.
- j. *VA's visit their clients at home for a second time 28 days after the incident was reported, again to provide support and to ensure the PEP regimen was completed. We have found that many rape victims are not well supported by their families, and sometimes even ostracised by their families. The support of her/his VA is therefore very necessary, and often a strong bond develops between them.*
- k. *When the case proceeds to court, the client is prepared for the ordeal either by her VA, or by a TVEP Case Monitor, based permanently at the court. Children are cared for whilst waiting by our Court Chaperone, in a playroom provided for that purpose.*

- l. The Court Monitor records the process of each case, noting the number of remands and any evidence of malpractice so that issue can be taken. This also enables us to track trends; we found, for example that a common ruse by the Defence Attorney is to deliberately call for remands until the victim eventually gives up and withdraws the case.*
- m. Following the completion of the case, the VA ensures that her client is informed of the outcome and what it means, and provided with further counselling if necessary. Recently the Access to Justice Team have been co-opted by Correctional Services to facilitate “Victim Offender Dialogues” prior to the release of convicted rapists, as part of their Restorative Justice Programme. This has provided TVEP with the unique and rewarding opportunity to truly see a case through to its conclusion, with the offender being reintegrated into society.*
- n. More than 78 fields of data are collected on the intake forms by the VA and Case Monitor, and captured onto TVEP’s database which now contains details of over 21,000 cases of SGBV. This has further enabled us to track trends; we were able to inform the police of a common modus operandi which resulted in the arrest of a serial rapist.

The impact of TVEP’s Trauma Services and Access to Justice Interventions is acknowledged by all our stakeholders. There are no longer delays in getting victims to trauma centres, and doctors are examining clients within 30 minutes of their arrival. The home visits conducted by the VAs have resulted in TVEP having the highest PEP adherence rate in the country – ours is consistently over 85% whilst the national average is $\pm 35\%$. A comparative study conducted in 2009 showed that symptoms of Post-Traumatic Stress Disorder (PTSD) were far less evident in clients assisted by TVEP, with our 24/7 individualised services, than from an alternative site providing limited services during office hours only (Wyatt et al, 2010). The Senior Magistrate has asked that we expand our services to other sites, as “cases from TVEP move more smoothly through the court”. Prosecutors often consult us on cases, and claim that there are far less withdrawals by victims in cases monitored by TVEP.

Finally, the extent of our impact on local police services can be deduced by the following anecdote emanating from our local Sexual Offences Court: a policeman talking to a new recruit and pointing to our Court Monitor was overheard to say “that TVEP – if you do your job well they are your best friend, but if you don’t – eish! You are in trouble!”