Process Evaluation of NGO Services at Thuthuzela Care Centres

Report compiled by Creative Consulting & Development Works:

Lindy Briginshaw - CEO and Founder
Susannah Clarke-Von Witt - Research and Evaluation Director
Leanne Adams - Senior Evaluator and Team Lead
Jenna Joffe - Evaluator
Mkhululi Mnyaka - Junior Evaluator
Dr Chris Colvin - Technical Expert
Lisa Vetten - Technical Expert
Dr Abigail Hatcher - Technical Expert

Data Collection Team

Leanne Adams, Jenna Joffe, Mkhululi Mnyaka, Itumeleng Romano, Lele van Eck, Charlotte Checha, Shirley Mphahlele, Zanele Mlambo, Morgan Mitchell.

Evaluation Technical Advisory Team

Phumelele Ngcobo (AFSA), Nomfundo Majola (AFSA), Dianah Takundwa (AFSA), Caroline Newbert (NACOSA), Lauren Baerecke (NACOSA), Memory Mahaso (NACOSA), Kerry Mangold (SANAC), and Pumeza Mafani (Department of Women).

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Acronyms

AFSA	AIDS Foundation of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
CBO	Community Based Organisation
CSI	Corporate Social Investment
DoH	Department of Health
DoJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
GBV	Gender Based Violence
GHJRU	Gender, Health and Justice Research Unit
GRIP	Greater Rape Intervention Project
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IRC	International Rescue Committee
KCC	Kgomotso Care Centres
LGBTI	Lesbian, Gay, Bisexual, Transgender and/or Intersex
M&E	Monitoring and Evaluation
MSF	Medecins Sans Frontieres
MSM	Men who have Sex with Men
NACOSA	Networking HIV & AIDS Community of Southern Africa
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
NSP	National Strategic Plan
OPD	Out Patient Department
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for Aids Relief
PR	Principal Recipient
PWID	People Who Inject Drugs
RCT	Randomised Controlled Trial
SAPS	South African Police Service
SAW	Social Auxiliary Worker
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
SOCA	Sexual Offences and Community Affairs
SORMAA	Sexual Offences and Related Matters Amendment Act
SW	Sex Worker
TB	Tuberculosis
TCC	Thuthuzela Care Centre
TOP	Termination of Pregnancy
TVEP	Thohoyandou Victim Empowerment Programme
UCT	University of Cape Town
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
YWG	Young Women and Girls

Contents

Executive Summary

The importance of follow-up practices undertaken via telephonic means or home visits was widely reported by all evaluation participants.

Background

Given the role gender inequality and resultant GBV play in disproportionate HIV and STI risk as well as other SRH outcomes, there has been an increasing trend of combining GBV intervention efforts with HIV prevention programmes, particularly in the space of post-rape care. In response to the urgent need for a multisectoral, integrated, and more sensitive approach to post-rape care, the Sexual Offences and Community Affairs Unit of the National Prosecuting Authority introduced Thuthuzela Care Centres in 2000 as a site for prevention, response and support for rape survivors. Within the space of GBV, HIV, and the National Strategic Plan, the Global Fund ZAF-C grant intends to strengthen South Africa's national response to HIV, TB and STIs within the GBV sector. As Principal Recipients of the grant, NACOSA and AFSA manage this via the disbursement of funds to NGO implementation partners (or sub-recipients [SRs]) who are responsible for direct service delivery through strategic interventions. Within the broader Global Fund GBV grant, the TCC programme provides finances to NGOs to place Social Auxiliary Workers and Social Workers at TCCs to support government service providers and to fill the gaps in the provision of psychosocial services to survivors.

Purpose

The process evaluation intended to assess the progress and quality of implementation of services provided by Global Fund-funded NGOs at TCCs with a focus on ascertaining how follow-up, HTS and adherence to PEP treatment services was functioning. The evaluation's second purpose was to identify factors that were affecting implementation, and provide recommendations that aim to assist in strengthening the programme via the improvement of implementation quality of psychosocial services for the remainder of the grant period.

Methodology

A mixed-methods approach, which incorporated both qualitative and quantitative primary and secondary data collection and analysis methods, was utilised for this evaluation. Primary qualitative data was collected via interviews conducted at a sample of 18 TCCs nationally. Interview participants included key informants, NGO, NPA and DoH programme implementers, and GBV survivors who had accessed services at TCCs. Secondary data was collected via literature and document review as well as an analysis of programme monitoring data.

Key Findings

Evidence collected suggests that the TCC programme was implemented as intended with a good degree of quality and a number of key strengths highlighted. NGO services were received positively by the NPA and DoH and were notably seen to be covering critical gaps in the services of NPA and DoH at TCCs. This included the provision of 24-hour services, HTS, STI and TB screening as well as PEP adherence support. In this way, NGOs reportedly assist to make the TCC system more effective and efficient. From the perspective of survivors, services were perceived to be acceptable and reportedly had a profound impact on their lives.

Psychosocial Support for Survivors

SRs were serving their mandates as the primary delivery agents of short-term psychosocial support services. Long-term psychosocial support was largely provided as intended, however, implementation was not consistent across all TCCs. The implementation of psychosocial support was affected by a number of contextual implementation issues.

Whilst support and supervision for SR personnel was generally implemented as intended, there was an indication that the minimum standards used in the provision of supervision were not sufficient and this impact the quality of service that NGOs are able to provide. Weaknesses in the quality and quantity of support provided were identified and, given the high workload and severity of cases, current support and supervision practices were deemed inadequate.

PEP Follow-Up and Adherence

NGOs provide an essential role in PEP follow-up and adherence practices and generally work in collaboration with nurses and doctors at TCCs to render this service. The importance of follow-up practices undertaken via telephonic means or home visits was widely reported by all evaluation participants. Whilst considerable barriers to PEP follow-up and adherence were reported, NGOs were reported to contribute to a number of facilitating factors. This is evidenced in the improved PEP completion rates experienced by both PRs of the first two years of the programme.

Sustainability

The withdrawal of Global Fund grant funding at TCCs may result in the loss of a number of NGO services. NGOs, however, did not seem to have detailed or systematic proposals for exit and sustainability strategies after grant closure. Many organisations reported relying on a combination of private and government funding, however, it seemed unlikely that this would cover the gap in funding. Whilst evaluation participants considered it government's responsibility to financially support the provision of psychosocial services to survivors, some were sceptical of government's ability to do so at the same quality standards of NGOs. Even if government, through the Department of Social Development, agrees to fund these services this financing is likely to be inadequate in meeting the full cost of the service which may severely limit NGOs' ability to sustain quality services and retain experienced staff.

Recommendations

Whilst the evaluation revealed some weaknesses in the TCC programme, key recommendations are provided in order to address these shortcomings. In accordance with this, the evaluation recommends that:

1. **NGOs increase community awareness of TCC service provision through:**
- Collaborations and partnerships with other governmental and non-governmental stakeholders
- Information leaflets and community dialogues
- Further focus on suggested targeted populations.

2. **To improve the provision of longer-term psycho-social support provided by NGOs, it is recommended that:**
- PR-SR engagements are continued and expanded on for the remainder of the grant period
- SRs rally Provincial Departments of Social Development and Community Safety (or equivalent) to cover the transport costs of survivors
- SRs provide continued frequent follow-up psychosocial support 3- and 6-months post initial TCC visit and follow-up on referrals made
- SRs ensure the same person is available for the running and facilitation of regular and ongoing support groups.

3. **NGOs devise a strategy for the implementation of further, more regular, structured debriefing and supervision for staff.**

4. **Further training on the following key areas is provided before grant closure:**
- Staff support and supervision
- Capacity building for newly qualified staff
- Awareness on HTS, TB, and HIV
- Sensitivities for key populations
- Work with child survivors and people with disabilities.

5. **NGOs collect monitoring data or information on:**
- SAW/SW qualifications
- Staff support and supervision practices
- Clients with disabilities
- Telephonic and home visit follow-up practices
- The running of support groups for survivors
- PEP dispensing methods.

6. **Roles and mitigating of tensions between NGOs, the DoH and NPA should be addressed via:**
- The development pf provincial and district level MOUs with the DoH and NPA at the beginning of a proposed grant phase
- Meetings with the DoH and NPA on a provincial and site-specific basis to strengthen partnerships, improve communication structures and increase information sharing.
- Revision of the TCC blueprint
- The cultivation of systemic thinking as a legacy of the Global Fund grant in the TCC system.

7. **NGOs should strengthen facilitating factors for PEP adherence and completion which include:**

- Further supporting the psychosocial well-being of clients via the inclusion of families in adherence support, the establishment and facilitation of survivors support groups, and the provision of further information and education to survivors placed on PEP
- The appointment of a Social Auxiliary Workers as a dedicated PEP adherence officer
- Strengthening the mechanism for the verification of PEP completion.

8. **To sustain existing NGO services the following actions ought to be undertaken:**

- The immediate focus of advocacy should be DSD funding allocated towards the prevention and mitigation of violence against women and children over the next three-year medium-term expenditure framework as part of the provincial equitable share
- PRs should consider supporting and becoming involved in the care work project house by the Shukumisa Coalition who have developed a strategy that seeks to influence how this money is allocated for post-rape services[1]
- Track the release of the Victim Empowerment Bill to ensure that this Bill allows for the effective funding of post-rape care
- Engage with national Department of Health's proposals to expand health services to rape patients at clinic level
- PRs could initiate processes that seek to develop other models of post-rape care
- PRs should consider releasing their data to researchers for analysis of the impact and use of the grant.

9. **Lastly, further research and evaluation should be undertaken via the following recommended activities:**

- Further use of monitoring data to demonstrate the impact and accountability of TCC services via statistical analysis;
- Further research and evaluation on key populations and TCCs; and
- Further research to better understand the factors affecting awareness of and knowledge about TCC services.

1 AFSA already provide funding to the Shukumisa Coalition through the Global Fund grant and both AFSA and NACOSA are members of the Coalition.

Background

Associations between sexual violence and risk for human immunodeficiency virus (HIV) and/or sexually transmitted infections (STIs) have been well substantiated in literature. Research has demonstrated that sexual violence and non-consensual sex show correlations with genital trauma and injury, which, in turn, promotes the transmission of HIV infection[1]. Globally, sexual violence is gendered, with more women and girls surviving sexual assault, than men and boys, often as a result of socio-economic and environmental factors. Imbalanced power dynamics and relations, physiological factors and social and cultural beliefs are some of the drivers of the link between gender-based violence (GBV) and HIV[2].

In South Africa, particularly, gender inequality and resultant GBV play a significant role in disproportionate HIV risk and burden among key populations, particularly adolescent girls and young women (AGYW)[3]. Prevalence rates for GBV for South African women within a given year are estimated at between 20% and 30%[4]. Given the substantial relationship between GBV and HIV, as well as other sexual and reproductive health (SRH) outcomes, there has been an increasing trend of combining GBV intervention efforts with HIV prevention programmes[5]. This is particularly important for the prevention of new HIV infections among vulnerable, high-risk populations.

HIV and TB in South Africa

Southern Africa is commonly regarded as the epicentre of the HIV epidemic, with South Africa showing the highest HIV prevalence[6]. The National Strategic Plan (NSP) for HIV, TB, and STIs (2017-2022) utilises the Thembisa model's mid-2016 estimates to place HIV prevalence at a rate of 12.8%. This translates to an estimated 7.1 million people living with HIV in South Africa[7]. In particular, HIV prevalence was reported as highest among key populations that comprise sex workers, men who have sex with men (MSM), and women of reproductive age. The NSP notes the continued impact GBV has on HIV and STI risk[8] with young women (between 15 and 24 years of age) demonstrating the highest HIV incidence with 100 000 new HIV infections per year (a rate of 2.01%) in 2015[9].

Similarly, South Africa ranks as the sixth highest in the world for tuberculosis (TB) prevalence, which the NSP highlights, is a leading cause of death in this country[10]. This is attributed to high HIV prevalence given the opportunistic nature of TB, which presents a risk greater to individuals with compromised immune systems. As such, HIV is seen as a key driver of the TB epidemic[11]. An estimated 63% of people living with HIV co-infected with TB[12], and TB is cited as the leading cause of death among people living with HIV, with TB accounting for 40% of deaths from acquired immune deficiency syndrome (AIDS) -related illnesses .

Post-rape care in South Africa

Sexual and gender-based violence (SGBV) is an extensive, normalised, and underreported problem that disproportionally affects women and children in South Africa. Whilst little nationally-representative data is available regarding the violent experiences of women, one study demonstrated that more than half (51.3%) of the women in Gauteng had experienced some form of violence at least once in their lifetime, with the same study interestingly suggesting that a large

Prevalence rates for GBV for South African women within a given year are estimated at between 20% and 30%.

1 Klot & DeLargy (2007); Vetten & Bhana (2001)
2 Lukas (2008)
3 Chege (2005); World Health Organisation (WHO) (2016); Richter, Manegold & Pather (2004)
4 KPMG (2014)
5 Chege (2005)
6 UNAIDS (2017)
7 Johnson (2016) Thembisa Version 2.5
8 NSP for HIV, TB, and STIs (2017-2022)
9 Johnson et al. (2016)
10 World Health Organisation Global TB Report (2015) as cited in the NSP for HIV, TB, and STIs
11 Lawn, Bekker, Middelkoop, Myer & Wood, 2006; Sharma, Mohan & Kadhiravan (2005)
12 NSP for HIV, TB, and STIs (2017-2022)

proportion of men (75.5%) admit to committing forms of violence against women in their lifetimes. With South Africa pegged as a one of the countries with the highest rates of violence against women in the world, a closer look at rape as a form of SGBV reveals evidence which points to the fact that that up to 50% of all South African women will be raped in their lifetime[1]. With over 41% of rapes reported in the country involving children, it is estimated that 25% of girls are likely to be raped before the age of 16 .

Considering the extent of GBV in the country, a number of individual services have been made available to assist survivors, as well as their families, to cope with the repercussions of sexual assault, including rape[2]. Nationally, post-rape care services are provided at a variety of separate locations including police stations, courts, healthcare facilitie and nongovernmental organisations (NGOs) to manage and treat survivors' health, provide psychosocial support and address justice needs. However, research into these services has revealed that navigation through various institutions and systems directly after such a traumatic experience is taxing, logistically challenging and can increase the risk of triggering secondary victimisation for rape survivors. Ill-informed and judgemental treatment of survivors, or holding survivors responsible for their own harm, can considerably worsen psychological distress, especially if staff providing these services are not specially trained and sensitive to such cases[3].

In response to the urgent need for a multisectoral, integrated, and more sensitive approach to post-rape care, the Sexual Offences and Community Affairs (SOCA) Unit of the National Prosecuting Authority (NPA) introduced Thuthuzela Care Centres (TCCs) in 2000 as a site for prevention, response and support for rape survivors. The establishment of TCCs was seen as a critical component of South Africa's anti-rape strategy that would serve to resolve many of the shortfalls associated with post-rape services operating in isolation.

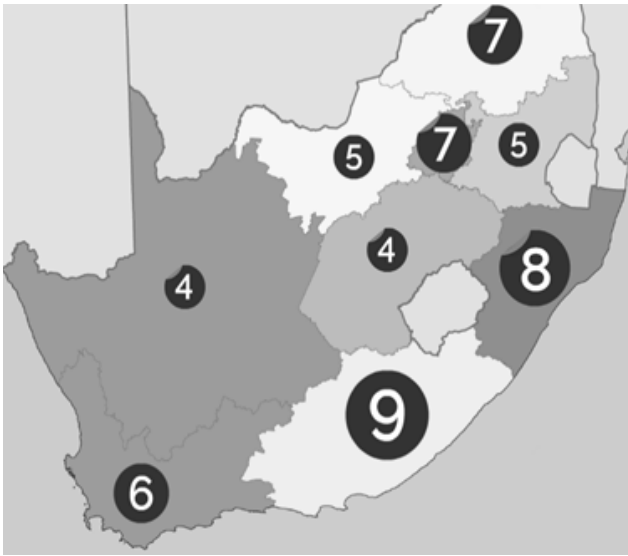
There are 55 functioning TCCs located in all 9 provinces across the country.

TCCs are intended to function as multisectoral one-stop facilities, which provide a broad range of essential services to survivors in one location which enable survivors to report the crime, receive healthcare and acquire psychological support. Whilst services vary across TCCs, most TCCs typically offer a set of essential services.

TCCs are intentionally located in or near communities where the incidence of rape is notably high. These Centres are usually based within primary or secondary health facilities. A small proportion of TCCs are located within detached structures known as park-homes, rather than within a health facility. TCCs should also have links with and be in close proximity to sexual offenses courts. These attributes collectively serve to achieve three primary goals of the TCCs:

1. Reduce secondary victimisation of GBV survivors
2. Improve conviction rates of rape perpetrators
3. Reduce case management time required to finalise a rape court case.

In the middle of 2016, the Foundation for Professional Development's TCC Compliance Audit (2016) reported that there are 55 functioning TCCs located in all 9 provinces across the country. Figure 1 below provides an indication of the distribution of TCCs per province. The relatively small number of TCCs



Distribution of TCCs Provincially Across South Africa

1 Cox, Andrade, Lungelow, & Schloetelburg (2007) as cited in Mpani & Nsibande (2015)
2 Sexual assault encompasses all non-consenting sexual acts, from unwanted fondling to rape, and can be with a part of the body, genitals or an object (Mpani & Nsibande, 2015)
3 Shukumisa (2017)

established across the country presents a challenge in terms of access to services for survivors on a geographical basis.

The TCC Blueprint was developed by the NPA as a guideline for governmental and NGO stakeholders who provide services at TCCs. The Blueprint outlines the steps and processes for the management of sexual assault survivors who enter TCCs. The Blueprint details an ideal prototype or model for how a TCC should be structured; standards for the level of care provided; norms and standards for managing sexual assault survivors; as well as the roles and responsibilities of key stakeholders who deliver their services within the TCCs[4]. Although this Blueprint provides an exemplary understanding of how the TCC model is supposed to function in theory, in practice the implementation of the model may vary from site to site, between and within provinces.

This evaluation aimed to further investigate the variation in the implementation of the TCC model as a response to post-rape care, however, current implementation practices may be a result of both the financial and human resources available, as well as the interrelationships between different role players within a TCC. Previous research[5] has found that stakeholder relationships at TCCs are frequently characterised by a mix of power dynamics between various government departments and NGOs within TCCs which, again, varies across sites.

Even though it is evident that there is a strong need for TCCs, recent evidence suggests that services provided by TCCs are underutilised[6]. A large proportion of the South African population is unaware of the locations or the services provided at TCCs. In addition, survivors are often deterred from accessing help due to pervasive social stigmas attached to rape. Further, various misperceptions about services offered at TCCs (e.g. that it is a requirement to report one's attacker) frequently inhibit their use. GBV training and sensitisation for survivors of sexual assault has been provided for TCC service providers[7]. Despite this, gaps may still be evident in some TCC stakeholders' (i.e. SAPS) treatment of survivors with some reports of poor institutional support, inappropriate care and poor treatment in interactions with such service providers.

Further detail on the links between the TCC system, key national policy and relevant legislation can be found in the full length literature review included as Annexure B.

A large proportion of the South African population is unaware of the locations or the services provided at TCCs.

Programme Description

Within the space of GBV, HIV, and NSP as outlined above, the Global Fund ZAF-C grant, titled "Investing for Impact against Tuberculosis and HIV", intends to strengthen South Africa's national response to HIV, TB and STIs the achievement of the following goals[8]:

1. Accelerate prevention to reduce new HIV and TB infections and STIs
2. Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all
3. Reach all key and vulnerable populations with customised and targeted interventions
4. Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP
5. Ground the response to HIV, TB, and STIs in human rights principles and approaches
6. Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs
7. Mobilise resources and maximise efficiencies to support achievement of NSP goals and ensure a sustainable response
8. Strengthen strategic information to drive progress towards achievement of NPS Goals.

The grant, which is being implemented from 1 April 2016 to 31 March 2019, focuses on GBV as a critical point of intervention of the problem of HIV, TB and STIs in the

4 Foundation for Professional Development (FPD) (2016)
5 Vetten (2015)
6 USAID (2017)
7 Via a comprehensive and multidisciplinary training undertaken by the Foundation for Professional Development funded by USAID
8 Whilst the grant was awarded during the time in which the 2012-2016 NSP was being implemented, the grant now supports the goals of the new NSP (2017-2022).

country. The grant aims to address the high incidence of HIV in vulnerable populations, especially adolescent girls and young women (AGYW) who, as previously outlined, experience increased HIV risk in South Africa. The Networking HIV/AIDS Community of South Africa (NACOSA) and the AIDS Foundation of South Africa (AFSA) comprise two of eight Principal Recipients (PR) of this grant. NACOSA and AFSA are responsible for the GBV programme consisting of numerous interventions, as depicted in Table 1 below. As PRs who manage the grant, NACOSA and AFSA disburse funds to NGO implementation partners (or sub-recipients [SRs]) who are responsible for direct service delivery through strategic interventions, as well as site-level monitoring and evaluation (M&E).

The above primary, secondary and tertiary GBV programmes are all intended to result in programme-specific GBV outcomes. At the national level, the GBV programme supports a national level advocacy campaign for legal reform, policy implementation, data and evidence, and a supported national strategy for GBV. Specifically, actions support the Department of Women (DoW) and the Department of Social Development (DSD) in the adoption and costing of a strategic plan for the GBV response. The GBV programme is located within a number of other GBV responses by other partners and government intended to address this epidemic[1].

It is against this background that the Global Fund GBV programmes are also anticipated to work in combination, albeit in varying degrees, to contribute to the grant's five broad goals as previously outlined. Although the grant provides funding for all of the above interventions within the GBV programme, TCCs were the focus and intervention of interest for this evaluation.

The Global Fund TCC Programme

A summarised programme theory of the Global Fund TCC programme, illustrated in Figure 2 below provides an overview of the TCC model with specific reference to the roles provided by Global Fund funded NGO stakeholders within the TCC process. A full-length version programme theory (see Annexure A) provides a broad demonstration of the intended outcomes of the Global Fund TCC Programme and how these relate to larger goals of the grant as outlined previously in this section.

A more detailed account of the function of NGOs, the NPA, Department of Health (DoH), South African Police Service (SAPS), and Department of Social Development (DSD) at

1 Including: the South African Integrated Programme of Action addressing violence against women and children (2013-2018); National Intervention Strategy for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Sector, 2014; Judicial Matters Second Amendment Act 43 of 2013; Protection from Harassment Act 17 of 2011; Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007; 365 Day National Action Plan to End Gender Violence, 2007; National Health Act 61 of 2003; South Africa's National Policy Framework for Women's Empowerment and Gender Equality (2000); Domestic Violence Act 116 of 1998; South African Police Services Act 68 of 1995

Gender-Based Violence Programme		
National Level		
National Advocacy Campaign		
District-based Community Level		
Primary Prevention	**Secondary Prevention**	**Tertiary Prevention**
Stepping Stones & Creating Futures Programme • Workshops to improve communication, psychological well-being, and knowledge of sexuality and gender • HIV prevention, management and treatment	**Shelter Programme** • Psychological support • HIV education and testing services • Life skills education • Economic empowerment **South African Police Service Training** • Accredited training for police officials to be sensitised to GBV	**Intimate Partner Violence Programme** • Counselling • HIV education and testing services • Adherence support • Referral to legal services **Thuthuzela Care Centres and Designated Facilities** • Services for victims of sexual violence and rape • Psychosocial support • HIV testing • Adherence counselling • Court preparation and support • Referral to other support services

NACOSA and AFSA-led GBV Programme Interventions at Primary, Secondary and Tertiary Level

	TCC Services or Activities				
	Initial Reception/ Intake	**Prevention (Medical Care)**	**Psychological First Aid Containment of Survivors**	**Follow Up (Psychosocial Care)**	**Evidence & Investigation**
Role of SAWs	Intake	HTS	Immediate crisis counselling	Longer-term psychosocial counselling	Support through medico-legal exam
	Information on services & procedures (what to expect)	STI Screening and referral	Bath/shower/access to change of clothing, care pack	Longer-term psychosocial counselling through reerral to SW (SR, DSD, DoH)	Support in reporting to SAPS & opening a case
		TB screening & referral	Victim advocacy role	Adherence support	Court preparation & support
		Information on PEP (based on HTS outcome)	Other referrals	Other referrals	
		Information on ART services depending on outcome of HTS			
	Community outreach & awareness				
	Assumptions: efficient service flow; adequate staffing; adequate resources available; space optimally designed/laid out;functional working relationships between stakeholders; client records maintained				
	Initial Reception/ Intake	**Prevention (Medical Care)**	**Psychological First Aid Containment of Survivors**	**Follow Up (Psychosocial Care)**	**Evidence & Investigation**
Role of SWs	In exceptional cases when: SAWs take unscheduled leave, 24 hour period (SW on call), special areas.			Longer-term psychosocial counselling through referral to SW (SR, DSD, DoH)	Reports & assessments (victim impact statements)
				Longer-term psychosocial counselling	Statutory services
				Adherence support	
	Assumptions: efficient service flow; adequate staffing; adequate resources available; space optimally designed/laid out;functional working relationships between stakeholders; client records maintained				

Role provided at TCCs by Global Fund-funded SAWs and SWs

TCCs, the psychological first aid services provided, the specific roles played by Social Auxiliary Workers (SAWs) and Social Workers (SWs) through the Global Fund grant, as well as the key focus areas of the grant (i.e. HIV testing services [HTS], sexual and reproductive health [SRH], key and vulnerable populations, linkages to care and follow-up, and sustainability) can be found in the full length literature review included as Annexure B. The Global Fund grant specifically provides finances to NGOs to place SAWs and SWs at TCCs to support government service providers and to fill the gaps in the provision of psychosocial services to survivors.

At the start of the grant in April 2016, Global Fund support at TCCs was implemented by NACOSA and AFSA SRs in nine priority districts, namely the Western Cape (City of Cape Town), Eastern Cape (OR Tambo District and Buffalo City), Gauteng (City of Tshwane), KwaZulu-Natal (Ethekwini and Uthungulu), North West (Bojanala), and Mpumalanga (Gert Sibande and Ehlanzeni). When further funding was awarded by the Global Fund in February 2017, NACOSA and AFSA were able to fund several additional SRs[2] to implement services at TCCs, in addition to these nine priority districts. The latest grant period, therefore, sees implementation in a total of thirty-one districts by thirty-five NACOSA and AFSA SRs, which has substantially increased the scope and reach of the TCC programme. The most recent tranche of the ZAF-C Grant funds NGO services at 41 of 55 TCCs nationwide[3].

As previously stated, the grant exclusively funds NGO services at TCCs and the most recent tranche places

2 Which included Western Cape (Winelands); Eastern Cape (Amatole and Nelson Mandela Bay); Gauteng (Ekurhuleni, City of Johannesburg, and Sedibeng); Northern Cape (Frances Baard and Pixley Ka Seme); Free State (Mangaung Metro, Leejweleputswa, and Fezile Dabi), KwaZulu-Natal (Ilembe, King Cetshwayo, and uMgungundlovu); North West (Tlokwe, Ngako Modiri, Dr Ruth S. Mompati, and Kenneth Kaunda); Mpumalanga (Nkangala); and Limpopo (Vhembe, Capricorn, and Waterberg).

3 The extensive funding provided the Global Fund to almost all TCCs across the country raises concern around TCC's ability to effectively implement the provision of psychosocial services without support from other donors.

particular emphasis on certain essential staff roles and key focus areas of the grant which are described below. It is relevant to note here that there may be overlap in roles between the NGO-funded services and the services mandated by other government departments within the TCC model. In some instances, a government department may be wholly responsible for a service, or an NGO may have full responsibility, or there may be dual functionality between government and NGO functions.

Literature review

Adherence to PEP to prevent HIV-infection after rape is low both in sub-Saharan Africa, as well as in more developed countries.

The following sub-section provides an overview of an in-depth literature review conducted during the clarificatory phase of this evaluation. Since evidence suggests that facility-based models which provide a first response to post-rape care are largely focused on the provision of healthcare to survivors, the review provides an overview of models which focus on responses to HIV within the context of post-rape care. Considering that the aim of the Global Fund ZAF-C grant is to bolster the country's national response to HIV, TB and STIs, the review focuses on the provision of post-exposure prophylaxis (PEP) as a one method of response to HIV within a gender-based violence setting and highlights some of the challenges in accessing and adhering to PEP that have been documented in literature.

Responses to HIV via Post-Rape Care

Generally, responses to HIV within the context of post-rape care are informed by the survivor's HIV status prior to the rape. While survivors who test positive for HIV are referred for further counselling regarding living positively, as well as possible ART, those who test negative and who report the rape within 72 hours of its occurrence may be prescribed a 28-day course of PEP to prevent infection with HIV. Of the two treatment responses it is ensuring access to PEP, as well as supporting survivors to complete their course of treatment that has attracted the overwhelming bulk of research attention.

The sub-section below draws on available literature to discuss challenges in accessing and adhering to PEP.

Challenges in accessing & adhering to PEP

The initiation of PEP is time-sensitive, with the first dose of drugs needing to be administered within 72 hours of the rape having occurred. The time-bound nature of this treatment can particularly disadvantage children who often only disclose sexual abuse some time after it has occurred[1]. Other delays found to affect access to PEP, for both adults and children, include a lack of awareness of the time-bound nature of PEP initiation, the time spent taking statements from rape survivors, as well as long waits in casualty[2]. Communities may also not know that HIV-infection can be prevented through the administration of PEP[3].

Research at Tintswalo Hospital identified further obstacles interfering with the timely provision of emergency contraception, HTS and PEP. Indeed, PEP was often the last step in the treatment chain. Further, while the majority of patients presenting for care were eligible for PEP, many arrived during hospital after-hours when the service was least prepared to meet their needs. In practice, problems with transport, lack of cell phone coverage and the belief that some women lied about rape undermined the provision of PEP[4].

PEP is dispensed in different ways. Where a patient does not appear to be in a position to give meaningful consent to HTS, a three-day starter pack of PEP is provided and the patient asked to return for testing and a further course of PEP (if eligible). At some facilities PEP is provided on a weekly basis, with return visits used as an opportunity to follow-up on patients' health and well-being[5]. In other instances (particularly in rural areas) the full 28-day course is given. Studies suggest that a substantial number of patients may be lost to repeat visits.

Adherence to PEP to prevent HIV-infection after rape is low both in sub-Saharan

1 Vetten & Haffejee (2005); Vetten et al. (2008)
2 Rohrs (2011)
3 MSF (2016)
4 Kim et al. (2009b)
5 Vetten & Haffejee (2005)

Africa[6], as well as in more developed countries[7]. A systematic review and meta-analysis of studies assessing adherence globally found 40.3% of patients completed the treatment, with these rates seeming to be better in developed countries than developing countries[8].

Patients have reported defaulting on their treatment due to forgetting to take their medication, or not taking their medication in the prescribed dosages[9], as well as due to side effects[10]. Time constraints also affected the amount of information health care providers (HCPs) could provide to rape survivors, including around adherence[11]. Lack of follow-up procedures and limited provision to rape survivors of medication to address the side effects of PEP were also identified as barriers[12]. For these reasons, rape survivors do not always understand PEP's drug regimen and, as a consequence, do not take the medication correctly[13]. Further, some rape survivors may be in no state to absorb all the health-related information they are provided in the immediate aftermath of the rape[14]. Interviews confirm that taking PEP is a complex experience for rape survivors, with the stigma attached to rape, as well as HIV, being particularly powerful barriers[15]. Being blamed for the rape and receiving inadequate social support inhibited women's ability to comply with the drug regimen.

In conclusion, the literature suggests a number of underlying factors and influences on survivors' ability to access and adhere to PEP medication. The evaluation sought to further understand these factors in the context of the TCC model.

Funding Landscape for GBV and Post-Rape Care

Despite South Africa's alarming levels of GBV, NGOs and community based organisations (CBOs) working in the sector find themselves in deep financial crisis. Several reports document that NGO services provided at TCCs are unsustainable[16]. This is primarily a result of financial insufficiencies, especially regarding the lack of responsibility government departments take in providing funding to NGOs, as well as the numerous shortcomings associated with NGOs relying on foreign funding, including competition for resources, short-lived grants and conflicting agendas[17]. This is further exacerbated by trends of declining funding for GBV programming in South Africa. Private donors, such as the corporate sector, have also provided little contribution to rape and domestic violence programmes and services.

Using South Africa as the context for investigation, a recent study found that where there is funding awarded to organisations addressing GBV, grants are primarily directed towards treatment, care and support services (tertiary prevention strategies), despite global trends indicating a shift towards GBV at a primary prevention level . This is likely a result of the fact that large funders of GBV programmes (i.e. the Global Fund, UNAIDS, PEPFAR, and UNFPA) typically focus on HIV/AIDS and SRH outcomes with key interests in ameliorating and eradicating these as consequences of GBV. It would seem, therefore, that the focus of funding for organisations addressing GBV is shifting towards an intersectional HIV/AIDS lens.

Given the trends of decreased and insufficient funding across the GBV sector, there is immense concern that the current funding for psychosocial services at TCCs is largely insufficient. The evaluation sought to identify the exit and sustainability strategies of NGOs and provides recommendations on addressing the sustainability of NGO funding for the provision of services at TCCs.

6 Draughon & Sheridan (2011)
7 Chacko et al. (2012)
8 *Ibid*
9 Vetten & Hafejee, (2005)
10 Vetten & Hafejee (2005); Rohrs (2011)
11 Vetten & Hafejee (2005); Rohrs (2011)
12 Rohrs (2011)
13 Vetten & Hafejee (2005)
14 *Ibid*
15 Abrahams & Jewkes (2010)
16 Vetten (2015); Shukumisa (2017)
17 Vetten (2015)

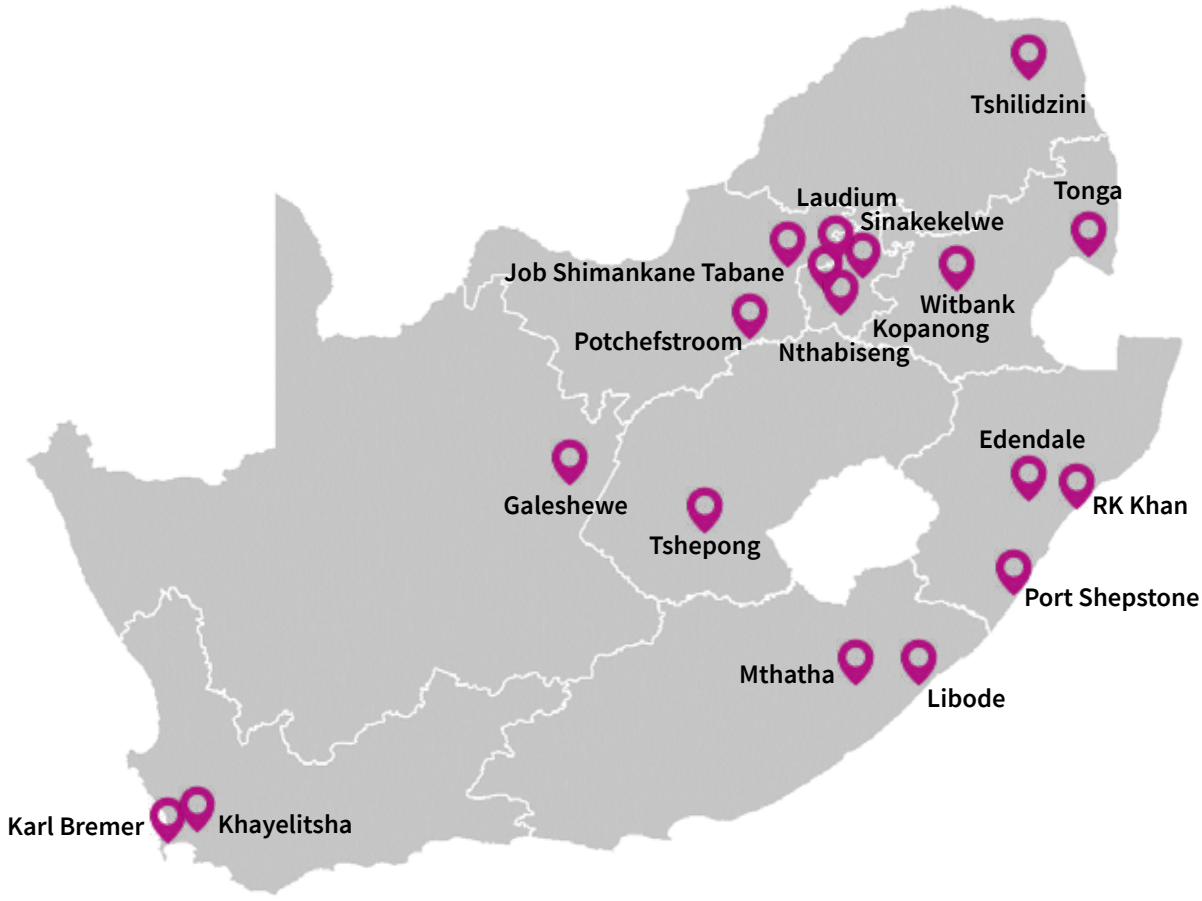
Role of evaluation in programme implementation

It is often difficult to implement what may appear on paper to be a good model for service delivery, into equally good service provision on the ground. Effective implementation of a service delivery model is understood as a careful balance between fidelity and adaptability. Fidelity refers to the extent to which programme implementers implement a programme as it was intended by those who developed the intervention. Adaptability, on the other hand, refers to a programme's sensitivity toward and ability to adapt to changes in the contextual realities in which it is implemented. The combination of fidelity and adaptability in programme implementation increases the likelihood that an intervention will achieve its intended outcomes. There is agreement among evaluation practitioners that the fidelity of implementation is a crucial component to effective implementation . Despite this, there are often challenges encountered within the contextual implementation reality in which the model functions which may prevent it from fully realising all intended outcomes.

Evaluation plays an important role in programme implementation by firstly ascertaining the progress and quality of implementation of services provided and how these are functioning within the context in which they are implemented. Secondly, evaluation also assists in the identification of contextual factors affecting implementation, and provides recommendations that aim to assist in strengthening the model through improving the quality of services implemented in order to achieve intended outcomes and goals. Overall, the evaluation findings are intended to be utilised to better understand which components of the services provided by SRs at TCCs are not working adequately in order to assist in shifting the provision of psychological first aid practices to ensure these have better utility and impact for survivors.

Relevant geographic areas

Primary evaluation data was collected on a national level. The following map illustrates the TCCs sampled provincially for inclusion in the evaluation.



Map of geographic areas for evaluation

Evaluation purpose

The process evaluation of psychosocial support services provided by Global Fund-funded NGOs at TCCs had two primary purposes. The first of these was to assess the progress and quality of implementation of services provided by Global Fund-funded NGOs at TCCs with a focus on ascertaining how follow-up, HTS and adherence to PEP treatment services was functioning. The evaluation's second purpose was to identify factors that were affecting implementation, and provide recommendations that aim to assist in strengthening the programme via the improvement of implementation quality of psychosocial services for the remainder of the grant period[1].

The evaluation presents findings, recommendations, and emerging opportunities that can be used to improve the implementation of NGO services at TCCs. Further, the evaluation provides specific recommendations on the role of first responders at TCCs for the remaining grant period. The evaluation also provides recommendations for programme strengthening, future programme planning and programme planning where other donors are concerned. Further recommendations are provided to scale-up the current model as implemented by AFSA and NACOSA SRs in the provision of psychosocial services to survivors.

The process evaluation, therefore, addresses current gaps in AFSA and NACOSA's understanding regarding the quality of service provision by NGOs to survivors at TCCs and the different contextual factors and mechanisms that drive service delivery at TCCs.

The key objectives of the evaluation were to:

1. Assess the quality of NGO services implemented at TCCs
2. Document data on current follow-up and PEP adherence practices at TCCs
3. Identify barriers and enablers to successful outcomes for rape survivors
4. Identify good practices that promote high quality services and high-quality outcomes for rape survivors at TCCs
5. Understand the sustainability of NGO funding to TCCs.

Effective implementation of a service delivery model is understood as a careful balance between fidelity and adaptability.

1 The identification of lessons learned was important for newer Global Fund-funded TCC programme components (e.g. the allocation of qualified SAWs/FRs and Social Workers to Global Fund grant SRs), as there is limited available evidence of their successes and challenges.

Findings, discussion & interpretation

"If the victim comes at night they're taken to casualties and then they will have to wait for the sister who comes in... in the morning. If you can just close that gap of not operating 24 hours it will help."

Site Coordinator

This section addresses the overall evaluation question regarding whether the TCC programme was implemented as intended, as well as the quality of overall implementation. This section is broadly organised according to four key evaluation theme objectives: quality of services implemented, PEP follow-up and adherence practices, key and vulnerable populations and sustainability. Evaluation questions are grouped and presented within each of these themes.

Data has been analysed and findings are presented at a PR level[1]. Findings are presented in combined and aggregated form (i.e. AFSA and NACOSA) when data suggested similarities across PRs. However, findings are disaggregated by PR in instances where differences in implementation were found between AFSA and NACOSA SRs. Whilst data is presented at an aggregated level, it is important to highlight that not all TCCs function in the same way. Many facilities have modelled their own functional systems based on what works in certain circumstances, and for whom. Whilst the aggregated nature of these findings may preclude the inclusion of specificities in implementation at a TCC level, context-specific adaptations and implementation of the model should not be disregarded if these adaptations enhance the functioning of NGO services provided at TCCs.

By and large, evaluation results suggest that the TCC programme was implemented as intended by SRs with a good degree of quality in the psychosocial services provided.

Quality of services implemented

24-Hour Service

According to the TCC Blueprint, as well as NACOSA's Guidelines and Standards for the Provision of Support to Rape Survivors in the Acute Stage of Trauma[2] (hereafter referred to as NACOSA Guidelines), TCCs should provide 24-hour services to survivors. Not only does this ensure that survivors are able to access PEP within a 72-hour period, it is also likely to promote better psychosocial outcomes[3]. Considering the importance of a 24-hour service, a facility's ability to provide services to survivors around the clock and on weekends can also be used as an indication of quality service provision.

Findings from a variety of stakeholder perspectives demonstrate that most, but not all, AFSA and NACOSA SRs were able to provide a 24-hour service. Instances in which SRs were unable to run a 24-hour service were reportedly due to limitations in the availability of forensic nurses and doctors[4]. In order to counter this, some SRs reported running a 24-hour crisis call line for survivors needing to be attended to after hours, or on weekends. Other SRs who did not indicate a functional 24-hour service reported that survivors were referred to casualty after hours and on weekends.

Interviews with Site Coordinators and/or Victim Assistance Officers highlighted that SRs operating around the clock in TCCs often assist the NPA in filling the gaps in their service by providing services to survivors after hours. Findings indicate that after hour duty is one of the major roles played by NGOs in TCCs. This finding is consistent with previous research conducted which demonstrates that NGOs frequently backstop TCC functions[5].

In instances where SRs were providing a 24-hour counselling service, the shortage of HCPs who work 24-hour shifts was frequently identified as a limiting factor in the provision of holistic services for survivors. The inability of some facilities to provide a 24-hour service was identified as a large gap in service provision which limited the quality of services provides and the need to eliminate this gap was frequently conveyed.

1 In order to maintain evaluation participant anonymity.
2 Which requires that all services work towards being available 24-hours a day, seven days a week.
3 Supportive intervention (i.e. initial trauma containment) closer to a traumatic event is likely to assist in the reduction of initial distress. Delays in trauma containment and the inability to reduce initial distress may increase the potential for further psychological damage.
4 Since the overall operation of TCCs is dependent on the DoH and NPA.
5 USAID (2015); FPD (2016); and Shukumisa (2017)

"We do offer a 24 hour service but the problem is that at night there will be no doctors to do the forensic examination but after hours the doctors will be available and the nurses will be available and our staff are available on call. Let's say one social auxiliary is at home and there is a victim at the TCC, someone will drive and go to pick-up that social auxiliary at home and bring her to the TCC to continue assisting the survivor. They are on call, they are all on call." Programme Manager

There are substantial implications to a survivor's experience of TCC services when access to services at any time of the day is limited. Not only was this reported to result in a backlog and increased waiting times[6] for survivors, instances of survivors spending the night waiting at a TCC to be seen, when services only convene the following morning, were reported at some TCCs. This results in survivors experiencing delays in the immediate initiation of PEP medication[7] on arrival at the TCC[8], or an inability to initiate PEP within the 72-hour period[9].

Other implications of a service that is not run on a 24-hour basis include unnecessary repeated visits to the TCC as not all services were accessed at the initial visit. Whilst the TCC model is designed to alleviate the secondary victimisation survivors experience after sexual assault, the lack of a 24-hour service may result in survivors experiencing further victimisation if services are received from staff not trained in the sensitivities required when dealing with survivors of sexual assault.

Psychosocial Support

The following section outlines the systems SRs have in place to ensure that rape survivors receive necessary short- and long-term psychosocial support and/or referrals.

Short-Term Psychosocial Support

NACOSA Guidelines state that SAWs/FRs are intended to function as the primary delivery agents of short-term psychosocial support services (i.e. intake, containment and initial counselling) to survivors at TCCs. Given that short-term psychosocial support is one of the first services provided to survivors at TCCs, it is crucial that SAWs/FRs deliver this service in an effective and supportive manner so as to ensure that further victimisation and harm to the victim is avoided.

First Person Survivor Sees

NACOSA Guidelines recommend that when a survivor arrives at a TCC, SAWs/FRs are required to implement psychological first aid and provide an explanation of all procedures that will be followed. Thereafter, the survivors should undergo a forensic examination, which the SAW/FR may attend at the survivor's request. Thereafter, the investigating officer may take the survivor's statement which may also in the presence of the SAW/FR at the survivor's request. According to the majority of TCC stakeholders, the first person to see survivors at TCCs is usually the SAW/FR or the NPA Site Coordinator. Evaluation participants expressed that there is no one person who is solely responsible for receiving survivors in most TCCs as this often depended on who was available at the reception or front desk when the survivor arrived. This differed from TCC to TCC but also depended on the time of day. For example, NPA staff do not work after hours, whilst SAWs/FRs do to ensure the 24-hour services are rendered. As such, during nights and weekends, it would likely be a SAW/FR to be the first person to meet a survivor on arrival.

"Commonly during the day she will see a Site Coordinator who will get a very basic history on an NPA form, with not great detail. Then she'll have all the procedures that she goes through explained. Once she's seen the Site Coordinator, she'll then go and see our lay counsellor who will give more detail about everything that is going to happen."
Nurse

Containment and Counselling

In accordance with the NACOSA Guidelines, the majority of evaluation participants indicated that SAWs/FRs were providing trauma containment and further initial counselling to survivors. SAWs/FRs were reported to demonstrate skill in approaching survivors and were seen to be cautious in the way that they conversed with the survivors about their incidents. The containment provided by SAWs/FRs was reported as helpful in calming clients down and subduing emotions, especially if survivors was experiencing uncontrollable emotions. Many evaluation participants noted the importance of this support in that contained survivors are more receptive to listening and understanding the information relayed to them by various TCC stakeholders, which is particularly crucial regarding PEP medication and the

6 Often in the casualty section of the health facility.
7 PEP should ideally be taken within two hours of exposure.
8 As the personnel on duty at the time of reporting are unable to dispense PEP medication.
9 As the survivor is only seen at the TCC after the 72 hour period.

reporting of cases. In addition to the above support, SAWs/FRs were also able to ensure that survivors understood all TCC processes and procedures This, in turn, was reported to ease the roles of DoH and NPA personnel as survivors were calmed and prepared for the next steps in the process. Initial containment and further immediate counselling was also reported to enable survivors to make informed decisions at the TCC without being forced or influenced in anyway.

"Okay what I normally do is that I let them be calm and say to them if I understand you correctly you said you don't [want] help! And so I leave her because you cannot force her. So I leave her but I explain that should she need to talk she can always come back here at the TCC or call and also should she feel scared of doing the face to face she can always call the land line so she can talk. Yes I tell her about other options that are available"
Social Auxiliary Worker/First Responder

Challenges in containment and counselling

According to NACOSA Guidelines, SAWs/FRs should conduct the containment and initial counselling of survivors in a space that is private as this makes it easier for survivors to trust SAWs/FRs with their stories and fosters a sense of confidentiality between the client and the SAW/FR. While evaluation participants pointed to the fact that containment and counselling services were implemented with a high degree of quality when there was a private and conducive environment, most participants noted that the availability of such an environment was a frequent challenge encountered in most TCCs. This was reportedly due to the fact that offices were small and often shared with other TCC service providers[1]. This finding is consistent with reports from previous research and evaluation undertaken on TCC service provision[2]. The unavailability of private space was reported to have a negative impact on survivors' experiences at TCCs with the potential for further harm which may result in survivors not wanting to return to TCCs for follow-up sessions if the recounting of their experiences were perceived to be too openly shared.

"That is the challenge that we have here. Our colleagues are aware that during counselling sessions they should not disturb us but because we share offices. When I see a client today... my colleague must go maybe wait in the restroom until I finish. When he/she sees a client I must also do the same."
Social Auxiliary Worker

In summation, the evaluation found that SAWs/FRs were serving their mandates as the primary delivery agents of short-term psychosocial support services to survivors at TCCs and these services were therefore implemented as intended. The implementation of this support was, however, affected by contextual implementation issues. For example, TCC space constraints reportedly impacted on the quality of short-term support.

Long-Term Psychosocial Support

Roles for SR staff in the delivery of long-term psychosocial support were provided by PRs via a core set of activities which were adapted as required based on the contextual implementation requirements of each SR. As a result, job descriptions for SWs and SAWs/FRs vary between SRs but are broadly encompassed in the following role description.

SWs based at TCCs are required to:

- Establish survivors' psychological and physical safety concerns by referring them to other service providers or linking them to shelters
- Provide follow-up support to survivors (either face-to-face or via telephone)
- Provide longer-term ongoing individual therapy to victims and their immediate families
- Conduct aftercare services outside the TCC
- Provide counselling and support to survivors for court appearances
- Facilitate support group sessions with survivors to increase their knowledge and awareness, and to empower them.

SAWs/FRs based at TCCs are required to:

- Follow-up on clients to ensure:
  - Adherence to PEP
  - Information about CTOP is provided if necessary
  - Interventions and referrals were received
  - General well-being
- Refer clients to:
  - Other necessary service providers (e.g. psychologists, shelters, etc.)

1 Since many SRs noted that they did not have offices of their own.
2 Vetten (2015); USAID (2015); FPD (2016); Shukimisa (2017)

  - The SW for long-term intervention
- Assist the SW in social care
- Assist with planning and facilitating support groups.

According to the evaluation findings, NACOSA and AFSA SRs employed five key systems to ensure that survivors treated at TCCs received long-term psychosocial support after their initial trauma.

1. Follow-up Appointments at TCC or SR

During a survivor's initial visit to the TCC, some SWs and SAWs/FRs reported scheduling follow-up appointments for the survivor to return to the TCC for further counselling or therapeutic intervention[3]. As a reminder of the appointment, some of these staff members indicated that they made phone calls to prompt the survivor for their upcoming session. NGO staff reported that survivors seemed more motivated to return to the TCC for follow-up HIV tests or to receive the remainder of their PEP medication rather than to receive further counselling and support. As such, these psychosocial follow-up appointments were strategically scheduled in accordance with follow-up appointments scheduled by DoH staff. This was reported to save on survivors' transport costs as there was no need to return to the TCC on separate occasions for medical and psychosocial follow-up appointments respectively. Findings revealed, however, that survivors often did not return to the TCC for follow-up psychosocial appointments. A common challenge faced by survivors was an inability to afford the cost of transport to return to the TCC. To counter this, NGO staff often employed other systems, namely telephonic follow-ups and home visits.

2. Telephonic Follow-Ups

This was reported by all sampled NACOSA SRs (10/10) whilst most AFSA SRs (5/8) sampled undertook telephonic follow-ups. This was typically undertaken by SWs or SAWs. According to SR Directors, Programme Managers and SWs, as well as NPA staff, telephonic follow-ups were often initiated with survivors who did not live near the TCC, or who could not afford transport and so could not easily return. These follow-ups were used to check on why clients may not have returned for a follow-up appointment, to check on a client's progress in recovery and adherence to PEP.

3. Home Visits

Half of the sampled of AFSA SRs (4/8) and half (5/10) of the NACOSA SRs sampled used home visits as part of their long-term psychosocial support model, according to NGO and NPA staff members. Home visits were typically undertaken by SAWs/FRs or SWs. Home visits were done in response to survivors not returning to the TCC or not being reachable by phone. Home visits typically involved providing counselling and support or investigating the home circumstances of child survivors. The latter was undertaken to assess whether children were in imminent danger or if it was necessary to remove them from their caretaker/s. Some SRs could not undertake follow-ups because the NGO did not have a car or financial resources to dedicate to home visit transport costs. Findings indicated this challenge was sometimes mitigated by having SWs join other stakeholders' in their cars when they conducted home visits, including DSD SWs and NPA staff.

"So we need to be there, we need to support them, we need to encourage them... Either telephonically, we do home visits, we do telephone calls for follow ups for counselling."

First Responder

4. Referral to Other Service Providers

NGO, NPA and DoH stakeholders reported that NGO staff frequently made referrals to other service providers where necessary to ensure that survivors received long-term psychosocial support. Referrals were typically made to:

- Other TCCs, local clinics, and SWs from other NGOs or DSD which were closer to, or based in, areas in which the survivor resided
- Service providers who were more trained or equipped to support a particular group of survivors, such as children, LGBTI individuals, human trafficking cases, individuals with mental health concerns or disabilities
- Shelters. Most NGO staff made referrals by completing a referral form. Several NACOSA and AFSA NGO staff ensured they followed-up with the referred service provider and/or the client themselves to confirm whether the survivor went to the service provider and attended follow-up sessions.

3 These appointments were typically scheduled with the SR SW.

"We conducted these group sessions where they will call all the survivors so that they can share their experiences. And some, they will see I am not alone. You can see how they overcome the trauma, and are ready to share, inform with their family."

Social Auxiliary Worker

5. Support Groups

According to SR Directors, Programme Managers, SWs, SAWs/FRs, and survivors, of the 18 SRs sampled, 7/10 NACOSA- and 5/8 AFSA-funded SRs reported implementing support groups for survivors. These groups were intended to allow survivors to meet and interact with other individuals who have also experienced sexual assault trauma and for psychosocial support to be collectively facilitated by an NGO staff member. Group sessions were reportedly implemented by staff at the SR.

Challenges with Long-term Psychosocial Support

Evaluation participants noted that several challenges have been faced in the process of conducting long-term follow-ups with survivors. Whilst these challenges are outside of the control or influence of the SR, key challenges mentioned by NGO staff were:

1. Survivors being unable to return to the TCC due to transport limitations, particularly an inability to afford transport costs. However, as stated above, the findings revealed that some AFSA-funded SRs mitigated this challenge by either providing survivors with transport, or providing them with the finances to attain transport to and from the TCC for their follow-up appointments.
2. As reported by NACOSA evaluation participants, survivors providing incorrect contact details on their intake forms, and as such preventing NGO staff from contacting survivors telephonically or for home visits.

According to the findings presented, SWs and SAWs/FRs implemented long-term psychosocial services in accordance with PR job descriptions. Although NACOSA job descriptions for SWs indicated that they are expected to provide follow-up support either face-to-face or via telephone, many also undertook home visits for those who could not return to the TCC or SR offices. AFSA-funded SWs provided ongoing support to survivors and this mainly happened at TCCs and through home visits. AFSA SR personnel's' referral to other services providers was a key theme of these interviews, and the referral to DSD SWs likely involved linkages to shelters if necessary. However, there was little indication to suggest that AFSA SR personnel followed-up with survivors to make sure they received support from the service provider to which they referred the client.

Overall, the findings suggest that both NACOSA- and AFSA-funded SWs and SAWs/FRs largely provided long-term psychosocial support as intended, however implementation was not consistent across all TCCs. Long-term psychosocial support, however, was affected by contextual implementation issues. For example, transport issues were frequently mentioned as impacting the provision of long-term psychosocial support.

Quality Standards for the Provision of Psychosocial Support

SRs should be guided by a number of quality standards in the provision of psychosocial support to survivors at TCCs. This includes NACOSA's Guidelines which provide principles to guide services. NACOSA Guidelines also encourage SAWs/FRs to refer to training manuals and any other guidelines or documents provided by their organisation to inform practice and make reference to a number of laws and policies[1] on which the guidelines are based.

Guidelines for the provision of support

Findings suggest that the majority of SRs were aware of and made use of a number of different guidelines, policies, laws, and protocols for the provision of psychosocial support. SR Programme Directors and Managers, SWs and SAWs/FRs referred most frequently to their use of the NACOSA Guidelines, their own internal policies and protocols, the TCC Blueprint developed by the NPA as well as the Social Work Minimum Norms and Standards. Reference was also

1 The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007; The Children's Act, 38 of 2005 (as amended); Older Person's Act, 13 of 2006; National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (issued by the Department of Health); National Instruction 3/2008: Sexual offences (issued by the South African Police Service); Regulations on services for victims of sexual offences and compulsory HIV testing of alleged sex offenders (issued by the Department of Justice and Constitutional Development); National Instruction 2/2012: Victim Empowerment (issued by the SAPS); Regulation 33076: Consolidated Regulations Pertaining to the Children's Act, 2005; (issued by the Department of Social Development); The Victims' Charter.

made to SRs' use of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, The Children's Act, The National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, and the Regulations on services for victims of sexual offences and compulsory HIV testing of alleged sex offenders.

Other Quality Standards Used for the Provision of Support

Findings suggested a number of other quality standards that SRs have implemented in the provision of psychosocial support.

1. Training

Training received by NGO staff was highlighted as a mechanism through which SRs were able to ensure that quality psychosocial support services were continuously being provided at TCCs. This included training received via PR training initiatives that were implemented, training offered through other TCC stakeholders (i.e. NPA) as well as ad hoc internal training offered by SRs according to the needs identified by staff. Reference was made to the fact that training on new laws, policies and approaches to dealing with difficult cases, for example, assisted in ensuring that SAWs/FRs and SWs were able to provide quality psychosocial services to survivors.

2. Qualifications and Experience of SAWs/FRs and Social Workers

Whilst the previous Global Fund grant funded lay counsellors to serve as first responders at TCCs, the new grant funds qualified SAWs to serve in this role. Considering that the new grant seeks to professionalise the psychosocial services provided via the placement of qualified SAWs at TCCs, the grant intends to enhance not only the quality of these psychosocial services, but the sustainability of the services since this was intended to facilitate the involvement of DSD in funding these positions. No secondary monitoring data on the qualifications of Global Fund funded SAWs placed at TCCs exists since PRs do not actively track the qualifications of staff employed by SRs. To account for this, the evaluation, therefore, sought to assess this in interviews with SR staff. Findings suggest that:

- The majority (9/10 NACOSA and 6/8 AFSA) of SRs sampled employ qualified SAWs as first responders at TCCs.
- There were a small number (4/10) of NACOSA SRs who reported some staff having SAW qualifications whilst other lay counsellors were either in the process of obtaining these via study[2] or had completed their studies and were waiting for verification of their completed qualifications. One NACOSA SR reported only one qualified SAW with other first responders trained as lay counsellors. Two AFSA SRs reported that none of their first responders were qualified SAWs.
- Interestingly, interviews revealed that a number of SR staff working as SAWs were actually qualified SWs, however, due to a diminished demand for this profession, were instead working as SAWs in order to secure employment.

These findings suggest that the introduction of qualified SAWs has had positive effects on the quality of psychosocial support service provision. The services lay counsellors are able to provide in previous grant tranches were seen as limited, SRs reported seeing improvements in the counselling and containment services rendered by qualified SAWs. Of particular significance was SAWs ability to implement continuous longer-term support services via conducting follow-ups both in terms psychosocial support and PEP adherence practices.

The employment of SAWs/FRs and SWs with extensive experience in handling cases of trauma and sexual assault was often identified as a further indicator for the provision of high quality psychosocial services. More experienced staff were seen to have greater confidence in their ability to provide adequate and appropriate support to survivors and were also better able to identify their ability to manage difficult cases (i.e. via the identification of transference and countertransference with clients, for example). Within this, there were a few instances where data highlighted recently graduated and/or relatively inexperienced

"Now that it has been extended to ensure that there are professional social workers and social auxiliary workers and offering not just containment and once-off sessions but ongoing support, psychosocial support to the survivors, I see added value certainly compared to what we had previously."

Programme Manager

2 Which had been funded by the Global Fund grant.

"I am taken as a family member even if I go home to ask them to support them and they don't seem to want to help."
Social Auxilliary Worker

SAWs (i.e. 2-4 years of experience). In light of the benefits identified above in the employment of experienced staff, this could be seen as problematic and may indicate a potential gap in services.

3. Oversight and Management

Oversight and management offered by SR Programme Managers or Directors and PRs was described as a further mechanism through which NGO staff were able to ensure quality service provision. This included the careful management of caseloads for both SAWs/FRs and SWs to ensure that client to beneficiary ratios were reasonable, to ensure survivors are attended to for adequate periods of time and to relieve the pressure SAWs/FRs sometimes experience when TCCs become busy. Other TCC stakeholders and TCC discussion forums involving the multidisciplinary team were highlighted as a further space through which the troubleshooting of operational processes allowed SRs to improve and maintain the quality of their services. Some SRs also mentioned that their long-term experience in being able to adapt to the working styles of the Site Coordinators, Victim Assistance Officers, doctors and nurses at the TCC enabled them to ensure that they were able to render quality services. The use of suggestion boxes at TCCs and client satisfaction surveys were other methods highlighted in SRs' attempts to improve the quality of service provision offered.

4. Referral Systems

SWs and SAWs/FRs described the processes through which they refer survivors to TCC-based DSD Social Workers or psychologists. Referrals were usually made when NGO staff felt that survivors presented with severe cases of trauma that could not be managed via the containment or counselling services provided at the TCC. These staff also frequently mentioned their practice of following-up on their referred cases to ensure that they had been seen by the relevant professional to whom they were referred. The referral of survivors to other mental health professionals, and the continued follow-up of these cases, demonstrates that SRs are able to supply survivors with high quality psychosocial services using clear referral and follow-up systems. A further key practice identified in the provision of high quality psychosocial services was SAWs/FRs and SWs enactment of ensuring that survivors had systems of support established at home, or had people from whom support could be sought when leaving the TCC.

"Because during my session I will ask the family member to come in, during the session and afterwards and pass the patient to him and then explain to the family member the importance of the support the family needs to give to the patient." Social Worker

5. Counselling and Therapeutic Practice

The practice of spending more than 30 to 60 minutes providing initial containment and counselling to survivors was mentioned as an indication of the provision of quality psychosocial services[1]. NACOSA SRs specifically spoke to their use of alternate forms of therapy, or their ability to adapt their therapeutic practice when dealing with difficult cases or children (i.e. the use of play therapy). AFSA SRs, on the other hand, mentioned a strategy of support in which SAWs/FRs may go 'incognito'[2] when providing additional psychosocial support to survivors via home visits, or in court appearances, in order to remove the stigma associated with rape, or resultant mental health care and support.

"I go just for support if you see the victim there, I am taken as a family member even if I go home to ask them to support them and they don't seem to want to help so when she sees me at the court she takes me as the aunt or sister or some family member they take me like that." Social Auxiliary Worker

On this basis, it is clear that SRs have a number of other quality standards and practices that are used, some of them novel innovations, to ensure the provision of quality psychosocial support to survivors at TCCs.

1 Although this was often reported to be highly dependent on the manner in which the survivor presented at the TCC.

2 By concealing their function as a SAW/FR or Social Worker by assuming the position of a sister or friend to the survivor.

Survivors' Perceptions of Services

This section addresses survivors'[3] perceptions of services provided at TCCs to provide a beneficiary perspective on the implementation of services in order to address the evaluation question regarding whether services were acceptable to survivors. In order to assess the acceptability of services for survivors, this section details survivors' prior awareness of TCC services offered, their perceptions of waiting times, their understanding of information on TCC procedures, and their perceptions of the psychosocial support services received.

Guidelines on the implementation of the TCC programme do not require SRs to implement awareness raising activities, however, some SRs undertake such activities as part of their broader work within communities surrounding TCCs. NACOSA Guidelines state that survivors should be attended to within 45 minutes, to one hour, of their arrival at the facility, should be seen as soon as possible by a SAW/FR who are then required to ensure that survivors understand all TCC processes and procedures. Finally, SR staff are then required to provide short-term psychosocial support in the form of containment and initial counselling.

Awareness of TCCs and Waiting Times

The majority of survivors reported being unaware of TCCs and the services they provide prior to accessing the facility on their first visit. This finding is corroborated by other research which identified a lack of knowledge around TCCs as the main barrier to their utilisation[4] caused by a lack of adequate marketing both on the part of government and NGO stakeholders[5]. Survivors also noted that their families and friends were often not aware of the existence of TCCs before the survivor's engagement with the Centre. In line with NACOSA Guidelines, the majority of survivors interviewed indicated that they did not wait for long periods of time to receive services and noted that these were generally received less than 30 minutes after arrival at TCCs.

Provision and Understanding of Information on TCC Procedures

After initial consultation with a TCC staff member (whether or not this was a SAW/FR), the majority of survivors interviewed demonstrated an understanding of the TCC's systems and processes and reported receiving an explanation on this by a member of staff[6]. Survivors reported that this provided them with a clear idea of what to expect, their rights, what would be asked of them, what medical tests may be performed, and the counselling that they could receive. A small number of survivors, however, did not always demonstrate this same level of understanding of the procedures of the TCC service model. Although it was unclear from these interviews, this may have been due to the fact that survivors were not always received by a SAW/FR or SW, but rather a nurse or doctor due to issues of availability.

"She never told me anything, she just examined me, like, she just examined me and then take off my clothes, that's like whatever. She never told me about the services."
Survivor

Perception of Psychosocial Support Received

The majority of survivors expressed overwhelmingly positive sentiments on their experiences of both the short- and long-term psychosocial support provided at TCCs. Many felt that they had been listened to, heard, and understood and felt that NGO staff were non-judgemental and open to providing support and care. The short- and long-term psychosocial context was seen as a space for survivors to express themselves, especially when they were unable to do this at home, or with their families. A few survivors found solace in the fact that they knew that counsellors were easily accessible, or just a phone call away. Many also found continued comfort with the telephonic follow-up systems, whether for PEP adherence or longer-term psychosocial support.

"No we did not hear of TCC, this is because there was nothing that has affected us as this occurrence. There was nothing we would have needed us to know in particular about TCC."
Survivor

3 The majority of survivors who agreed to be interviewed reported two to three previous visits to the TCC, excluding the day of the interview. A smaller number of survivors reported accessing the TCC more than five times prior to the date of the interview.
4 USAID (2015)
5 Shukumisa (2017)
6 It was not always clear whether this was a SAW/FR or not.

Some survivors, however, expressed dissatisfaction with longer-term follow-up support. This was noted in terms of the consistency of the SR staff member responsible for facilitating support groups hosted for survivors. The changing of facilitators was seen as disruptive to therapeutic processes and reportedly halted the continuity of sessions as participants frequently needed to re-stablish rapport with new facilitators. Additionally, the perceived continuity and frequency of follow-up psychosocial support provided by SRs was seen as an area for improvement. Some participants expressed that SRs could have done more to follow-up with clients after the first telephonic follow-up or home visit even if clients were assessed to be coping at the time of follow-up. In instances of sexual assault, the effects of secondary trauma may still occur even after initial trauma is contained and managed on a survivor's first few visits to the TCC. As such, sustained long-term support and follow-up is imperative.

"What I can say is that with the support groups when we first arrived we met up with someone. On the second time we met up with someone else. What I would prefer is that it be just one person because when you start with a new person there is that thing that we had never spoken with that person before and there are things that we have to start from the beginning." Survivor

"For me, when they came to me and asked me whether I was ok, I said yes, I'm ok and I think they also just left it there. I think maybe they should have come came back and asked me maybe again. I should have come here and said, I told you I am fine, but I'm not ok. Is it my fault or is it their fault? I don't want to blame anybody now, you see here, because I'm the one who said I'm ok. That they shouldn't come there and I know I'm alright, I'll cope with this whole thing." Survivor

The services rendered by SAWs/FRs and SWs made survivors feel less afraid to talk about their experiences, encouraged and motivated them, made them feel stronger, worthy and less alone, improved their confidence, and assisted them in finding closure. Many viewed the TCC not as a hospital, but as a home which housed a second family and was always accessible, even in the longer term. Some survivors also found value in sharing a space with others who had undergone similar experiences. There was also an appreciation for the availability of a multitude of services in one location. Almost all survivors mentioned that they would recommend the TCC and the services received at the facility to family, friends, or others who had been through a similar experience. When asked with whom they felt most comfortable at the TCC, survivors indicated that counsellors, SWs, and TCC nurses were the personnel who made survivors feel most at ease. Some of these themes are further captured in the word cloud presented in the figure below which was constructed using transcripts of survivor interviews.

Evidence collected from interviews suggests that services provided by SRs were certainly acceptable to survivors and had a profound impact on their lives.

Word Cloud of Survivors' Perceptions of Services Provided at TCCs

Support and Supervision

This section presents findings relating to question of whether SRs provide adequate support and supervision for SAWs/FRs and SWs. This was assessed based on the frequency, type, content and person providing support and supervision activities as described by evaluation participants.

Applicable to both NACOSA- and AFSA-funded SAWs/FRs, NACOSA Guidelines state that no SAW/FR should work without regular supervision. Whilst the type and frequency of supervision is determined by the functions performed by SAWs/FRs, as well as their level of experience, some types of supervision suggested in these Guidelines includes:

1. Weekly individual interviews and debriefing
2. Monthly team meetings
3. Peer group supervision

NACOSA Guidelines also recommend that SAWs/FRs should also have access to case debriefing and support outside of supervision, when needed, to help them with particularly difficult cases or cases that have a direct emotional impact on them. At a minimum, it is recommended in these Guidelines that all SAWs/FRs receive at least one session of supervision per month and that senior staff are available to provide debriefing and support when needed and outside formal supervision sessions.

Support and Supervision for SAWs/FRs

According to NACOSA's job description for SWs, SWs based at TCCs are required to supervise and mentor NACOSA-funded SAWs/FRs. They are also required to provide one-on-one supervision and performance feedback sessions for SAWs/FRs on a regular basis. The provision of refresher training or mentoring for SAWs/FRs should be conducted as required. Similarly, AFSA-funded SWs are required to monitor all activities undertaken by SAWs/FRs to ensure accountability and good quality of services rendered. SWs are also required to attend weekly group sessions to debrief cases and ensure emotional wellness. They are responsible for debriefing of SAWs/FRs immediately after crisis duties.

Qualitative evidence derived from interviews with SR Directors, Programme Managers, SWs and SAWs/FRs indicated that:

1. All NACOSA- and AFSA-funded SAWs/FRs received supervision, and that supervision was provided by a SW.
2. The majority of SAWs/FRs were supervised at least once a month, but many were provided with some form of support weekly, and a minority twice a month.
3. Findings were mixed as to whether support was provided one-on-one or in a group setting.
    - For NACOSA, all SAWs/FRs received support on an individual basis, with most additionally receiving further support through group sessions or group meetings.
    - For AFSA, most SAWs/FRs received supervision on an individual basis, whilst a few received it in a group setting. Data suggested that some SAWs/FRs received support in both formats.
4. Findings for NACOSA SAWs/FRs also indicated that most SAWs/FRs received debriefing either internally or from an external service provider (e.g. psychologist), which was either part of their supervision session, scheduled or made available when required.
5. Findings were mixed as to whether AFSA-funded SAWs/FRs received extra debriefing. From the perspective of SWs and SAW/FRs, debriefing was not available for some SAWs/FRs, whilst from the perspective of mostly SR Directors and Programme Managers, debriefing was available in some form.

Support sessions (either formal supervision, debriefing or group meetings) reportedly focused on:

1. Reviewing cases, especially challenging cases
2. How SAWs/FRs did in managing the case and where they could improve
3. Finding out which cases required further follow-up by the SW
4. Planning; filing, admin, and reporting
5. Finding out how SAWs/FRs were coping emotionally and managing stress.

"The way she talks, it's like I'm talking to my mother, you understand? So I felt comfortable like that like, I can talk anything to her. She understands everything that I'm saying."

Survivor

"We focus a lot on the way we work and then things that touched us and the things that went well during that week. Like cases, maybe I can say I had this case like this and had trouble here and there and I got help how, or maybe it was a difficult case and how I handled it. And then she helps us if you say I struggled then she would advise that next time you should try it this way."

Social Auxiliary Worker

NACOSA- and AFSA-funded SAWs/FRs agreed that the support that they received from SWs was helpful. They found that SWs helped them with skills development, particularly how to handle cases and also boosted their confidence in their work. They also felt that they could turn to them when they felt overwhelmed by their workload, or by the severity of cases. They felt that the support helped with their own coping and resilience.

"I talk to my Social Worker. First thing, when I feel it's too much, I go to her. So she is the one that's actually helping me to cope. She helps a lot, my Social Worker helps a lot. So they [are] good at yeah...at giving advice and helping, giving you...do this, do this, go there and referring us." Social Auxiliary Worker/First Responder

The consensus, however, among NACOSA-funded SR Directors, Programme Managers and SAWs/FRs was that:

1. The supervision and support that SAWs/FRs were receiving was not sufficient. This inadequacy was expressed both in terms of quantity and quality.
2. Although all SAWs/FRs typically received supervision and support on a regular basis (monthly at minimum, as stipulated by the Social Work Council's Minimum Norms and Standards), given the high workload and severity of some of the cases, monthly sessions were deemed inadequate. SAWs/FRs indicated that difficult or traumatic cases could affect them emotionally. Some indicated that they struggled to make it to sessions if their client load was too high.
3. Some SAWs/FRs wanted their supervisions or debriefings to place a greater emphasis on their emotional wellbeing and for them to be less formal.

Additionally, according to both NGO staff and NPA staff, some SAWs did not have any debriefing available to them. The perceived inadequacy of support likely impacts the quality of service the SAWs/FRs are able to provide to survivors. This is particularly problematic as SAWs/FRs should be the first person a survivor sees on arrival at a TCC. As such, should survivors have a negative experience with the SAW/FRs because they are burnt out or emotionally unsupported, their experience through the TCC system would likely be negatively affected and may affect their perception of services and desire to return to the TCC for follow-ups and long-term support.

"No, I think they are more burnt out than that. I will love it if there were two counsellors on duty per shift, they will be able to do debrief with each other per client to see a rape survivor and just talk about it to someone else." SR Director or Programme Manager

Findings were mixed as to whether the support received by AFSA-funded SAWs/FRs was adequate or not:

1. One the one hand, from the perspective of SR Directors and Programme Managers, it was sufficient. These evaluation participants felt that the check-ups were provided regularly, and that support was provided when needed and thus should have provided the support that SAWs/FRs needed.
2. On the other hand, from the perspective of SWs and SAWs/FRs, the support was insufficient. These evaluation participants felt that the support provided was not enough to counter SAWs/FRs workload and/or the severity of cases they deal with. Particular mention was made that more debriefing was needed for AFSA-funded SAWs/FRs.

"I think, yoh… their job is too much. They need formal debriefing because they work a lot. There's too much on their plates. So debriefing, I think debriefing will do. Formal debriefing." Social Worker

In conclusion, whilst support and supervision of SAWs/FRs was generally implemented as intended, there was an indication that the minimum standards used in the provision of supervision were not sufficient in providing adequate support which may impact the quality of service that SAWs/FRs are able to provide. Weaknesses in the quality and quantity of support provided were identified and, given the high workload and severity of some cases, current support and supervision practices were deemed inadequate.

Support and Supervision for Social Workers

Since neither PR provides guidelines for the supervision of SWs and the job descriptions of these staff do not outline this either, the

evaluation refers to the South African Council of Social Service Professionals Supervision Framework for the Social Work Profession. According to this framework, supervision or support should, at a minimum, be provided fortnightly to SWs in their first year of practice. SWs with more than one year of experience should, at a minimum, receive supervision once a month.

Information on the support and supervision provided to SWs was difficult to ascertain from evaluation participants. Interview questions relating to this thematic area may have been phrased in a compounded manner (i.e. when participants were asked to talk about support and supervision, they may have been inclined to talk only about SAWs/FRs and not about SWs, as would have been intended). This is evidenced by the fact that data revealed that participants' responses primarily focused on perspectives of support and supervision for SAWs/FRs. The lack of data collected on support and supervision provided for SWs may speak to the fact that these systems are not necessarily in place. From the data that was collected, some conclusions can be drawn on the support and supervision of SWs. However these must be interpreted in light of the limited data.

From the collective perspectives of SR Directors, Programme Managers and SWs, findings revealed that:

1. Most SWs at NACOSA and AFSA SRs received some form of supervision or support.
2. In most instances, SWs had supervision sessions and/or debriefing monthly, however there was also evidence to indicate that some SWs received support every two weeks, weekly, or quarterly, depending on the TCC. However, it is not clear from the data whether those receiving support every two weeks were those who were in their first year of practice or not.
3. The focus or content of sessions reported included addressing challenges, reviewing follow-ups, help with report writing, or supporting the SW with cases that were traumatic for him/her personally.
4. The type of supervisor provided to NACOSA SWs ranged from an internal line manager, programme coordinator, board chairperson or the SR director (some or all of whom are qualified SWs), to external parties such as a psychologist or a SW from another NGO.
5. SR Directors, Programme Managers and SWs indicated that AFSA-funded SWs were either supervised, debriefed or generally supported by a psychologist, industrial psychologist, a DSD Social Worker, the SR Director, or the TCC Site Coordinator.

Additionally, several NACOSA SRs made support or debriefing available when SWs required this outside of prescribed supervision schedules. Some NACOSA SRs additionally implemented staff group meetings, whereby TCC staff members are provided with an opportunity to debrief and share their experiences with other TCC staff members, either within the TCC, or externally with staff members from other areas or provinces.

Findings indicate that SWs found that:

1. The support they received helped with their personal and work development and comforted them in knowing that they were not alone in the challenges that they faced. However, from the few perspectives garnered from both AFSA and NACOSA SR Directors, Programme Managers, SWs and NPA staff members on the adequacy of supervision for SWs, most found that the support and supervision was insufficient.
2. SWs felt overwhelmed by the stress of their work and burnt out, and that more debriefing should be advocated for. Given that SWs oversee and support numerous SAWs/FRs, and additionally typically provide long-term psychosocial counselling to survivors at the TCC, it is expected that SWs may experience a high workload as well as difficulty in managing cases that may be traumatic or sensitive for them.
3. Some AFSA- funded SWs indicated they did not receive formal supervision at all, that supervision was infrequent, or that they were sometimes unable to attend due to busy work schedules. This left SWs feeling unsure about whether they

"In terms of making sure that all of our staff is not burnt out among our staff and psychologically they are okay, we make sure that we debrief them every month, they are debriefed by the psychologist."
Director

were working correctly or managing their work as best as they could be. AFSA SR Directors, Programme Managers and SWs indicated that there is a need for more debriefing so that SWs have a platform to de-stress and be able to debrief on extreme cases.

"You know, we have a formal meeting, we set up a date and I meet with him [SR Director] and the M&E officer. He used to come here but not often. I need supervision, because even my work what I'm doing as a Social Worker, I don't know if I'm on the right track or not. Up to so far there's no one who comes and supervises my work."
Social Worker

In line with the South African Council of Social Service Professionals Supervision Framework for the Social Work Profession, SWs received support at least monthly and there was also evidence to indicate that some SWs received support every two weeks, weekly, or quarterly. However, evaluation participants indicated that the support and supervision for SWs was inadequate. Inadequate support received by SWs may affect their ability to provide quality supervision to the SAWs/FRs and quality psychosocial support to those survivors that they see for long-term counselling.

HTS, STI and TB Screening

As SRs are funded within a health grant, HTS, STI and TB screening is an important component that shapes SR programming. This section addresses whether SR programmes demonstrate a strong HIV/TB prevention element in the form of HTS, STI and TB screening services. Trained SAWs/FRs are required to provide pre- and post-test HIV counselling, as well as follow-up counselling as required. The role further requires that the SAW/FR perform both TB and STI screening.

HIV Testing Services (HTS)

Across both PRs, evaluation participants reported a combined role in the provision of HTS in which SRs and DoH personnel reported working together to deliver this service. Although not consistently reported among the evaluation participants at each TCC, pre- and post-test HIV counselling was largely reported to be provided by SAWs/FRs, SWs and/or specific HTS counsellors.

Generally speaking, PRs aimed to ensure between 1 and 2 SAWs/FRs were trained on HTS at each SR. In TCCs, however, in which known obstruction from DoH was evident in SAWs/FRs' involvement in HTS, SRs did not receive accredited HTS training. In 7 of the 10 NACOSA SRs and 3 of the 8 AFSA SRs sampled, SAWs/FRs and SWs had been trained to conduct an HIV pre- and post-test counselling and perform the 'prick test' as part of HTS . Despite this, in the majority of TCCs, evaluation participants reported that HCP personnel are the key service providers involved in performing the actual HIV test. In a minority of reports (1 NACOSA SR and 1 AFSA SR), SAWs/FRs and/or SWs reported having received no HTS training and subsequently had no involvement in the

"I definitely don't think it is sufficient and I think it is something we need to work on and hopefully through this process it highlights the importance of providing debriefing for our staff members."
Director

provision of HTS, including pre- and post-test counselling. Role conflict between DoH HCPs and SR personnel was highlighted as the main reason for this, as well as when SR staff had not been trained to deliver HTS. In contrast to this, instances where the responsibility of HTS, STI, and TB screening services was shared by DoH and SR personnel were highlighted as advantageous as these dual roles ensured that support was provided to TCC stakeholders as and when needed.

"I do the HIV pre and post counselling, and then I do STI screening. Sometimes the centre is so swamped, now I can at least ask the first responder or the social auxiliary worker if they can so long start with counselling on the other side. And then we also have the HIV counsellor from the NGO she also lends a helping hand in the counselling of the clients. She also helps me with the screening of STI and the screening of TB and she comes back and gives me the information and then I take it from there." TCC Nurse

STI and TB Screening

Although sometimes not reported consistently among the evaluation participants at each TCC, it was generally described that SAWs/FRs perform STI and TB screening services. This was undertaken using the TCC intake form which includes a section that covers the relevant screening questions. These questions were reportedly asked by SAWs/FRs during the containment period with the survivor. As with the provision of HTS, in many TCCs, SRs work collaboratively with DoH to provide STI and TB screening services and perform follow-up services on TB and STI testing where necessary. Evaluation participants mentioned that clients who were screened and showed indications of TB infection were referred to the hospital at which the TCC was based or other local clinics for treatment.

However, in a few instances, interviews with HCPs revealed that DoH is not aware that SRs were undertaking TB screening as part of their role. One AFSA SR reported that the inclusion of TB screening was newly introduced as part of their work within the TCC. The recent inclusion of the screening service could provide context to the instances where DoH is unaware of the SRs role in TB screening. At a minority of TCCs, DoH reportedly exclusively performs STI and TB screening services.

Accredited HTS Training and Further Training for SAWs/FRs

The majority of NACOSA SRs reported that SAWs/FRs had undergone NACOSA accredited HTS training. SRs, however, reported that there were instances where not all SAWs/FRs had undergone this training. In a few instances, SAWs/FRs had undergone training but were not practising HTS as they were still awaiting certificates and accreditation. A minority of NACOSA SRs reported that none of their SAWs/FRs had undergone formal training, but were still undertaking the respective counselling and screening activities.

Findings suggest that AFSA SAWs/FRs received HTS training prior to commencing work at TCCs, however, some evaluation participants were not always certain if this training was accredited. In some cases evaluation participants noted that they had not undergone formal training and instead relied on their supervisor and "on the job training" to support their work.

The role of further and regular continuous training, in many SRs, was reported to be well institutionalised with a number of organisations making clear provision for this within their budgets in order to offer ample training opportunities for TCC-based staff. This, in turn, was seen be SR staff as an appreciated investment in their professional growth and development. Training opportunities centred not only on HIV related subjects, but also included training on legislation (i.e. the Sexual Offences Act), domestic violence, survivor sensitisation, psychosocial assessment, counselling practice, first aid, and GBV awareness raising, for example. In some instances, this training was reportedly offered through accredited external training providers such as NGOs or the Services Sector Education and Training Authority (SETA).

Further Training Provided to SWs

A prerequisite for the appointment of SWs within SRs is that they possess the necessary tertiary qualifications and have the required skill and knowledge base for work within an HIV-focused role prior to their appointment. Overall, evaluation participants reported that the further HIV, TB, and STI training provided for SWs while in the employ of the SR often

"We play a role during our session of containment because I have a form that I need to fill in... When they agree that we can test them then we check that ok you do not have a cough what-what if you are coughing, how long have you been coughing, do you lose weight and all that screening."

Social Auxiliary Worker

occurs alongside additional training provided to SAWs/FRs as outlined above. Given that many of SWs obtained their qualifications some time back, the need for "top up" or "refresher" training was frequently identified.

"I went for the counselling course and after that there were advanced sessions like trainings on HIV. Maybe this month we will be trained for a week on something. So at least we did get training."
First Responder

In conclusion, findings suggest that HTS, pre- and post-test counselling was generally implemented as intended with a small number of SRs reported undertaking HIV finger prick testing at TCCs. TB and STI screening was also found to be implemented as intended. In many cases, this role was largely implemented collaboratively with DoH in the implementation of services and the provision of follow-up. A small proportion of SRs reported being uninvolved in HTS and TB and STI screening due to restrictions placed on them by DoH whose personnel were reportedly performing this function exclusively. Findings were mixed with regard to whether all SAWs/FRs had received accredited HTS training and additional training was found to be provided in HTS and TB screening. Evaluation participants also reported that SWs received further HIV and TB training whilst working within the TCC programme, often alongside further training provided to SAWs/FRs.

SR Links and Partnerships

This section addresses the extent to which SRs have links and relationships with key partners in their communities as reported in interviews by SR Directors, Programme Managers, SWs and SAWs/FRs. The findings presented below speak only to the connections between SRs and stakeholders outside the confines of the TCC, and thus do not speak to relationships with NPA or DoH stakeholders working within the TCCs in which SRs are based. SR links with NPA and DoH stakeholders are addressed in following sections dealing with NPA and DoH perceptions of NGO services.

According to PR job descriptions, SWs are expected to deliver community awareness raising about the TCC programme and GBV through workshops, or educational sessions. SWs are also expected to network and conduct promotional activities. SAWs/FRs, on the other hand, are expected to engage with communities and volunteers with the aim of networking, education/awareness, life skills and development, attend relevant community forums and meetings, and network with relevant community gatekeepers. SAWs/FRs are also expected to promote access to community resources and to aid intervention against social ills.

Awareness Raising

Community-Based: All (10/10) NACOSA- and (5/8) AFSA-funded SRs reported undertaking some form of awareness raising. These were typically in the form of awareness raising campaigns, events, or community engagements to either raise awareness of the TCC or educate the public about GBV. These were commonly implemented by the SR and other TCC stakeholders or other NGOs in the sector, and were typically undertaken in local communities, and clinics.

School-Based: Several (6/10) NACOSA-funded SRs and some (3/8) AFSA-funded SRs had links with schools or the Department of Education (DoE). Not only did SRs undertake awareness raising events and programmes at schools, there was also indication of a symbiotic referral relationships between schools and the TCC where schools referred learners to the SR or TCC for support services if needed. Findings suggest that awareness raising activities at school may have been more successful than other community-based efforts in improving the knowledge of communities around how GBV manifests and about services offered by TCCs. This is particularly important given that survivors from sampled TCCs often indicated that they were not aware of the TCCs before their first visit. It is also essential that children, who account for the largest population of survivors seen at TCCs, are aware of how they might experience GBV and how they can access TCCs autonomously.

"Yes we do a lot of campaigns surrounding child protection week and then also 16 days of activism and all the TCCs and stakeholders go to the schools to do a talk to advise them on what to do when they come to a situation where they feel a child needs to be referred." Director

"Then [NGO] also has a relationship with the Department of Education where they provide school programs and services where they teach learners about services that are provided at the TCCs and the domestic violence as well, they go to schools and teach them." Social Worker

Links with Key Partners

GBV-Focused Platforms: Only a few SRs (5/10 NACOSA and 3/8 AFSA) reported links to GBV-focused NGOs or platforms. Examples included the Gender Justice Forum, Shukumisa, and other local and international organisations focused on GBV issues. SRs would have likely networked and developed relationships with other GBV-focused NGOs and CBOs through Shukumisa and the Gender Justice Forum. Participants indicated that SRs referred clients to these other local organisations, especially if the organisation had a particular speciality, such as domestic violence, and also worked with them on awareness campaigns.

Organisations Specialising in Key and Vulnerable Populations: Several (6/10) NACOSA-funded SRs and half (4/8) of the sampled AFSA-funded SRs also had relationships with organisations, service providers or forums that specialised in, or worked with, key and vulnerable populations. Several SRs were linked with organisations specialising in children such as Childline and Child Welfare, where they could make referrals for child survivors. They also participated with other NGOs on platforms like the child protection forum, child justice forum and Yezingane Network. This is likely because many, if not most, TCCs see child survivors, however, SWs and SAWs/FRs may not necessarily be trained to support such clients. Only a minority of SRs had links with organisations or service providers focused on sex workers and/or LGBTI persons, such as Lifeline and the Transgender Fund. This may be because SRs do not see many survivors who come from key populations, or because they may not be aware that they are from key populations. There were also only a few SRs that made referrals to organisations or service providers that specialise in services for persons with physical or mental disabilities.

VEP Forums and AIDS Councils: Most (8/10) NACOSA- and half (4/8) of the sampled AFSA-funded SRs were part of the Victim Empowerment Programme (VEP) , and attended either local, regional or provincial forums. SRs who attended these forums would have likely had the opportunity to network with other organisations and stakeholders in the GBV, community safety and human rights sectors. SR Directors and Programme Managers indicated that half (4/8) of the sampled SRs and several (3/10) NACOSA-funded SRs were also part of an AIDS Council, either at district, local, provincial or national level. As with VEP forums, SRs who sat on an AIDS Council would likely network and form relationships with stakeholders with an interest in the drive to an enhanced response to HIV, TB and STIs.

Other Links and Partnerships: NACOSA- and AFSA-funded SRs also reported relationships with service providers outside of the TCC.

- SRs noted links with other clinics, particularly local clinics that were located near where survivors lived. Referrals were frequently made so that survivors could access PEP treatment and adherence support as well as psychosocial support from a clinic that was closer to them. Data, however, indicated that SR staff were not necessarily responsible for making these referrals, and that these may have been done by NPA or DoH personnel.
- A few SRs also made referrals to other service providers who were not based at TCCs including psychologists and dieticians (for malnourished children), and shelter services.
- Both NACOSA- and AFSA-funded SRs also often made referrals to DSD for cases where there was a need for a child to be removed from the home, or a survivor required a locally-based SW. In turn, DSD also made referrals to SRs.
- Other types of partnerships or engagements noted by SRs included links with traditional leaders, councils and healers, religious leaders, neighbourhood watches, and community policing forums. Linkages with such partners likely assist in identifying cases from the community and referring them to the TCC for further support.

Taken together, consistent with PR job descriptions, SRs delivered community awareness raising initiatives, engaged with community and government organisations, attended relevant councils, forums and platforms for networking, and referred clients to relevant service providers where necessary. Whilst the data indicated that these relationships exist, the depth and

"I wasn't taught how to work with clients with disabilities as such. So I had to refer that client to the psychologist, our psychologist."

Social Worker

quality of these links could largely not be established. Relationships with organisations working with key populations appeared to be limited. Whilst this may have been a result of having few key population clients, and thus having little necessity to refer, partnerships with such organisations should be prioritised for awareness raising purposes.

"When we received Global Fund, we had to change the way we do things, to align what we were doing with what they require from us, so that's an opportunity of learning for us to get things going, but since we got those systems in place, there's never been a time where there were concerns or chaos issues around our M&E so things are running smoothly."

Programme Manager

Implementation as Intended

Evidence collected suggests that the TCC programme was implemented as intended. The evaluation points to the influence of external contextual factors in instances where the programme was not implemented as intended. These factors were also shown to have some effect on the quality of services provided by SRs. Whilst these factors are often not within the control of SRs, PRs or the grant as a whole, it is important to note the prevalence of such factors within the systemic and multidisciplinary TCC environment in which SRs work and their impact on the implementation and quality of services.

Recording and Reporting

This section addresses the extent to which SRs have accurate and robust recording and reporting systems and tools. Overall, findings suggest that the majority of SRs demonstrate reliable and strong recording and reporting systems.

Factors that Promote Accurate and Robust Recording and Reporting

1. **SR Experience:** Many SR personnel involved in the recording and reporting of data emphasised that the activities associated with record keeping were simple, clear, and easy to understand. Whilst some SRs noted that recording and reporting tasks involved a significant amount of administration for SAWs/FRs and SWs, the majority were able to manage this workload with client caseloads. There was some distinction between older, more experienced SRs who had strong and well-established monitoring systems that had been developed prior to their involvement in the Global Fund grant and those SRs for whom the establishment of data collection, capture, verification, and reporting systems was a newer endeavour. Inexperienced SRs initially perceived recording and reporting requirements of the grant as too demanding as they placed an increased workload on SR personnel who were not well-equipped, nor inclined for the level and rigour of reporting required. Whilst this may have been a result of initial inexperience with the grant's reporting requirements, some SRs saw this as an opportunity for further learning and improvement as they adapted to reporting processes. This can also be seen as an important process in the capacity building of smaller SRs and a key success for the Global Fund grant. Not only does this assist these organisations in their sustainability, the improvement of their recording and reporting systems also in their ability to apply for future funding from other donors.
2. **Dedicated M&E Staff:** SRs identified a number of key personnel who contributed significantly to ensuring the accuracy and robustness of reporting. SRs with a dedicated M&E manager/officer, quality assurer or data capturer noted that these personnel assisted in ensuring that all data was received, reviewed, and verified enabling strong and reliable reporting systems. These personnel had often established quality assurance systems to examine and improve the quality and validity of data received from TCC staff, where necessary.
3. **Continuous Data Monitoring:** At a TCC level, SRs highlighted the continuous data monitoring provided by SWs and Programme Managers as a further supportive factor in their ability to maintain robust reporting systems. On-the-spot intervention made by these personnel through changes and corrections to recording and reporting was identified as a further contributing factor in the quality and accuracy of SR reporting. SRs noted improvements in their recording and reporting systems through the involvement of the abovementioned personnel.

"Constant monitoring is actually done by managers and social workers at the site, so interventions are provided on the spot, so it's going very well." Director

4. **Training**: Training was another factor that was seen to have either enhanced or inhibited SRs ability to ensure accurate and strong recording and reporting systems. Findings highlighted mixed perceptions of training provided by AFSA to SRs, with some organisations noting that they had not received on induction into the GBV programme[1]. Some mentioned that training was delayed after the updating of tools, whilst others reported receiving training on induction. One AFSA SR mentioned the fact that the organisation had sought M&E training from other external organisations. NACOSA SRs, on the other hand, expressed positive perceptions of training received from the PR. Both AFSA and NACOSA SRs highlighted the fact that training on recording and reporting systems was ongoing at site visits and quarterly SRs meetings.

"They take us for training either, when they do their site visits to us, they would go through the training tool, or at the, these quarterly meetings, they definitely make time to take us through the tool, yes." Programme Manager

5. **PR Support and Feedback**: Many SRs noted the good working relationships established with PRs and SRs frequently referred to the available support and supervision received by PRs as a key factor in their ability to ensure quality data collection, entry, and reporting. Continuous and timely feedback received on data verification was perceived as essential. PR supervision in meeting programme targets and support given when implementation did not occur as intended was important to many SRs. NACOSA SRs identified quarterly meetings as a further mechanism in which feedback and guidance were received. Some SRs attributed the improvements seen in the quality of their recording and reporting systems to the assistance of PRs.

"We have the site visit from them [NACOSA], she is absolutely awesome really a lovely women and she is diligent and extremely thorough she talks through the reports where the counsellors worked on. The feedback is fantastic." Director

6. **M&E for Planning and Learning:** A further theme highlighted in interviews was the way in which data gathered through the recording and reporting process was able to inform SR planning and learning. The majority of sampled SRs spoke to the fact that data collected had allowed them to pick up on trends and they had learnt more about the way in which survivors were interacting with the services provided at TCCs. Other examples of this were instances were SRs mentioned using data collected in the incidence of reported cases, to plan community awareness raising interventions in order to target areas considered 'hotspots' for sexual violence. This data was further used by SRs to feedback, not only to staff on the ground (i.e. SWs and SAWS/FRs), but also to TCC stakeholders at implementation meetings on trends in the incidence of cases reported at the TCC. This illustrates how monitoring data can and should be used and promotes the sharing and use of information that is collected. Some SRs mentioned their ability to further extend the utility of their data through its use in advertising material and information that was shared with communities to promote the awareness of NGO psychosocial services at TCCs.

Challenges in Recording and Reporting: Access to Information

Although findings were largely demonstrative of the quality of SR recording and reporting systems, some SR Directors, Programme Managers, and SWs highlighted access to information as a significant challenges that was impacting on the accuracy and robustness of recording and reporting. Access to patient files from DoH TCC nurses and doctors was highlighted as a major challenge which was preventing NACOSA SRs from reporting on health-related data. This challenge was especially prevalent in cases where SRs were not involved in any form of HTS or PEP counselling and follow-up. Some of these SRs also reported difficulties in verifying the accuracy of patient reports if this information was sought from patients

"We wish the funding would not come to an end and we have learned a lot from working with AFSA, they have always responded to our emails and our reports and given us feedback all the time. We are very grateful."
Director

1 But found the system easy to use as it was familiar from previous work

"So most of the challenges are at site level where we don't have access to that information to be able to report to NACOSA on those indicators."

Programme Manager

telephonically as a solution to the SRs inability to access DoH files. Whilst this may be something that is not within SRs' control, this, this remains a significant issue.

Efficiency

The section addresses the extent to which inputs or resources been efficiently allocated for programme implementation. Efficiency is generally defined as the value of outputs and outcomes (at the relevant level of quality) in relation to the total cost of inputs[1]. Considering that, at the time of the evaluation, the TCC programme was still being implemented, the totality of outputs and outcomes of the programme had not yet been realised, nor had they been monetised. As such, a true efficiency analysis could not be undertaken for the purposes of this evaluation. The evaluation instead employed a simple analysis to assess the current resource allocations of the programme against emergent findings on programme implementation in order to guide recommendations on the allocation of such resources for the remainder of the grant period. To address this, the evaluation was guided by both quantitative[2] and qualitative data[3]. Three key themes emerged from the data.

Transport

A key theme of these interviews was the allocation of resources for travel related costs. A learning from the previous grant pointed to a clear need for travel budget for SRs in order to undertake both PEP and longer-term psychosocial follow-up visits with clients. Despite this allocation of funding, burn rates for travel-related costs received from PRs indicate that both SRs for each PR significantly underspent with AFSA SRs reporting a cumulative burn rate of 27% and NACOSA SRs reporting a burn rate of 35% for Year 1 and Year 2 of the programme.

Some SRs felt that the budget for travel costs, whilst sufficient for their purposes (i.e. the refuelling of vehicles), may be too broad as they do not make use of it for public transport purposes. One of the reasons for this included the fact that public transport is time consuming since using taxis often requires extensive time waiting at taxi ranks for taxis to fill up. Similarly, travelling long distances in rural areas either by taxi or by bus is an equally time-intensive activity. The time consuming nature of using public transport has deterred SRs from using this as an option for travel since it is not seen as an efficient use of time for SR personnel. In terms of the provision of travel-related costs, this may point to an inefficient allocation of resources when SRs who do not make use of public transport for the above time-based reasons. PRs and SRs may thus need to reconsider these allocations for the remainder of the grant period. For example, if possible, consideration of the reallocation of transport-related budget to other line items may be necessary.

Other SRs who rely on public transport[4] also noted underspending of the travel budget. An inability to dispense cash to survivors was the key reason these SRs were unable to fully utilise this budget. Whilst within the South African context it is understood that the dispensing of cash is necessary, the Global Fund grant policy restricts the use of cash within programmes as this presents increased risk for fraud[5]. Whilst some SRs have submitted written requests for cash disbursements for travel-related expenses in some instances, there are strict controls in place with this process which often inhibit SR access to cash in this form as it is not aligned with Global Fund policy.

In order to make use of the transport budget item, some SRs mentioned re-allocating this line item to other travel-related expenses such as transport for SR staff debriefing sessions, supervision focus meetings, and training. This is indicative of an innovative and efficient re-allocation of resources as these were reassigned based on programme implementation needs. It is recommended that other SRs are encouraged to rethink their use of the transport-related budget for other activities where necessary in order to utilise based on the outstanding implementation

1 Better Evaluation (2017)
2 % spend by SRs on the TCC programme for Y1 and Y2
3 From interviews with SR PMs and Directors
4 For NGO staff and survivors.
5 Since it can be difficult to verify that cash was used for the means intended (i.e. PRs are not always able to ensure that cash handed out to survivors for transport costs, for example, is always received by these survivors for the purposes of transport).

needs to the programme for the remainder of the grant period.

Interviews with SR Programme Managers and Directors revealed some innovations regarding the efficient use of the travel budget allocated to them. One SR provided an illustration of a solution in which an agreement had been reached with local taxi marshals in providing an invoice reflecting a fixed fee structure for trips for survivors to and from TCCs within the province in which the SR is based. These transport fees are then are then calculated based on the estimated number of clients SWs expect to see each month. Thereafter, the taxi marshals provide transport services for clients of the SR on a needs basis and submit a receipt of the number of trips done at the end of each month. The SR then uses this to submit a travel claim which, upon PR approval, is paid out to the taxi marshals.

Human Resources

Considering that the focus of the grant is on ensuring TCCs are capacitated with SR-funded personnel, human resource (HR) burn rates reflect that the SRs is performing adequately in their ability to station the required personnel at both a ground and oversight level at TCCs. This is reflected in cumulative burn rates with AFSA SR burn rates are shown to be at 86%[6] and 76%[7] and NACOSA SR burn rates 87%[8] and 71%[9] for HR-related expenses in Year 1 and 2 of the programme.

This points to the efficient use of these resources considering that findings in previous sections of the evaluation report indicate that NGO staff are often able to cover gaps in the work of other TCC service providers due to staffing and resource constraints. In addition to this, the budget allocated to SR Directors, Finance Managers and M&E Officers also indicates efficient allocation considering SRs reported that the oversight and management practices received from these personnel enabled them to provide high quality services to survivors at TCCs.

A further innovation demonstrating efficient resource allocation identified by an SR was their attempts to begin the implementation of a stand-by SAW/FR system to avoid wasteful expenditure. The allocation of too many SAWs/FRs during 'quiet' periods at TCCs (i.e. when there few new cases presenting) was seen as a waste of resources. Instead, the SR proposed to station fewer SAWs/FRs at a TCC during known down times and should a situation arise in which further support was required, a stand-by SAW/FR could be contacted to provide further capacity if an influx of survivors was received.

Furniture

This budgetary line item was intended for use in the purchase of furniture for SR office spaces outside of the TCC and/or at the TCC itself (in cases where SRs had access to such spaces). If SRs did not have a need for these specific items, requests could be made to purchase other items (i.e. a printer) using this budget line with approval from PRs.

Burn rates for the furniture line item reflect that whilst NACOSA SRs appear to be performing adequately in their allocation of these resources with a 67% burn rate, AFSA SRs, on the other hand, appear to be overspending on this line item with a 140% burn rate for Years 1 and 2 of the programme.

This is contrasted by qualitative data which highlights that some SRs noted limitations in their ability to adequately furnish and equip their working spaces for the kinds of client populations mainly seen at TCCs. This was specifically highlighted in reference to furniture and equipment suitable for child survivors. One NACOSA SR indicated that seating used by SAWs/SWs needed to be at the same height as children who were seated for counselling so that children did not feel intimidated in the therapeutic setting. Another AFSA SR indicated a lack of toys used as part of play therapy for children. Both examples of limited resources were said to be impacting on the SRs' ability to effectively render psychosocial services to clients.

Considering that some of these findings are contrary to the burn rates reported by SRs in regard to furniture costs, it is recommended that a further investigation of spending

"One of the things we are trying to encourage within that team is that there is a stand-by counsellor at each site so that if there is a rush, suddenly a whole lot of survivors coming in at the same time for whatever reason they can call on a stand-by counsellor to then come in."
Director

6 For programme management (including Director, Finance Manager and M&E Officer)
7 For SWs and SAWs
8 For programme management (including Director, Finance Manager and M&E Officer)
9 For SWs and SAWs

on this line item by SRs is undertaken to understand the situation in greater detail.

Reception of NGO Services within the TCC System

"When you are interviewing a child you are not supposed be higher than the child, because already by your age you have certain authority to this child. So when you are interviewing them you have to get through to their levels which is not conducive for us we cannot do that here."
First Responder

As a multi-stakeholder system, NGOs work with and alongside NPA and DoH stakeholders in TCCs to provide survivors with a set of holistic services under one roof. This section presents findings on how PR-funded support and services have been received by NPA and DoH stakeholders.

Positive Reception

Across TCCs, PR-funded NGO services were largely perceived very positively by the NPA and DoH. Site Coordinators, Victim Assistance Officers, doctors and nurses spoke to the fact that NGO personnel were filling gaps in the TCC system that would otherwise be lacking, or not possible to execute, making them essential to the functioning of TCCs. These findings are corroborated by USAID's Impact Evaluation Baseline Report[1] as well as FPD's TCC Compliance[2] Audit. NPA and DoH stakeholders indicated that SWs and SAWs/FRs bridged certain gaps within the TCC system by:

1. Providing services 24/7 or after-hours
2. Compensating for DSD staff shortages in managing caseloads.
3. Compensating for DoH or NPA staff members when unavailable.
4. Providing specialised skills, such as specialised trauma containment and management of child cases.
5. Providing resources such as phones, internet, food, transport, transport money, and comfort packs for survivors.
6. Campaigning to raise awareness in communities of the existence and purpose of TCCs.

"TBD, that stands for Total Bloody Disaster. Simple as that. We cannot do without them. We want to care for the patient as a whole, psychological and medical, every kind of need and we can't do it as doctors, we are not trained Social Workers. We can't counsel and do the kind of work that they do. Therefore without them we not offering a service and we not a proper TCC." Doctor

NPA and DoH stakeholders across TCCs agreed that PR-funded NGO staff provided quality services to survivors. This included the fact that NGO staff:

1. Treated survivors with care, reduced secondary victimisation in the TCC system and believed that survivors were happy with the services received from them.
2. Were well-trained, effective and efficient
3. Helpful in their capacity for specialisation in dealing with child cases.
4. Often provided higher quality services than other psychosocial support service providers, including DSD SWs and DoH psychologists.
5. Often went above and beyond their expected duties and could be relied upon to assist other stakeholders where needed.

"The NGOs they are of high quality if I were to rate them the work that they are doing here comparing with our Social Worker in the field, they are different, they are more dedicated and they are paying more attention to all client which is important and, they are providing a high-quality job and I am satisfied." Doctor

Additionally, NPA and DoH personnel indicated that the services provided by PR-funded SWs and SAWs/FRs:

1. Had a positive impact on survivors and that the psychosocial support helped survivors (and/or caregivers of child survivors) to deal effectively with the trauma, and aided their recovery in the long-term.

"And in terms of the quality of the service, you know it's second to none, we've got no complaints from patients. And I can show you reams and reams of patient feedback, surveys that we did with nothing but compliments. I think they're also doing their best like everybody else… doing their best with that little they have." Doctor

"Based on my experience, I would say those services are excellent." Site Coordinator

1 USAID (2015)
2 FPD (2016)

2. Empowered their clients and went beyond the trauma incident to try addressing survivors in context of their circumstances.
3. Helped to prepare survivors for court.

"They [survivors] will be saying it's fine, I am very happy, I had some breakdowns and stuff like that but I managed to sit down and do counselling sessions with my Social Worker and now I am emotionally fine, and even though I am not 100% fine, I am calm… I am better than before, when I would come for the psychosocial intervention and then I think that is very helpful." Victim Assistance Officer

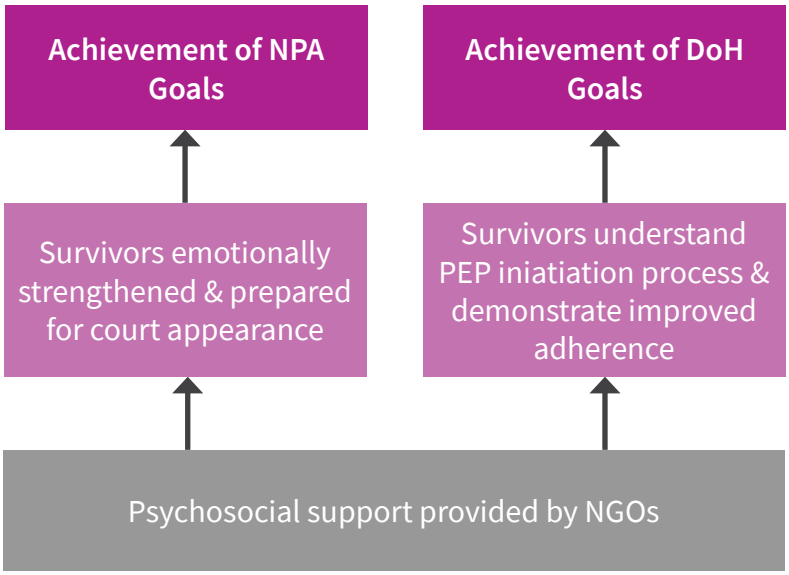
Finally, NPA, DoH and key informant evaluation participants also indicated that the services provided by SR SWs and SAWs/FRs assisted the work functions of other TCC personnel. More particularly:

1. SAWs/FRs role in containing survivors assisted in making NPA and DoH personnel's jobs more manageable, as survivors came to these stakeholders soothed and cooperative.
2. Some SAWs/FRs reportedly assisted nurses with pre- and post-test HIV counselling, STI and TB screening and with filling in forms.
3. Some SAWs/FRs reportedly assisted NPA staff to complete reports for court and contributed to strengthening survivors emotionally before they appeared in court.

Findings suggest, therefore, that the psychosocial services provide by NGOs support both the work of DoH and the NPA and that this is an essential service which contributes to the broader outcomes of the TCC model. The relationship between these services is illustrated above.

Several NPA and DoH personnel indicated that the working relationship with the SR staff was good, which helped to provide survivors with holistic, quality services.

"It helps a lot because in terms of when we are going to court… It's very helpful for us as NPA [inaudible] the psychosocial, and it's hard and when the victims are going to court, they are healed." Site Coordinator



Relationship between psychosocial services provided by NGOs and NPA and DoH goals in the TCC system

Negative Reception

Whilst feedback on NGOs was largely positive, some HCPs and key informants expressed some criticism of NGOs. The negative assessment of NGOs pertained to the following:

1. The role of the NGO was unclear

There was a perceived duplication of work between NGO SWs and DSD SWs in TCCs where both personnel were based. There was also uncertainty around the NGO's role in HTS, and DoH expressed resistance to sharing details of patients' results. These findings are corroborated by prior evidence emanating from other research and evaluation undertaken regarding TCC services . It is thus essential that the role of the NGO, and specifically the respective roles of SWs and SAWs/FRs and lines of authority be illustrated for TCC staff at some sites. Only with such clarity, can there be an understanding of where and why NGO staff are involved in certain services and functions at a TCC, and can conflicts be mitigated.

"You know what it makes our life easier because remember most of the time the patients come in such a terrible state. At least when the first responder is there, counsels the patients, calms the patients down and give patients guidance of what is going to happen when the patient reaches me. So at least I find the patient fairly calm, cooperative."
Nurse

2. **HCPs perceived NGO personnel to have a limited skillset**

Examples included the perception that the NGO was unable to counsel adult survivors, and that SAWs/FRs are not able to remove survivors from their homes and place them in shelters. Importantly, the former most likely pertains to an NGO that specialises in counselling child survivors, whilst the latter is not within the job scope of NGO personnel, but DSD SWs only. Another example provided was the perception that NGOs were not undertaking follow-ups effectively, and they relied on DoH's follow-up appointments. However, as noted in the section addressing long-term psychosocial support, the evaluation found this to be a best practice in that psychosocial follow-up appointments were strategically scheduled in accordance with follow-up appointments scheduled by DoH staff since survivors were reportedly more motivated to return to the TCC for their HIV test results and medication. This was reported to save on survivors' transport costs as there was no need to return to the TCC on separate occasions for medical and psychosocial follow-up appointments respectively. This criticism thus speaks to the abovementioned point that the roles and mandate of NGO staff requires clarity for TCC stakeholders.

3. **There is a need for better communication and information sharing among all stakeholders within the system.**

One nurse indicated that a SW often did not communicate when she was not coming to the TCC, because she believed it was not her mandate to report to anyone but the NGO. However, a lack of communication can impact service delivery. For example, the absence of a SW on duty may limit the TCC's ability to attend to follow-up clients. As such, this points not only to the need for the DoH and NPA to share their data with NGOs, but for NGOs to share their data with other TCC stakeholders. The sharing of psychosocial and PEP data via SRs or PRs would likely promote the DoH and NPA to support and advocate for NGO services to other government departments and to other potential funders.

"Accountability equals communication. If I know you are my NGO at my TCC, you're providing X service. You inform me on a quarterly basis, remember you report to me X number, I've given it to those and these and this is the reasons. Now somebody else comes from outside my bosses, what does that NGO do. I can respond with confidence without trying to hide behind my ignorance... Then it will also be difficult for activists and those people to stand on platforms and criticise left right and centre." Key Informant

Overall, PR-funded NGO services have been well-received by NPA and DoH stakeholders. Both stakeholder groups communicated the value that the NGO lent to the TCC system, and acknowledged that without their services, there would be many fractures and limitations in the system. Whilst a minority of DoH stakeholders provided negative feedback, some these factors are outside the control of the SR. It is, however, important to be aware that this is the context in which SWs and SAWs/FRs work. It also indicates that in some TCCs, DoH is resistant to integrate services, and to accommodate the psychosocial work being undertaken by NGOs.

TCC Programme Strengths

This section presents a synthesis of findings on the strengths evident among SRs in the implementation of the TCC programme. Interviews with evaluation participants highlighted three key strengths:

Passion for work

Staff who were passionate about their work and willing to go beyond what was necessarily expected of them were generally seen to provide high quality services to survivors. As indicated in the previous section, DoH and NPA personnel indicated that NGO staff often went over and above their standard duties or scope of work. Some SR personnel indicated a personal passion for their work and how this drove them to provide the best quality service that they were able to. This is especially important given that these personnel operate in under-resourced, under-staffed and often traumatic environments and thus required this type of passion to overcome some of these hindrances.

"Yes I can refer you to a case of a little girl who was ignored by the whole family and we cannot say what the reason was but we did not have a transport to take our auxiliary worker and what she did is the auxiliary took her own car and visited the house of that girl and that to us as management was a job very well done... they can go an extra mile to ensure that they deliver the services to the victims." Programme Manager

Collaboration and teamwork

NGO, NPA and DoH stakeholders across all TCCs sampled indicated that team work and effective working relationships among TCC stakeholders played a pivotal role in delivering quality services to survivors. This was realised though:

- Supportive working relations
- Clear channels of communication
- The sharing of information, such as client files.

The strength of effective cooperation, collaboration and communication among all stakeholders led to

well-coordinated and high quality services for survivors which enabled them to move smoothly and quickly through the TCC system from service to service without hindrances.

Stakeholder implementation meetings

These referred to both meetings held with other TCC implementation partners (i.e. NPA and DoH) as well as SR quarterly meetings hosted by PRs which brought all SRs together. TCC-specific meetings allowed for all stakeholders to discuss particular cases, best practices, lessons learned, challenges, and plans to resolve or mitigate these. SR quarterly meetings, on the other hand, allowed NGO staff to receive feedback on their services, possible ways to improve and were perceived as an opportunity to meet and learn from other NGOs operating at TCC sites. Both TCC and SR quarterly meetings were seen as a good opportunity and platform for learning from other stakeholders so that challenges could be more adequately addressed and services be improved.

"The implementation meeting at the national level with all of the TCC stakeholders was incredibly valuable, lovely to meet these other organisations and to talk different issues." Director

In summary, a number of strengths in the implementation of the TCC programme were observed as part of the Global Fund grant not only enhance the quality of SR services, but the services of other TCC stakeholders too.

TCC Programme Weaknesses

This section presents a synthesis of findings on the weaknesses evident among SRs in the implementation of the TCC programme. Interviews with evaluation participants highlighted three key weaknesses:

Training

Although much training is provided to SAWs/FRs and SWs in various forms, further training was identified as a current need in the following areas:

- Further HIV/STI/TB awareness and knowledge including refresher training for more experienced staff
- Sensitisation training for key populations (i.e. LGBTI persons, sex workers, and people with disabilities)

"My history that I am long in this organisation doesn't mean that something that I learnt 2009 I still know it today. I may know it because I have learnt about it but it is good to refresh especially if we are working with such." Social Worker

Newly qualified staff

Training, induction and mentorship. In some cases, evaluation participants identified a lack of experience of newly qualified SAWs/FRs and/or SWs as a programme weakness. Further capacity development if such SR staff is required in two forms:

- First responder training offered by PRs based on the NACOSA Guidelines and Standard Operating Procedure for Service for Rape Survivors (hereon referred to as the NACOSA SOP)
- An induction and mentorship process lead by SRs for their particular context.

"We need somebody who has worked and who has experience in terms of GBV because if the person doesn't even know what a target is, what the Sexual Offences Act is, because all this comes into play as social workers. Even the NGOs need to capacitate their social workers and social auxiliary workers in terms of providing with training before they come to TCC." Site Coordinator

Follow-up capacity

Evaluation participants mentioned some limitations placed on SRs longer-term follow-up ability due to transport and staff resource constraints. Transport issues were raised both in terms of a lack of access to vehicles for the provision such travel (i.e. the SR did not own or have access to their a vehicle in order to conduct home visits) as well as the distances of travel required should SR staff wish to make home visits to follow-up on clients (which were often done by SR staff in pairs due to concerns over safety). In instances which required long distance travel using public transport when no vehicle was available, SRs identified staff resource constraints as a further limiting factor as this meant that two SAWs/FRs or SWs spent a day undertaking home visits which often meant there were few SR staff based at the TCC on such occasions in order to receive new clients.

"I feel like all our cases go particularly well because we all work well together. If there is no teamwork a case cannot go well. If people are well connected and they can they can work well together and they can provide that magnificent service to the patient, then you are also a victor as much as your patient is."
Social Worker

"If we have funding to employ two more social auxiliary workers, we could go on home visits and do a follow-up with the ones that we've lost, because we do have their home addresses, we can follow them up. But remember now this program doesn't have a car either. Following up somebody takes an hour to go there. If you don't have a car, the social auxiliary worker will be gone for the whole day." Programme Manager

PEP Follow-up and Adherence Practices

This section reviews the PEP follow-up and adherence support practices provided by SRs at TCCs through the Global Fund grant. It describes the standard model of care (i.e. scheduled visits and typical roles played by various staff) as well as variations to this model of care. It also examines the importance of the multidisciplinary team approach to integrated care, the crucial role played by SRs via active follow-up (phone calls and home visits), the possibilities for expanding the role of NGOs and SAWs/FRs, and the reported adherence and PEP treatment outcomes. It concludes with an overview of the key barriers to and facilitators of successful PEP adherence and treatment outcomes.

"When the client comes in, understand that the client is still traumatised and maybe they [the nurse] can tell her something but she won't absorb all the information."
Social Worker

PEP Schedule

All evaluation participants reported a similar overall model of service utilised for PEP initiation and follow-up at TCCs which consisted of:

- An initial intake to provide initial debriefing and support, draw blood for an HIV test and, depending on the outcome of the test, initiate PEP.
- A short-term follow-up visit 3-7 days later to provide more thorough counselling and PEP education, and, at some TCCs , to deliver the results of the initial blood tests and provide survivors with the rest of the 28-day course of medication for PEP.
- A 6-week visit to do a repeat HIV test
- A 3-month visit to do a repeat HIV test
- A 6-month visit to do a repeat HIV test.

Different Systems of Service

Several nurses, SWs and SAWs/FRs noted the difficulty of properly educating and counselling survivors during initial intake, given the traumatic circumstances of this first visit to the TCC. They argued that this was an important rationale for having the first follow-up visit 3-7 days after intake at a time when survivors would have had a chance to recover from the immediate impact of the trauma and better understand the next steps for managing the medical, psychological and social challenges that lay ahead.

There were, however, some variations within this overall approach. Some TCCs had this initial follow-up visit at 3 days, others at 5 or 7 days. Some also described follow-up HIV tests that extended to 9 months and even a year after initial intake. For the most part, however, the model of initial intake—first follow-up—6 week test—3 month test—6 month test was consistent across sites. Several TCC stakeholders did speak about the importance of tailoring these models of service delivery to client needs, especially when there were challenges around transport, or when clients seemed to be particularly vulnerable and in need of more frequent contact and support.

"The previous time I think it was much better. Because they were given PEP for a week, it was not a full package of 28 days. It was much easier for us to monitor them directly because they would be here and we will be sitting down with them, the adherence officer and we will be buzzed also to go through counselling, to say how is the medication, how far is it, were they able to complete the course and the likes." Social Worker

The Role of NGOs in PEP Initiation, Follow-up and Adherence

A fairly consistent picture emerged with respect to the roles played by various DoH and NGO staff at TCCs in relation to PEP initiation. These roles included:

1. Initial intake

SAWs/FRs were reported to be involved in opening folders and completing paperwork, offering initial emotional support and debriefing, and preparing the client for the next steps in the intake visit. Clients were then referred to nurses and/or doctors who would undertake a medical exam, conduct HTS, if appropriate, initiate the patient onto PEP and set a date for a follow-up appointment. Survivors would sometimes then go back

to the SAW/FR for further support and counselling before returning home.

2. First follow-up visit

Clients would often be scheduled to see the SW and, in TCCs where only a PEP starter pack had been dispensed, visit the nurse to receive their HIV test results, discuss their PEP treatment and address any concerns about side effects. SAWs/FRs were sometimes involved in this visit but the focus of this was a follow-up visit with the nurse and initiating a relationship with the SW.

"And then after all of that we give them a letter to come back to the centre but also reminding her to go for ongoing counselling and that will be also monitoring their post exposure prophylaxis. Reminding them that we want them to talk to someone who'll be supporting them at home when they are taking their medication. For us it's very important that our clients that have tested negative they really remain negative." SR Director

3. Subsequent visits at 6 weeks, 3 months and 6 months

Involved HIV testing and counselling and were primarily conducted with the nurse at the TCC. In between the initial intake visit, and these later HIV testing visits, however, SAWs/FRs would also offer a range of active follow-up and support services, ranging from in-person conversations during visits to a series of phone calls and home visits (discussed in more detail on page 59).

The division of roles in the first few visits to the TCC was not always clear or rigidly enforced. In some TCCs, SW were more actively involved in the follow-up process by, for example, making phone calls and tracking down patients who had missed appointments. In most cases, though, SWs relied on SAWs/FRs to offer this kind of follow-up and were only able to offer support in-person. There were also some cases where SWs or nurses would act as first responders when SAWs/FRs were occupied with other clients or otherwise unavailable.

SAWs/FRs and SWs also spoke about being involved in monitoring activities relating to PEP, with frequent reference to diaries or registers used for the scheduling of follow-up appointments and other methods for tracking clients and their progress. HCPs reported that this kind of monitoring of PEP was not generally possible within the existing services and appreciated SR support in this aspect of care.

"So, I think they are doing a great job. If it was me, I would keep the NGO people working. They are recording outcomes, the proper follow up. At times we don't have time for us to see if the patient has completed full PEP, has followed up on all the visits. That's the extra job they are doing in the centre." Doctor

Finally, as described above with respect to the models of service implemented, TCC stakeholders often noted the importance of being flexible in who provided what kinds of PEP-related services. Several also spoke about the need to improvise support arrangements for clients when they had particularly pressing needs, or when the TCC itself was straining under resource or capacity constraints.

The Value of the Multidisciplinary Model and Integrated Care Systems

Many participants noted the importance of a multidisciplinary model in their approach to PEP provision. This allowed TCCs to offer the kind of integrated care to survivors that would otherwise have been unavailable. This integrated approach was perceived to be much more effective and efficient from both the perspective of TCC staff as well as the perspective of survivors. This kind of model was also able to cover critical gaps in the availability of the usual DoH services by operating at nights and over the weekends.

"If the victims go to [hospital] over the weekend, on Fridays you are there at night, the chemist is not opened which means you're not able to get the prophylaxis. How many people are we going to sit with now, that would be HIV positive after a week? With the service of the NGO, that is going to assist us, so that the people we be able even to be followed home, to be called to come. By Monday they don't care, they're not interested, but now each time one is doing that follow-up, the person would be able to come in and be able to get the treatment and the social work services." Site Coordinator

This model of care was not without

its complications. A multidisciplinary approach requires careful coordination and communication with a wide range of staff and organisations. Working across the DoH/NGO divide was not always straightforward, with several participants wishing for better integration and communication. Despite the difficulties, the overall sense from TCC staff was that the multidisciplinary approach to integrated care was not only feasible and working well, but highly effective for everyone involved in that this complemented and supported the work of DoH nurses and doctors.

The Place of Active Follow-Up: Phone Calls and Home Visits

"How many people are we going to sit with now, that would be HIV positive after a week?"
Site Coordinator

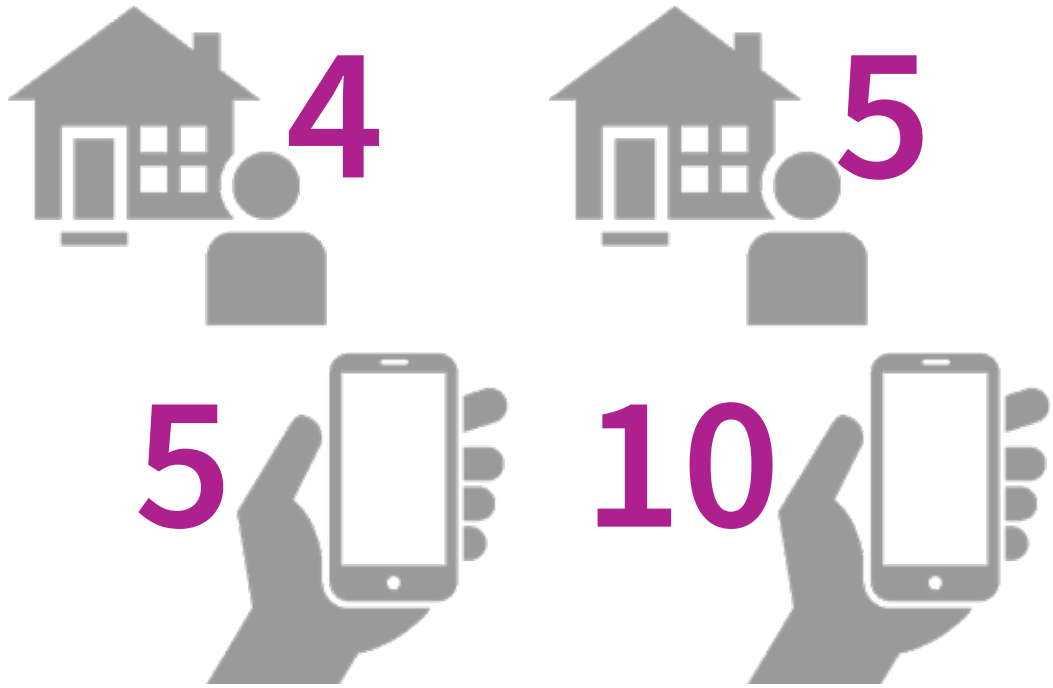
Besides inputs made in the model outlined above, the most important activity provided by NGO staff, and especially SAWs/FRs, was active follow-up of clients via some combination of phone calls and home visits. In the absence of monitoring data in this regard, it was reported that 4 of the 8 sampled AFSA SRs undertook home visits, whilst telephonic follow-ups were conducted by 5 of the 8 sampled AFSA SRs. Five of 10 sampled NACOSA SRs undertook home visits, whilst all 10 sampled SRs conducted telephonic follow-ups with survivors. The importance of these phone calls and home visits were widely reported by all categories of evaluation participants. HCPs in particular felt that this kind of follow-up filled a critical missing gap in their ability to support clients, emphasising that, from their perspective, there was very little they could do from the site of the TCC to support survivors once they had returned home.

"The services are excellent because they are doing a lot, very good job to our clients, counselling and giving them transport and doing home visits and in most of the cases they do the calls. They do call them to come for the results and whatever, like counselling… they even give us reports to say they were able to reach which people and which ones didn't return back and we work hand in glove with them nicely." Nurse

During these follow up calls and home visits, SAWs/FRs and SWs reported that the main emphasis was on:

1. Encouraging survivors to continue taking the PEP medication
2. Reminding them about upcoming TCC visits
3. Helping them identify and manage side effects.

SAWs/FRs also spoke frequently about the importance of identifying PEP supporters from a client's family or friends and including



Number of SRs Conducting Home Visits and Telephonic Follow-Up

them in these follow-up conversations and home visits. For child clients, these supporters were generally the child's caregiver(s) or parent(s). For others, the supporter might be a mother or other close family member, or a close friend. SAWs/FRs spoke about how these supporters were often a critical component in the effectiveness of the follow-up process.

"That is very tough in that we ask the person [the supporter] that is our ear and eye that they must see to it that they [the client] really took [the] medication or that they see that they swallowed it." Social Worker

In order to prepare clients for these forms of follow-up support, SAWs/FRs and SWs spoke about the importance of preparing clients for these calls and visits, and the need to sometimes negotiate with them around the timing and location. Not all home visits were scheduled as a regular part of follow-up. In some case, visits were only made if clients did not make a TCC visit. Also, not all clients were comfortable with home visits given the inadvertent disclosure of the assault and/or use of PEP that these visits could prompt. Home visits were described by SAWs/FRs as a particularly important opportunity to develop a more holistic understanding of the psychosocial context of a client and offer more comprehensive and tailored forms of support and advice in order to promote PEP adherence practices.

"I think when they go out to home visit, they will even check, like my colleague said, they check the home environment, they check all the psychosocial environment, uh, uh, issues and also just to follow up if on PEP as well." Victim Assistance Officer

During home visits, SAWs/FRs would thus not only offer further educate and counsel on PEP, PEP adherence and management of side effects, but would also provide advice on sexual health more generally, managing relationships and disclosure issues with partners, and other psychosocial issues. SAWs/FRs did so both because these other psychosocial factors could influence PEP adherence and also because the home visits provided an opportunity for a more multifaceted and holistic form of support. SAWs/FRs reported that their main challenges in offering these kinds of active follow-up were lack of access to phones with sufficient airtime and transport and incorrect phone numbers and addresses provided by the clients. There was some mention as well of difficulties in providing this kind of follow-up in settings where there was a lot of labour migration (either across borders, to other provinces, or between villages and cities).

The Role of SAWs/FRs and Opportunities for Expansion

As described in more detail above, and in line with their mandated responsibilities, the roles of SAWs/FRs at TCCs consisted primarily of acting as the first person to receive survivors during the initial intake visit and served in offering active follow-up and adherence support to clients during the course of their PEP treatment. Several SAWs/FRs also spoke of their role as a client advocate and as the person that could connect together the various strands of medical, legal and psychosocial support services offered via the TCC.

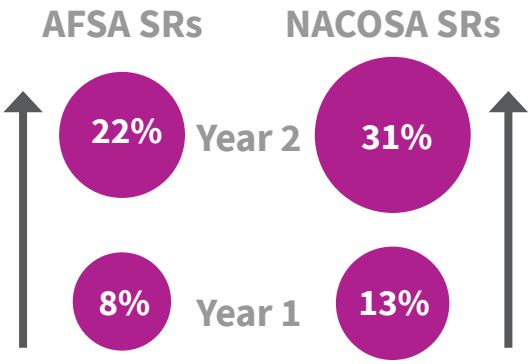
When asked how the role of SAWs/FRs, and SRs more generally, in PEP adherence might be usefully expanded, participants expressed two main ideas:

1. Upskilling and training of SAWs/FRs to offer a wider range of services. This included including training in HIV testing services in TCCs where this had not already occurred.
2. Provision of more comprehensive forms of support to clients on PEP. This support should integrate PEP treatment issues with issues of HIV more generally, as well as other sexual and reproductive health issues like gender-based violence and termination of pregnancy. One survivor also said that the adherence support services at TCCs should formally include families in the process.

Adherence and PEP Completion Outcomes

Quantitative PEP monitoring data collected by PRs demonstrates that PEP completion rates improved over the first two years of the programme. These figures are illustrated according to PR on the following page.

"We provide services to clients who are sometimes not permanent residents of our local communities so it's very difficult to trace people who go back home."
Programme Manager



PEP Completion Rates of AFSA- and NACOSA-funded SRs

Consistent with other research internationally, adherence to PEP to prevent HIV-infection after rape is low both in sub-Saharan Africa[1], as well as in more developed countries[2]. A systematic review and meta-analysis of studies assessing adherence globally found 40.3% of patients completed the treatment, with these rates seeming to be better in developed countries than developing countries[3]. South African studies have reported compliance rates of anything from 0% to over 90%[4], 57%[5], 66%[6] and between 31.9% to 38.2% in another study[7]. The anecdotal reporting of PEP completion rates by evaluation participants rendered a similar picture with many participants reporting poor PEP completion rates and significant difficulties in getting clients to return for follow-up and/or stay adherent to PEP.

"No we're not doing well with the PEP follow-up, [because] of the phone numbers, because of the addresses and because of clients not coming back for follow-up sessions you know 20% for the PEP [we] were able to reach, the rest, 80%, we were not able to reach."
Director

"By their word of mouth and secondly, when they bring the empty packets and the children, when they bring their empty bottles, we take that they have completed the treatment."
Doctor

Measures for the verification of PEP adherence were generally a combination of self-report from clients (sometimes with confirmation from supporters who accompanied them on visits) and counting pills and checking medicine bottles to ensure the original supply had been exhausted.

Roughly equal reference was made by evaluation participant to both methods with a possible slight lean towards self-report methods for verification[8]. It is important to note here the limited validity with these verification methods. Recall bias and social desirability bias (among both TCC personnel and survivors) are important limiting factors[9].

Factors Affecting PEP Adherence and Follow-Up

Despite the generally positive perception about PEP adherence and treatment outcomes, participants also described a wide range of barriers and challenges with respect to PEP medication and adherence.

Barriers and Challenges

Findings highlighted five key barriers and challenges in PEP adherence reported by evaluation participants.

1. Transport. This was reported as the most prominent structural barrier across TCCs and was noted by all TCC stakeholders. This finding is consistent with previous research on barriers to PEP adherence[10]. Whilst SAPS was identified in the provision of transportation for clients to and from their intake visit, many survivors found it difficult to mobilise sufficient funds for transport to follow-up visits. This pattern seemed to be the case in both rural and urban areas. This barrier was especially critical at the first follow-up visit since some clients would have only been given a 3-7 day supply of PEP at their initial visit. Missing this follow-up meant that continuing on PEP would have been difficult. Some clients were reportedly able to get their follow-up medication from a clinic closer to their home, but in these cases, TCC staff were concerned that clients would miss out on the more comprehensive psychosocial services offered by the TCC.

1 Draughon & Sheridan (2011)
2 Chacko et al. (2012)
3 *Ibid*
4 Vetten & Haffejee (2005)
5 Carries et al. (2007)
6 Roland et al. (2011)
7 Abrahams et al. (2010)
8 Since interviewed evaluation participants were not asked about the specific method used to verify the completion of PEP medication, such information was not reported consistently and must be interpreted with caution.
9 So too is the 'survivor bias' that is present in accounts of low sero-conversion rates. The clients who were most likely to return for follow-up visits and stay adherent on PEP were also most likely to remain HIV negative.
10 This finding is consistent with previous research on barriers to PEP adherence

2. Side effects of PEP. Survivors and TCC staff described a wide range of side effects[11]. Other literature points to side effects experienced as the most common reason for low adherence[12]. Some clients did not understand the side effects were the result of PEP, and some mistook them for the effects of HIV infection. Most clients, however, made the connection to PEP and often reported that the side effects were a primary reason for discontinuing PEP. Much of the SAWs/FRs follow-up efforts were spent identifying side effects and encouraging clients to come back to the clinic for symptom relief, or to simply persist through it as the body adjusted to the medication. Some evaluation participants also argued that PEP was a psychological reminder of the sexual violence survivors had experienced and thus a barrier to adherence as well. Others added that the general effects of trauma would make it difficult in any case for some patients to maintain regular adherence.

"Yes because always when I take those pills I was reminded, I was thinking about the things that happened to me. So sometimes it feels like I don't want to take those pills but because my kids are there for me to take those pills, I was able to take those pills." Survivor

3. Family and community. Evaluation participants felt that the frequent problem of incorrect phone numbers and addresses was the result of stigma and denial with families and communities, of both rape as well as HIV . In accordance with previous research , SAWs/FRs and SWs reported a strong need to be sensitive of the fact that some clients did not want family or friends to know about their rape(s) and were worried about breaches of confidentiality. This may have reduced their motivation to take PEP, increased their social isolation via weak family support , and limited their options for social and psychological support during the 28 days of treatment.

4. TCC experience. Poor treatment, service quality, and patient-staff relationships at health facilities also emerged as barriers to effective follow-up and linkages to care . There was mention in some interviews of a suspected fear on the part of survivors to return to clinics for follow-up visits if they had lost their clinic card or if they had defaulted on their PEP medication. Lack of continuity of provider was also reported as a barrier to motivation to return to the clinic for follow-up.

"So as a professional nurse, I do as well call them. Find out what is going on. Because some will come with "Sister, I didn't want to come because I lost the card." So you remind them like, "Are you aware that you must like come back for the follow up?" TCC Nurse

5. Food insecurity. Survivors reported that PEP medication had much more intense side effects if taken on an empty stomach. Many clients, however, reported serious problems of hunger and food insecurity in their households . SR efforts to provide clients with food for the 28 days of PEP were of limited impact, however, since recipients of this food aid would typically have to share any food with other members of the household.

"I would be dizzy and get hungry very quickly and other times I don't even have enough food at my place so I choose to skip a day without taking them because of the after effects, so I'll find myself not taking them other days. Yes when I saw I didn't have enough food because when I took the pills I had to eat so when I didn't have enough food I would be very hungry, I felt weak and I would vomit." Survivor

A number of other barriers to effective PEP adherence and follow-up were mentioned in interviews and are consistent with themes found in previous research conducted in this area[13]. These included concern that PEP pills look like ARVs for ART, poor understanding of PEP and HIV, and fear of positive HIV

"Some of them are ashamed of going back because people will label them you know that they are rape victim and they are HIV positive... then they feel ashamed going back because they don't want people to know, they just want to forget about it."
Social Worker

11 This included rashes, nausea, drowsiness, weakness, headaches, swollen feet, hunger, thirst, and frequent urination.
12 Vetten & Haffejee (2005) and Abrahams & Jewkes (2010)
13 Abrahams et al. (2010)

diagnosis. These three themes point to a poor understanding of PEP. Other themes included disruptions due to migration, fear of encountering perpetrators in the community, and alcohol abuse. While these barriers were mentioned less frequently, this is qualitative exploration of the types and aspects of these barriers. A quantitative assessment would be required to more confidently determine which of these barriers are most frequent and impactful for those taking PEP.

Facilitating Factors

Participants identified four key facilitators of successful PEP adherence and treatment outcomes.

"And my mom at home she always reminds me, sometimes I forget that time. Did you take your pills? Then I'd say no I didn't. Come and take your pills."
Survivor

1. Psychosocial support. The most prominent set of facilitators were ones that supported the psychological well-being of clients while on PEP. TCC staff and survivors alike noted the important role of having PEP treatment supporters, of broader family and peer support, and the particular role of mothers and children in providing reminders and encouragement to stay adherent. This finding is consistent with previous research which demonstrates the importance of this factor in adherence[1].

"The travel budget was specifically for us when we go out to do the follow-ups or to see these people in their homes, but now we've got our own funding that [we] will give people... give them money to come and visit the social worker... and then we also give them food when they come here."
Programme Manager

2. Motivation. Evaluation participants also noted it was important to remind clients that staying HIV negative was an achievable goal and the provision of motivation for adherence was seen as extremely important. In accordance with other studies, fear of contracting HIV was reported as a strong motivation for completing PEP[2]. One NACOSA SR reported an innovation in the role of a dedicated adherence counsellor based at the SR's offices. The adherence counsellor was solely responsible for telephonic follow-ups with clients in order to relieve other SAWs/FRs and SW from this work load and this position functioned as a further mechanism aimed at improving adherence outcomes. Some TCC staff mentioned techniques used in counselling practice which focused on PEP adherence as a way to take back some control over their lives and develop a degree of empowerment that had been taken away from them.

"But in most times, they do finish the course. I think it's more because they are scared. Especially when your HIV status is negative and you don't want it to be a positive. So it motivates you to finish the pack in the end." Social Auxiliary Worker

3. TCC experience. Participants also spoke about the importance of good patient-staff relationships and the empathy and support received from the staff at TCCs. Considering the common experience of poor treatment for survivors at regular health facilities, it is not surprising that survivors reported that being treated with care at the TCC was a crucial facilitator for remaining engaged in care.

"I think it's the counselling we're offering them, yes. I think they are they are given…a space where they can offload. I think it's the counselling that keeps them coming back, cause when they go back, it's noted, they are not the same as when they came in." First Responder

4. Financial support. Finally, throughout interviews, evaluation participants identified the important place that financial support for food and transport played in supporting PEP adherence. Too often, these resources had to be mobilised in an ad hoc fashion and out of the pockets of TCC staff. Whatever the source of this support, however, there was a broad consensus that this type of support was a critical facilitator of PEP adherence for many clients.

In conclusion, whilst SRs are generally reported to be offering initial emotional support, debriefing, and preparation for survivors in relation to PEP at intake, they also provide extensive support to DoH HCPs in the continuous monitoring and follow-up of clients in relating to PEP adherence. This included the provision psychosocial support via telephonic follow-up and home visits, the importance of which was widely reported by all categories of evaluation participants. SRs

1 Abrahams et al. (2010); Vetten & Haffejee (2005)
2 Vetten & Haffejee (2005)

were also noted as covering critical gaps in the availability of DoH services by operating at nights and over the weekends and were seen to make the system be much more effective and efficient. Whilst adherence rates appear low for the first two years of the programme, these seem to be consistency with other research both locally and intentionally. Factors that act as challenges to as well as facilitate PEP adherence were highlighted as was their similarity to findings of other studies.

Key and Vulnerable Populations

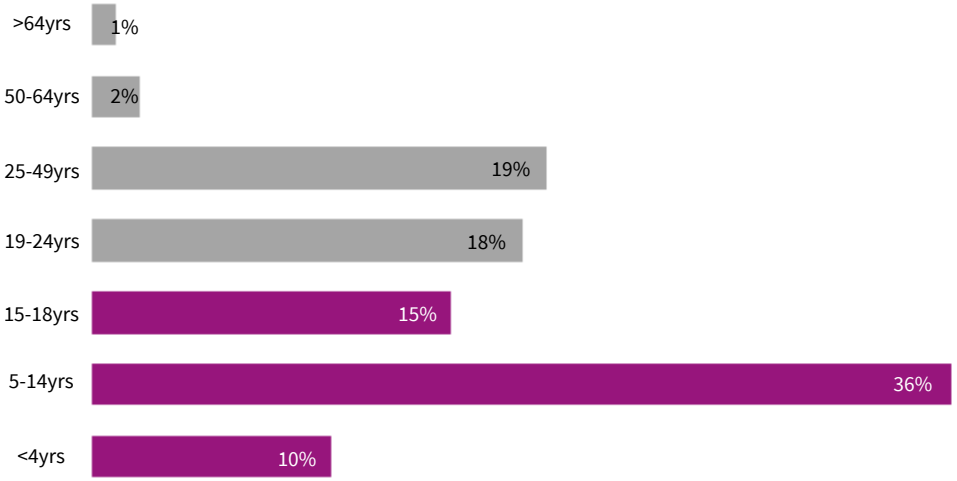
This section presents findings on how well adapted the TCC programme is to the needs of key and vulnerable populations. Findings suggest that all SRs sampled saw survivors from either key or vulnerable population groups, or both.

Children, Adolescent Girls & Young Women

Most SRs sampled reported the largest number of clients seen at TCCs were children. These findings are corroborated by USAID's Impact Evaluation Baseline Report which found that many TCCs reported children between 0 and 12 years of age to be the largest group of survivors served. Whilst children are not considered a key or vulnerable population as per definitions provided within the scope of the Global Fund grant, they are an important population not only because of the frequency at which they report to TCCs, but also because TCC stakeholder practice must be adapted to or tailored for work with child survivors.

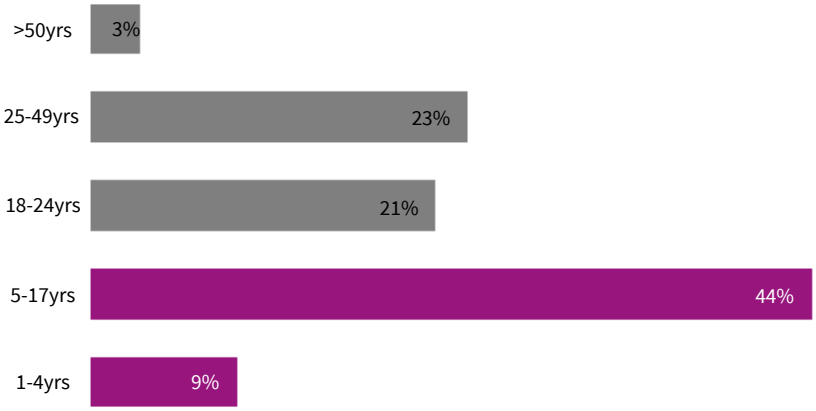
Children (between 1 and 18 years of age) account for 61% of clients seen at TCCs by AFSA SRs in Years 1 and 2 of the programme.

Percentage of child clients seen by AFSA SRs at TCCs in Y1 and Y2



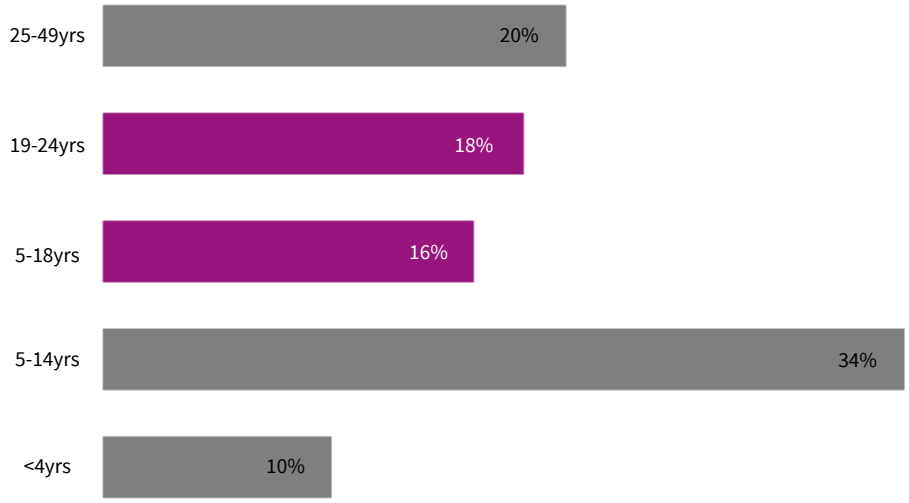
On the other hand, children (between 1 and 17 years of age) account for 53% of the clients seen by NACOSA in Years 1 and 2 of the TCC programme.

Percentage of child clients seen by NACOSA SRs at TCCs in Y1 and Y2



A further notable population group seen at TCCs was that of AGYW (i.e. adolescent females and young adult women between the ages of 15-24 years of age). This was corroborated by a PR key informant interviews which indicated that most survivors seen from vulnerable population groups at TCCs are young women and girls. As per the graph on the following page, females between 15-18 (16%) and 19-24 (18%) years of age collectively account for 34% of the population of adolescents and young women/men clients seen at TCCs by AFSA SRs in Years 1 and 2 of the programme. It is interesting to note, however, that female survivors in the 5-14 (34%) and 25-49 (20%) year age groups are seen in higher numbers at TCCs than survivors who fall into the AGYW age groups.

Proportion of female clients seen by AFSA SRs at TCCs in Y1 and Y2 that are AGYW

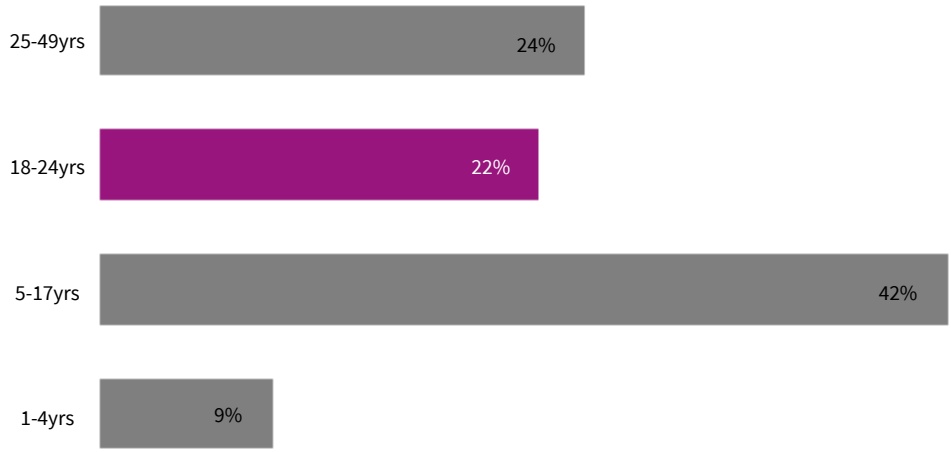


Sexual violence experienced by male children and subsequent post-rape care is generally over-looked and consequently poorly understood.

As per the graph below, females between 18-24 years of age account for 22% of the population of adolescents and young women/men clients seen at TCCs by NACOSA SRs in Years 1 and 2 of the programme. As with AFSA SRs, female survivors in the 5-17 (43%) and 25-49 (24%) year age groups are seen in higher numbers at TCCs than survivors who fall into the AGYW age group.

A further point of interest from data collected on child survivors seen by both PRs at TCCs is that the proportion of male survivors between 5 and 14/17 years of age far outweighs the number of female survivors within the same age category (i.e. 55% males and 34% females for AFSA SRs and 65% males and 43% females for NACOSA SRs). It is difficult to corroborate this trend with findings from other studies

Proportion of female clients seen by NACOSA SRs at TCCs in Y1 and Y2 that are AGYW



Whilst these findings for both PRs is partially consistent with the previous finding that child survivors usually account for the largest proportion of clients seen at TCCs, it is worth noting that the considerable number of female survivors in the 24/5-29 age category who report to TCCs presents. Considering that women over the age of 18 constitute the bulk of survivors who report rape , this as an equally vulnerable group in addition to AGYW.

or official statistics since there is very little data on the prevalence of male rape and almost no data on the rape of male children in South Africa. The frequent denial of its occurrence, coupled with the considerable focus often placed on populations considered more at risk for sexual violence (i.e. AGYW and young adult women), may explain why sexual violence experienced by male children and subsequent post-rape care is generally overlooked and consequently poorly understood.

LGBTI, Sex Workers and Individuals with Disabilities

Although there is provision on intake forms for SRs to collect data on key populations seen, clients seldom provide this information. Although it may be possible that SRs have reached many more survivors who form part of this key population, since PRs are only able to report on number of key populations seen at TCCs if clients disclose this information to SR staff, the true reach of the programme in this domain remains unclear and is likely currently underreported. In addition to this, the numbers of key populations seen at TCCs are often so negligible that PRs report not undertaking any analyses on these figures. For instance, in Y2 of the programme, all NACOSA SRs reported seeing the following number of self-disclosing clients: 11 LGBTI survivors; 2 sex workers; 1 PWID survivor; and 10 MSM survivors.

This is corroborated by qualitative findings which demonstrated that whilst most SRs reported to have seen individuals from key populations, they reported that they did not see them frequently. In line with the quantitative figures on key populations from NACOSA SRs in Y2 of the programme, qualitative data reported by evaluation participants revealed that the most prevalent key populations seen at TCCs were members of the LGBTI community.

Less than half of SRs sampled reported to have seen clients who were sex workers, but notably of those who did, AFSA SRs were more likely to report receiving these clients[1].

People with disabilities were also reported to be seen frequently at TCCs by evaluation participants. Whilst this evaluation acknowledges that people with disabilities are not included in the Global Fund's definition of key or vulnerable populations[2], NACOSA and AFSA SRs reported to frequently see survivors from this particular population. Disabled adult survivors of sexual violence presents as a population with compounded vulnerability. This vulnerability is further compounded for child survivors with disabilities[3]. The evaluation, therefore, considered it necessary for this group to be considered here. While both NACOSA and AFSA SRs reported to deal with individuals with disabilities, NACOSA SRs more frequently reported to have seen this population than AFSA SRs .

It should be noted that the evaluation did not interview survivors who were from key populations[4] or those who were children[5]. Consequently, the unique needs of these populations could not be obtained directly from theses groups' perspective. The needs of these populations are broadly understood here primarily from the perspectives and feedback of SWs, SAWs/FRs and caregivers of child survivors interviewed.

Programme Adaptations for Key and Vulnerable Populations

SWs and SAWs/FRs who saw survivors from key and/or vulnerable populations noted various ways that they themselves or other TCC staff interacted with key and vulnerable populations. It should be noted here, that the themes that emerged most from interviews were how staff adapted to children, LGBTI persons, sex workers, and persons with disabilities. As such, practices of dealing with AGYW did not directly emerge. It is likely that dealing with AGYW survivors was considered normal or standard service for SR staff, and thus it was not notable as a unique population group that required specified methods for the provision of psychosocial support.

Child Survivors

SWs and SAWs/FRs indicated that they implemented activities and methods specific to child survivors, and that their practices were sensitive to children in the following ways:

1. **Communication with caregiver.** In most if not all cases mentioned, the caregiver would be the individual who brought the child to the TCC. Therefore, SR staff relied on the caregiver to provide information about the child, but also to convey

"I had this case, a 5 year old girl, and she didn't want to speak to her mother about what happened. And then her mother asked me if I can speak to her in private, so she left us. And then we were playing house, and then she told me, on that level, what had happened to her. They open up more easily when you're on their level."

First Responder

1 Considering that information on the number of clients who are sex workers seen at TCCs is often not recorded by SRs, the evaluation was unable to triangulate this qualitative finding with monitoring data.
2 Although the NSP recognises people with disabilities as a vulnerable population.
3 Children with disabilities are 2.9 times more likely to be victims of sexual violence, whilst children with mental or intellectual impairments are reportedly 4.6 times more at risk of sexual violence (Hughes et al., 2012).
4 Considering that information on the number of clients with disabilities seen at TCCs is not recorded by SRs, the evaluation was unable to triangulate this qualitative finding with monitoring data
5 Given the logistical difficulties already inherent in interviewing survivors, the evaluation did not additionally request TCCs to organise survivors from key populations specifically.

information to the child and about the incident. Additionally, TCC staff also reported needing to relay more complex information to the caregiver such as medication requirements, or any developments made during the child's treatment at the TCC, especially if a child was in danger.

2. **Age appropriate communication.** This may have included language, ideas, methods or activities that children would understand for their age group, as well as being warm and friendly. Examples included playing games with a child, or letting the child use toys or drawings to convey what happened to them.
3. **Conscious of potential danger.** Some SR staff noted that a child's home circumstances would be assessed to evaluate if they were in danger. This was typically assessed by speaking to the individual who brought the child in, or by what was uncovered during the child's containment or counselling sessions. If, during intake or containment, SAWs/FRs felt that a child was in danger (e.g. if the child lived in the same environment as her/his perpetrator or was being neglected), they referred the case to the SW to investigate further, and, if necessary, to conduct a home visit and remove the child from the home and take her/him to a place of safety.
4. **Specialised SRs.** Since some SRs specialised in working with children, their staff members had been frequently exposed to working with children and likely had training, or education, in working with this population group.
5. **Child-friendly TCCs.** Examples provided were that TCCs had a playroom with games, toys, and/or colouring books; TCCs were painted throughout with colourful child-friendly imagery, or that children received a comfort pack or toy.
6. **Use of child-specific guidelines.** Some SR staff indicated that they used the Children's Act and child protection legislation to guide them in working with children.
7. **Relationships with specialised organisations**. As indicated in the section about SR links and relationships (see page 40), several SRs were linked with other organisations specialising in children where they could make referrals if necessary. They also participated with other NGOs on several forums.
8. **Links with local schools.** Many SRs formed relationships with local schools so that children could be referred to TCCs, and also undertook awareness raising activities at schools and in communities.

LGBTI Persons and Sex Workers

Results for LGBTI and Sex Workers are presented together here as evaluation participants often spoke to both groups collectively as a key population, and practices employed by SWs and SAWs/FRs were consistent across both groups. SWs and SAWs/FRs primarily expressed that if they ever had clients who were members of the LGBTI community or sex workers, they would treat them the same as any other client, regardless of their gender identity, sexual orientation or sexual practices. They tried to not be judgemental and to respect the individual when providing services to them. Participants also indicated that they would not directly ask these clients if they were LGBTI or a sex worker, allowing the client to choose whether they wanted to disclose this information or not. This is aligned with the guidance provided by PRs that key population information should only be documented if the survivor voluntarily discloses this information, and they must not be directly asked. Only a few participants indicated that they had received training or education on how to work with/treat individuals from key populations.

"You know, I don't judge anybody, because I just have to put myself in that patient's shoes at that moment and understand the pain she's going through or he's going through and I'm here to serve them. I'm here to guide them. I'm here to show them the support that they need. And wherever, whatever she is or whatever he is, whatever she falls under which prostitute or LGBTI, for me a person is a person first of all. If something happens to a person, I have to put myself in her shoes, you know try to feel this person is actually in pain."

Social Worker

According to key informants, key population survivors (LGBTI and sex workers) often face barriers in accessing services. In healthcare settings this may be due to overt and covert stigma, discrimination and unfair treatment from healthcare providers, but also from SAPS. Given that sex work is a criminal offense in South Africa, many sex workers also experience barriers when attempting to report a crime, and sexual violence experienced by sex workers will often go unreported to police as a result of fear of the police themselves (with reports of extreme violence, torture and rape by police)[1], and fear of arrest[2]. Additionally, with cases of rape, many are not believed[3]. As such, it is possible that sex workers may not even be referred to TCCs by police. They may, in fact, rather be detained at police stations, preventing them from

1 Sonke Gender Justice & SWEAT (2017)
2 Kurtz, Surratt, Kiley, & Inciardi (2005); Decker et al. (2015)
3 Sonke Gender Justice & SWEAT (2017)

Photo courtesy of the Rape Crisis Cape Town Trust

accessing PEP medication within the 72 hour window. According to a recent report by Sonke Gender Justice and Sex Worker Education and Advocacy Taskforce (SWEAT), when sex workers attempt to report crimes against them they can be prevented from opening cases, and they are commonly held without charge and without being informed of their rights[4]. In countries where sex work is criminalised, law enforcement of sex work can therefore serve as a barrier to preventing HIV prevalence and incidence among sex workers as a result of arrests and imprisonment[5], which consequently can prevent them from accessing preventative treatment.

Few SWs or SAWs/FRs reported receiving sensitivity training for these key populations. Without such training and a full understanding of the sensitivities surrounding key populations, it is possible that SR staff may have unknowingly or unintentionally made statements or expressed behaviours that were considered unpleasant and uninviting to key populations, for example using incorrect pronouns for transgender persons. Moreover, without sensitivity training, it is an assumption of this evaluation that the sensitivity to key populations would have had to rely largely on the personal consideration and benevolence of the service provider. Whilst the data indicated from the perspective of SWs and SAWs/FRs that SR staff were generally non-judgmental towards members of key populations, this is a one-sided perspective and could not be corroborated by survivors from key populations who used TCC services. Therefore there is a relatively unclear picture about the services provided to key populations at TCCs, however it must be noted that the concern of stigma, discrimination or victimisation in healthcare settings is common among key populations[6].

One key informant suggested that working with other Global Fund key population programmes would be a helpful avenue to inform these populations about the TCCs, and concurrently would assist in sensitising SR staff to the unique needs of key populations. Others indicated that NGO staff hired at the TCCs must be sensitive and unprejudiced to these populations, and that when SR staff make referrals to other organisations, they must ensure that these organisations have the capacity to manage these cases adequately.

"There are a lot of complexities towards those populations, and there are a lot of misconceptions there's very real experience of having to open a case first before you can go to a TCC, and that can serve as a real barrier to accessing the services and perceptions about how someone may be treated, even just going to a regular health centre."

Key Informant

4 Sonke Gender Justice & SWEAT (2017)
5 Shannon et al. (2015)
6 E.g. Delany-Moretlwe, Cowan, Busza, Bolton-Moore, Kelley, & Fairlie (2015); and Roberts & Fantz (2014)

Child Survivors with Disabilities

SWs and SAWs/FRs indicated that the majority of TCCs saw survivors who had either a mental or physical disability (most often the former). As stated above, although the evaluation recognises that this population is not included in the Global Fund's definition of key or vulnerable groups, it was a population group many TCCs saw, especially among children, adolescents and young individuals.

SWs and SAWs/FRs indicated that their practice had to be adapted depending on the type of disability the survivor had. Some required that the SW or SAW/FR speak slowly and allowed time for them to respond. As with child survivors, if a survivor had a disability, SWs and SAWs/FRs also reported communicating with their caregivers, or the person who accompanied the child to the TCC, to ensure important information was relayed. Some NGO staff rather referred individuals with disabilities to service providers that specialised in this area, including psychologists and or a psychiatric hospital. Of all key and vulnerable populations mentioned in this section, evaluation participants expressed the most difficulty providing services to this population group, as they struggled to effectively communicate with these survivors and to understand from their perspective how they were feeling and coping. There were only a few SRs that made referrals to organisations or service providers that specialised in services for persons with disabilities, and there was little indication of awareness raising in this area.

"You find that you are not helping the client you are talking with the guardian because maybe they cannot talk properly and they cannot hear you properly because we do deal with deaf people as well, it doesn't sit well with me I just become stressed out because I do not know how they feel, I just get the information of what happened from the person they came in with and how they feel, how they will continue and how they will cope with this thing I do not know. It is a big challenge I won't lie." Social Worker

Taking the findings in this section into consideration, the TCC programme was adapted in some ways to the needs to key and vulnerable populations. The evidence suggests that both SWs and SAWs/FRs reported to treating key populations fairly without discrimination or prejudice, and that they adapted their methods of providing care and psychosocial support to be appropriate for the age group and understanding of children and people with disabilities.

Sustainability

Financing post-rape care services in South Africa is constrained and attempts to ensure that NGOs' TCC-based services outlive the end of the Global Fund grant will need to understand these current limitations if they are to be surpassed. This section is introduced by briefly sketching the anticipated impact of the loss of NGO services on the TCCs should funding be withdrawn. The section then outlines how SRs propose dealing with the loss of funding from the Global Fund. Their efforts are then located within the broader landscape of private funding. From there, the section turns to the public funding of post-rape care, specifically that provided by DSD. The DoH's approach to post-rape is then discussed before some final conclusions are drawn around the components of post-rape care. Recommendations around how these may be pursued are dealt with separately in the next section.

Anticipating the Impact of the Conclusion of Global Fund Grant Funding

All TCC stakeholders interviewed thought that the ending of this tranche Global Fund grant funding on 31 March 2019 would have dire consequences for the services currently being offered. Loss of NGO services was expected to particularly affect:

1. **Availability of services after hours and on weekends.** A time at which health staff are most unavailable and clients most in need of care. This is consistent with evaluation findings on the provision of 24-hour services at TCCs which that highlighted that SRs operating around the clock in TCCs often assist NPA and DoH personnel in filling the gaps in their service by providing services to survivors after hours.
2. **Quality of the services.** It was highlighted that services may suffer and their psychosocial dimensions be lost, thus reducing the TCC to a health and legal

service only. Certainly, it is unlikely that the PEP adherence support offered by SRs would continue.

The dire consequences envisaged were not imagined. Some TCC staff had previously experienced the effects of the loss of NGO services following the ending of funding contracts while others had worked at health facilities without the kind of integrated support offered by NGOs and were thus able to contrast these with services where NGOs were present.

Sources of Funding

At the time of the interviews SRs were all, obviously, supported by the Global Fund, with additional funding derived from a combination of government and private sector funding and other income generation schemes. This included donations, grants, and subsidies from local development agencies, local CSI efforts, and international donors. Despite mentioning private sources of funding as critical sources of support, it was not clear to what extent it could cover the shortfall created by the withdrawal of Global Fund monies. It was also not clear from the interviews how SRs planned to expand upon these funding sources; few offered detailed or systematic proposals when asked about their exit and sustainability strategies. Some SRs reported having held financial planning meetings and participating in PR-run sustainability training workshops. Most had identified a range of potential alternative funders and many had funding proposals in the pipeline to these potential supporters. This predominantly included applications to DSD. Other private funders, however, included foundations and trusts, local development agencies, local CSI efforts, and international donors. For SRs, the services offered at TCCs are a moral imperative and a core objective of their work; they are determined to find the means to enable their continuation.

Private Funding

Other sources of private funding are not waiting in the wings, however. As a general point, donors do not often prioritise services for funding, considering care and support to be the responsibility of the government – especially in a middle-income country like South Africa. Further reinforcing this deprioritisation of services in relation to gender-based forms of violence such as rape, is donors' tendency to favour funding prevention activities over services, along with the belief that work with women has not been effective in stopping violence[1]. A very recent illustration of this was offered by one of the evaluation's key informants who noted that in 2016 when many NGO services in the TCCs faced closure, a group was formed to discuss how the services could be continued and supported. The group had subsequently become focused on work with men, including securing funding for this work.

According to this same key informant, obtaining funding for post-rape care was further complicated by the particular approach towards programming adopted by HIV donors. One source of the lack of appeal of care and support services was their lack of novelty; services did not appear innovative – often an important criterion for funding. Outside of supporting adherence to PEP, it was also difficult for donors to see how post-rape care and support was directly linked to HIV. It was thus not clear where TCC services could be located programmatically. The absence of robust national data demonstrating incontrovertible evidence of the links between GBV and HIV outcomes, the key informant suggested, also made it difficult to argue for GBV services within the context of HIV.

"I just told you now, oh my God where will we get a social worker if they are not around? Meaning that I will have to send my patient home uncounselled and come back after five days and have this person now who is so suicidal. No! It will not work!"

Nurse

The corporate sector does not appear to be a ready source of funding either. According to the Business in Society Handbook[2], the social welfare sector attracted 15% of corporate social investment. Victims of violence and abuse, as a category, received 4% of the funds disbursed within this category. The National Lotteries Commission is not an easy option for funding either. While 47% of lottery funds should be allocated towards the charities sector, lottery funds cannot be awarded to the same organisation for two consecutive years in terms of regulations issued in 2015. As a result of this policy organisations may only apply for funds every second year.

Against this backdrop it is unsurprising that SRs reported experiencing many challenges in trying to attract and manage diverse,

1 Vetten (2015)
2 Trialogue (2017)

changing and unpredictable funding sources, as well as juggle reporting and auditing requirements for multiple funders. Their uncertain financial situation made long-term planning difficult, including in relation to how they could develop their services to better meet their beneficiaries' needs. According to SRs, short-term project funding was always more readily available than consistent and long-term core funding for service provision. Consistent with other research, this unsustainable funding model was reported to severely limit NGOs' ability to sustain quality services and retain experienced staff[1].

"If they were to go we would suffer a lot, because the government is untrustworthy."
Victim Assistance Officer

Government Funding

In the event of the withdrawal of finding, evaluation participants[2] in more than half (13/18) of the sampled sites mentioned that the government would (or should) take over. Opinions on government's ability to do so were mixed, however. While some stakeholders[3] did not have a great deal of confidence in the government's ability to provide the current set of services at the same level of quality, others[4] were more confident they would be able to take over and continue psychosocial support services being offered at TCCs.

"[But] some of the systems, they are not yet changed regarding the gender-based violence, especially in South Africa... if you're going to depend on government alone, you're not going to win this war." Site Coordinator

"Well I think even if it is provided by government I think it will still benefit the survivors...Because they will be providing sort of the same service to the survivors, a holistic service to the survivors, like I said, with training and monitoring, ja it can work." Programme Manager

Still other stakeholders[5] saw this as a highly specialised field of work that could not be provided by government's general community development workers or community health workers.

"If they deliver a generic service community development workers, these people are not immersed in the topic of sexual violence which is a highly complex and specialised field. You need [a] certain character and ethos. All these things come from specialised NGOs that [is] the model." Director

Regardless of respondents' views on government's capacity, most TCC stakeholders considered it to be government's responsibility – their constitutional duty even (especially in relation to children) – to financially support the provision of psychosocial services. While there was some support for the National Prosecuting Authority taking over funding (given the law enforcement dimension) or the Department of Health (given the medical function of TCCs), most respondents thought the DSD should be responsible for funding the service, given the Department's leadership of the victim empowerment programme.

The Department of Social Development and the Funding of Services

Social welfare services in South Africa have historically been provided through partnerships between the state and the non-profit private sector (including faith-based organisations). This partnership takes concrete form in the money allocated by the DSD towards the provision of social welfare services by the non-profit sector. However, only a subsidy, or partial payment of the full cost of the service, is contributed because it is expected that NGOs will source the balance of their costs elsewhere. These additional sources of funding may include other government departments, donor organisations, corporate social responsibility programmes from the private business sector, trusts and foundations, and the proceeds from lotteries.

Services receive a small percentage of the DSD's overall budget – 10% - with the remaining 88% spent on grants and 2% on administration[6]. Almost all of the budget for services is distributed through the provincial departments of social development which bear the primary responsibility for subsidising

1 Shukumisa (2017)
2 Including SR Programme Managers/Directors, Nurses, Doctors and Site Coordinators/Victim Assistance Officers, and Key Informants
3 This perspective was shared not only by SRs, but also by some doctors and site coordinators.
4 HCPs and NPA personnel
5 SR, NPA and DoH personnel
6 Department of Social Development (2016)

the NGOs based in that province. Because the size of the subsidy is at the discretion of the province, rather than standardised through national policy, there is considerable variation in the amounts paid to organisations both within the same province, as well as in different provinces. In virtually all cases, the subsidies are inadequate to meeting the full cost of the service and have not kept pace with inflation.

Subsidies are of three types:

1. Post subsidies cover part of the costs of a particular category of worker and vary significantly[7]
2. Programme subsidies partially fund the delivery of a service itself
3. Service delivery subsidies which are paid on in accordance with the number of beneficiaries the NGO delivers a service to.

In 2015, 13 of the 27 NGOs based in TCCs reported receiving subsidies from the DSD[8]. These were largely in the form of post subsidies but some organisations had also received service delivery subsidies (the Western Cape in particular). More than half of the SRs (12 of the 18) sampled for the evaluation noted that they were still receiving subsidies from DSD, however, it was not clear to what extent NGOs could continue to rely on DSD funding. PR funding allocated to SW and SAW salaries are also more generous than DSD subsidies. Should NGOs be made solely reliant on DSD subsidies following the withdrawal of the Global Fund grant, this could present difficulties in terms of NGO workers' labour rights[9].

What is likely to make the situation even more difficult in future is government's increasing emphasis on prevention over services. This prioritisation is already evident from the Department of Planning Monitoring and Evaluation's report on government's response to violence against women and children. This shows care and support to be the activity least-funded by government[10] – a bias likely to be further entrenched through the Integrated Programme of Action (IPoA) Addressing Violence Against Women and Children (2013–2018) developed by the Inter-Ministerial Committee on Violence chaired by DSD. While two of its objectives relate to the provision of services, the IPoA nonetheless notes the need 'to shift national programming approaches away from crisis response to prevention and early intervention'[11].

Looking to DSD to maintain NGO services in the TCCs is thus an option that comes with many hazards, which is perhaps implicit in this SR's comment:

"The Department of Social Development is not an option because they've got a lot of new tricks where it comes to funding so we apply to micro foundations and things like that and I think from our vision, this is a very supported service, it's a core activity, we can't stop this. We need to continue and we don't see ourselves withdrawing our service again because of funding from the TCC." Programme Manager

These difficulties notwithstanding, SRs did consider it important to lobby government through a united front in order to amplify the voices of individual SRs and TCCs.

"We can't hold government accountable to the [individual] TCCs. Basically, we as NGOs try to have a conciliating relationship with the government or just a favour to deliver the programme that is beneficial to them. That's very strange. So that's what the coalition of organisations in the gender-based violence are looking at, the strategic level, to see how you can influence the lawmakers." Director

Several SR Programme Managers or Directors spoke about the importance of having PRs assist in and support SR efforts to lobby policy and lawmakers at a national level for this kind of support (although one participant also felt that individual NGOs needed to do more on their own to contribute to this longer-term effort to lobby those with

7 In 2016/17 subsidies ranged between as little as R5 415/month in the North West Province, to as much as R14 536/month in the Western Cape. In the Eastern Cape social auxiliary workers received a post subsidy of R2 981 per month. This amount has not been increased since 2005 and is now below the March 2018 minimum monthly wage for farm and forestry workers – R3 169.19. In Gauteng the lowest subsidy in 2016/17 for an auxiliary social worker was R8 060 per month (Budlender, 2018).

8 Vetten (2015)

9 While the amounts organisations receive will generally be less, it is not lawful to alter employees' pay downwards.

10 KPMG (2016)

11 Department of Social Development (2014)

resources and decision-making power). Many SRs also pointed out that it was very difficult for them to put pressure on government since so many of them depended on government funding for their survival. Finally, one SR made the compelling point that the problems of sexual assault and HIV are well known within South Africa, but much less is known about the urgent lack of funding for critical services across the country to deal with these problems.

"To be honest, NGOs cannot do that. They can try but they need some higher institutions like...NACOSA and AFSA...if those bigger institutions start mobilising the government... it will end up complying to what we need, but for us who are at the local level, it becomes very difficult. And also amongst the NGOs we do not have common understanding when it comes to advocating issues because some of them would say once I raise my issues with government they no longer fund me, so it makes it difficult for us to speak with one voice at the end of the day...but if we make noise, the government will be left with no option but to support us." Director

Some participants felt that lobbying efforts needed to cover several departments given the multidisciplinary nature of the services offered at TCCs.

These recommendations point in the direction of thinking beyond the parameters of the current TCC model.

"We cannot say TCCs should be a sole responsibility of the Department of Health, because if we say that, then we are implying that the NPA services or the psycho-social services are not important, are not primary. We are implying that the primary important thing is for the patient to receive medical care. I do not believe that we should make it a sole responsibility of one department. It needs to be a collection of stakeholders coming together and say 'Okay me, I am coming to bring the service and here are the resources that I am bringing'." Doctor

Beyond TCCs: Broadening Approaches to Post-Rape Care

TCCs are not the only example of post-rape care in South Africa and at least two different models are evident in health facilities, with a possible third in progress. Medecins sans Frontieres (MSF), working with the provincial department of health, has established Kgomotso Centres in North West Province while the national Department of Health has designated 265 facilities to provide clinical forensic medicine services and PEP. Excluding the 55 TCCs in existence from this total, over 200 health facilities remain providing services whose capacity to do so is largely unknown. Seeking to understand this better, MSF interviewed 167 (or 63%) of these facilities telephonically – although without specifying how many of the facilities in their sample were TCCs. They found that 7% of the sample were entirely unable to address rape and would refer patients elsewhere. Thirty per cent of facilities did not have access to a social worker's services and less than half (46%) had a separate area or room whose use was dedicated to rape patients. In more than half of the sample, care was provided either from casualty or out-patient services generally. Of the 265 services, 86% were located in hospitals .

Because hospitals are not evenly distributed across districts and provinces, their accessibility is limited. In a key informant interview conducted as part of the evaluation, the head of clinical and forensic medicine in the national Department of Health thus reported planning to develop a model of rape care based at identified clinics linked to police and court structures. She did not see these as replacing the TCCs but as one way of making services more accessible to a greater number of rape complainants. Whilst she could foresee a role for NGOs in this model but thought it need to be worked out very clearly. As has already been noted, when multi-disciplinary models of response and intervention are established there is a need to be clear around lines of authority, as well as the roles of each party. When these are absent or vague this can contribute to conflict in facilities.

The Department of Health is, however, experiencing challenges of its own in relation to the provision of the health component of post-rape care. Indeed, in a key informant interview, a senior health official openly debated the prioritisation of sexual violence by the Department of Health, pointing to the budget and blurred lines of responsibility as evidence of neglect. At national level,

sexual violence can fall under Maternal, Child and Women's Health, as well as Clinical and Forensic Medicine, and HIV/AIDS. The budget for post-rape care and associated activities is limited and extracted from the budget allocated to PEP under the HIV/AIDS programme. Work on sexual violence also appears to have stalled. The Sexual Offences and Related Matters Amendment Act, which came into operation at the end of 2007, necessitated changes to existing health policy, protocols and management guidelines. A draft of the revised policy and management guidelines was completed by 2012, however, these have not been finalised due to disagreements over the section dealing with PEP. The management guidelines on PEP, both for occupational exposure, as well as rape, are only now in the process of being drafted and discussed.

Seeking to expand the reach and number of post-rape care services through health facilities is a complicated exercise. It does not expand the scope and ambit of this care but simply increases the number of sites offering such care. Important and necessary as this is, it does not solve the existing problem that post-rape care is being primarily driven by the objectives of the legal and health systems and only secondarily by those of psychosocial services. Consequently, the inclusion of psychosocial services in TCCs is chiefly justified in terms of how these serve the interests of law and health (i.e. do they improve complainants' testimony in court, or do they contribute to desired health outcomes?). It is precisely this habit of treating psychosocial services as a means to other ends, rather than a good in their own right, that guarantees the ongoing precarity of NGO services. Until and unless they are seen as core, psychosocial services will continue to be treated as add-on services always subject to the ongoing availability of funds. One way to address this is to develop a model of comprehensive post-rape care.

Post-Rape Care: A Comprehensive Approach

Offering comprehensive post-rape care should begin by identifying its various elements. These would likely include:

- **Health care** and treatment for injuries, sexually transmitted infections (including HIV) and preventing pregnancy (among other things)
- **Victim advocacy and support** during different aspects of the evidence-gathering and trial process
- **Psychological first aid** and other forms of crisis intervention
- **Short-term counselling** (including to family members also affected by the rape)
- **Longer-term therapeutic assistance**, including for substance abuse and more complex psychological difficulties; and
- **Psychiatric treatment** and intervention.

Once these components have been defined, it then becomes possible to identify where these are best located (i.e. police stations, health facilities or courts), when they should be offered in the process of coping with a rape (crisis, long-term integration), as well as the different modalities of service that may be required (i.e. individual or group counselling). This model would also need to be adjusted to meet the demands of rural, peri-urban and urban areas.

Recommendations

The following section presents recommendations which aim to assist in strengthening the programme via the improvement of the implementation quality of psychosocial services for the remainder of the grant period. Recommendations are organised according to broader evaluation questions and the sub-themes which were extracted from these questions. Recommendations are further organised according to:

1. Immediate actionable recommendations aimed at PRs
2. Longer-term recommendations aimed at stakeholders within the GBV sector

Immediate Actionable Recommendations for PRs

1. Increase Community Awareness of TCC Service Provision

Considering that the majority of survivors reported being unaware of the existence of the TCC and the services that were accessible at the Centre, it is imperative that additional attention is dedicated to awareness raising for TCC services in communities. Whilst SRs are not mandated to undertake awareness raising as part of their current scope of work, as there was limited funding for the TCC component, some SRs manage to do this as part of their work in the TCC as well as via broader activities in the community. According to the TCC blueprint, however, Site Coordinators are mandated to coordinate and participate in public awareness and education interventions (on a quarterly basis at a minimum).

The majority of survivors reported being unaware of the existence of the TCC and the services that were accessible at the Centre.

Collaboration and Partnership

Within the remaining time of the grant, it is important that feasible and easily implementable solutions are devised in response to these challenges. It is, therefore, recommended that in addition to the continuation of internally-driven awareness raising activities within their organisations, SRs also focus on:

- Collaborating with NPA Site Coordinators to further drive campaigning and educational activities in broader communities surrounding TCCs[1].
- The formation of strategic partnerships with:
  - Other CBOs, or with community leaders who would be able to facilitate buy-in in these communities
  - GBV and gender-justice focused organisations as well as LGBTI and sex worker focused organisations, especially those funded by the Global Fund, who may have particular programmes with, or access to, key and vulnerable population groups
  - Local schools to target children.

Information Leaflets and Community Dialogues

The provision of information on TCC and TCC services could be actioned through:

- The development of flyers, posters, or leaflets for distribution in local communities. This could be done via organised awareness raising campaigns or via home visits already undertaken as part of service provision by SRs.
- NPA-facilitated community dialogues in which community members are educated on SGBV issues and prevalent misconceptions of TCC services are addressed and dispelled.

Targeted Populations

In their efforts to raise awareness about the services provided at TCCs, SRs should pay particular attention to the following groups based on their frequency of reporting to TCCs:

- Children and caregivers
  - Male children between 5 and 17 years of age
  - Disabled children
- AGYW
- Disabled adult survivors

1 PRs could play an oversight role in this regard to ensure that these actions have been implemented and may be required to facilitate should SRs experience any difficulties.

- Female survivors between 24 and 29 years of age
- Key populations
  - LGBTI persons and sex workers

Children

When targeting children, it is important that SRs ensure children are:

- Informed about how GBV manifests to enable them to self-identify if they have been assaulted.[2]
- Empowered with knowledge and information on where and how to access TCCs so they can seek help without relying on a caregiver to identify the assault and report it.[3]

Key Populations

When targeting key populations, it is important that SRs ensure these individuals:

- Are informed that TCCs are key population-friendly and that TCC staff are sensitive to the needs of key populations.
- Do not need to fear facing discrimination or prejudice.
- Do not need to go through SAPS to access TCCs.[4]

2. 24-Hour Service Provision

24-hour service provision will result in better outcomes on a number of programmatic levels including timely psychosocial support and PEP initiation. Gaps in the provision of a 24-hour services were still evident with some SRs unable to implement services due to external constraints placed on them by DoH. The evaluation recommends that PRs and SRs devise plans to lobby TCC stakeholders to advocate for 24-hour functioning at TCCs. This could be done through the use of monitoring data to advocate for potential of improved PEP outcomes (i.e. comparing TCCs where there is a 24-hour service offered vs those in which it is not in terms of PEP initiation and adherence rates).

PRs and SRs could demonstrate the importance the provision of psychosocial support has on NPA and DoH outcomes and that a 24-hour service can work to assist to strengthen the work of these stakeholders. Further recommendations include:

- Encouraging SRs who have the capacity but are not already doing so to run a 24-hour crisis call line for survivors needing to be attended to after hours, or on weekends. In this model, stand-by first responders or SWs can contacted to provide further for survivors as and when needed.
- The referral of survivors by SRs to other post-rape care facilities that are not TCCs but are operational 24-hours. Examples of these could include trauma centres or clinics as well as one of the 265 facilities established by DoH identified above which provide clinical forensic medicine services and PEP.

24-hour service provision will result in better outcomes on a number of programmatic levels including timely psychosocial support and PEP initiation.

3. Long-Term Psychosocial Support

A number of weaknesses arose regarding follow-up constraints due to transport costs for survivors and incorrect contact details provided by survivors. Many of these issues have been identified in numerous other pieces of research[5] and evaluation[6] and some innovations in addressing these challenges were highlighted in the findings of this report[7]. On this basis, the following recommendations are made:

- **Continuation and expansion of PR-SR engagements:** The evaluation understands that a considerable amount of work has already been undertaken by PRs in consultation with SRs around brainstorming and actioning solutions for these issues. It is, therefore, recommended that these kinds of engagements, via SR quarterly meetings and other PR consultative forums, continue and are expanded as they are a fruitful source for programme adoption and improvement.
- **Sustained long-term follow-up support:** The perceived continuity and frequency of follow-up psychosocial support provided by SRs was seen as an area for improvement. In instances of sexual

2 Given that many perpetrators groom children to believe these practices are 'normal' and should be kept a secret.
3 Particularly in instances where the caregiver is neglectful, or the perpetrator is a family member, or partner of a caregiver.
4 SAPS may be a significant hindrance for sex workers, who may be detained for illegal sex work in the process of reporting their assault.
5 Vetten (2015); Shukumisa (2017)
6 FPD (2016); USAID (2016)
7 Agreements with local taxi marshals, for example.

assault, the effects of secondary trauma may still occur even after initial trauma is contained and managed on a survivor's first few visits to the TCC. As such, sustained long-term support and follow-up is imperative at 3- and 6-months after initial TCC visits.

- **Follow-up on referrals**: Although many, if not all TCCs referred patients to other service providers for various reasons (e.g. closer to home, required specialty such as children or disabilities), it appeared that not all TCCs necessarily made follow-ups to ensure that survivors went to those appointments. In instances where SRs are not conducting follow-ups on referrals, it is recommended that this aspect of programme implementation is attended to and strengthened. Follow-up should be undertaken not only with the survivor, but the service provider as well. It is necessary that survivors are continuously followed-up, especially in terms of PEP treatment and adherence, even outside the TCC setting, so that they do not become lost in the system[1].
- **Support groups:** In response to dissatisfaction expressed by survivors, it is recommended that SRs work toward ensuring that the same person (usually a SW) is available for the running and facilitation of regular and ongoing support groups. Changes in facilitators make it difficult for survivors to develop rapport with counsellors and may impede the progression of therapeutic practices as new facilitators may frequently need to re-orientate themselves to support group participants.

4. Support and Supervision

In line with SOPs recently developed by PRs, it is recommended that SRs devise a strategy for the implementation of further, more regular, structured debriefing and supervision for SAWs/FRs and SWs stationed at TCCs. Improved standardisation of support given to these personnel is recommended for both AFSA and NACOSA SRs. The evaluation suggests that this is implemented as follows:

- Availability of a supervisor[2] for debrief immediately, or as soon as possible[3], after a crisis or particularly difficult case
- At a minimum, weekly supervision in the first year of practice and fortnightly individual check-ins thereafter[4]
- Weekly group debriefing and supervision sessions.

PRs should ensure that particular attention is given to:

- The capacity and expertise of those given the responsibility of the provision of support and supervision, both for SAWs/FRs and SWs
- Ensuring good emotional wellbeing of SR staff
- Practices to avoid burn-out of SR staff

The implementation of supervision and support for SWs and SAWs/FRs needs to be more stringent, and systems should be set up for the monitoring of support and supervision activities. This is further addressed in the recording and reporting section (see page 87 below).

1 These recommendations are in line with those made in the recent DREAMS Rapid Assessments undertaken by FPD in 2017.
2 This could take the form of the SR TCC Social Worker or an external psychologist or Social Worker
3 An 'on-call' system could be used here
4 These could be short 15-30 minute sessions with the TCC SW or and external SW or psychologist

Photo courtesy of the Rape Crisis Cape Town Trust

5. Training

Evaluation findings revealed a number of areas in which further training is required:

- **Support and supervision:** It is recommended that social workers are provided with additional and specific training on how to support and manage first responders in a health-based psychosocial context.
- **Capacity building for newly qualified SAWs**: Owing to the inexperience highlighted with some recently qualified SAWs, it is recommended that SRs make provision for training, induction and mentorship of these personnel. This should be aimed at building their capacity to ensure they are able to manage cases within the often difficult environments within which they work. Further capacity development if such SR staff is required in two forms:
  - First responder training offered by PRs over a one week period based on the NACOSA Guidelines and SOP; and
  - An induction and mentorship process lead by SRs for their particular context.
- **Further training on HTS, TB, HIV awareness and knowledge:** including refresher training for more experienced staff.
- **Sensitation training on key populations:** LGBTI and sex worker sensitisation is a recommended area for further training to improve the quality of services rendered to these survivor groups. This training should be coupled with an assessment of how SRs actually implement what they have learnt in the TCC setting to ensure that the training is translated into practice. Given that the Global Fund funds other programmes with key populations, it is recommended that SRs of the TCC programme collaborate with the SRs of key population programmes who may assist in:
  - The mapping of sex work hotspots which are in close proximity to TCCs in which SRs render services. This could assist to identify TCCs that require urgent sensitisation.
  - The design of sensitivity training for TCC SRs, but also in outreach initiatives, awareness raising and information sharing regarding TCC services[5]. SRs likely already interact with one another on mutual platforms such as the provincial coordination meetings as part of the Community Systems Strengthening (CSS) programme which is funded by the Global Fund. Collaborations should be geographically dependent, and, therefore links would either need to be on a national or provincial scale.
- **Working with child survivors:** Although some SRs specialise in working with children, many SRs do not have specialised skills in regard to working with this population group. Given that child survivors form the largest client population seen by SRs at TCCs, it is essential that those SRs without specialised knowledge in this domain are provided with training to deal with child survivors at least in the short-term. This will ensure that containment is appropriate and that children receive quality psychosocial support before being referred to specialised service providers.
- **Working with survivors with disabilities:** Whilst there is a need for more training for SR staff in working with survivors who have disabilities, the evaluation notes that the lack of training in this area is not unique to SRs in the TCC context as this challenge is experienced across the sector including in other GBV NGOs/CBOs, hospitals and clinics, and sexual offences courts.

6. Recording and Reporting

Whilst SR and PR recording and reporting systems were generally found to be robust, a number of gaps in these systems emerged which could assist in providing a more detailed picture on the quality of services implemented. Gaps emerged particularly in relation to some programme activities not directly related to health outcomes. To address these gaps, the evaluation recommends:

- **Collection of information on SAW/SW qualifications:** It is recommended that PRs implement a system whereby the qualifications obtained by SAWs are consistently tracked and monitored. Not only will this assist in ensuring that SRs are compliant with grant requirements, data on qualifications obtained may be correlated with service quality, and may also be useful data for SRs in potential future funding negotiations the DSD.
- **Skills audit:** Further to this, it is recommended that PRs undertake an audit to ascertain the current landscape across SRs with regard to the number of qualified SAWs/SWs in order to determine what can be done before the end of the grant. Within this audit, data should be collected on the number of SR personnel with HTS training as well as which SRs are conducting HTS at TCCs. Whilst this was conducted by NACOSA at the beginning of the grant, a follow-up audit will provide an updated picture of the landscape and further training opportunities could be better identified through this practice.
- **Collection of information on support and supervision:** It is recommended that PRs implement a system whereby SRs track information relating to the support and supervision provided to SAWs/FRs and SWs. This should include the type of supervision

5 Given that key population SRs have access to these communities and can help promote the services offered at TCCs to them.

undertaken, the frequency at which it is provided, and the person responsible for its provision. Considering the bearing adequate support and supervision has on the ability of personnel to provide a quality service, it is important that SRs and PRs have a quantified indication of the provision of this support. This will assist SRs and PRs in understanding how the implementation of support and supervision are occurring at each TCC, how this affects service provision, and will provide them with an opportunity to intervene, should this be seen as insufficient.

- **Collection of information on clients with disabilities:** Given that SRs frequently reported to have seen individuals with disabilities, particularly children, it is necessary that the programme monitoring system track clients with disabilities. This is necessary to understand the compounded vulnerability that some already vulnerable populations may face should they also have a disability, and how this may affect SRs' abilities to provide services to them and undertake awareness raising among this group, especially given that evaluation participants expressed difficulty providing services to this group.
- **Collection of information on telephonic and home visit follow-up practices:** The collection of quantitative monitoring data on these practices will enable SRs and PRs to undertake analyses on data to assess adherence effectiveness rates for these different models of follow-up support. Such data could also be retrospectively applied to SRs[1] before grant closure to provide an indication of these trends. Factors that either facilitate[2] or hinder[3] these types of support models could also be tracked to illustrate important considerations in each model. Should trends in the effectiveness of the telephonic or home visit model appear, these practices could be expanded or replicated by other SRs.
- **Collection of information on SRs running support groups:** The collection of quantitative monitoring data on the number of SRs implementing support groups[4] will allow PRs to gain further understanding of longer-term reach of the programme as well as the impact of this on other programme outcomes such as PEP adherence and SRH outcomes, for example.
- **Collection of information on PEP dispensing methods:** Quantitative data on which the different PEP dispensing methods used by TCCs (i.e. initial 3 day starter pack or full medication course) should be collected. This data could then be correlated with adherence and completion outcomes to ascertain which dispensing model works best for adherence outcomes in different contexts.

Clients must give informed consent for information to be shared with other service providers when being treated by a multi-disciplinary team.

A major challenge in the collection of client information centred on issues in accessing DoH-related health information. This is a sensitive matter as whilst the NPA advocates for use of shared files and the sharing of information at TCCs, the DoH has a differing perspective in relation to concerns around patient confidentiality. Good practice in this area should be that clients/patients must give informed consent for information to be shared with other service providers when being treated by a multi-disciplinary team. On this basis, should clients/patients provide informed consent for the sharing of their information, issues raised by DoH around patient confidentiality should, in theory, fall away and all information should be shared between service providers in the said multi-disciplinary team.

However, issues with collaboration within the TCC space are abound and since DoH HCPs do not necessarily require the psychosocial information recorded by SRs in client files, this places SRs in a reduced position of power. In order to address this challenge, it is essential that the roles and mandates of TCC partners are clarified with DoH so that HCPs have an improved understanding of why it is important for SRs to have access to this information. In this instance, and in line with recommendations below on the use of data

1 In other words, PRs could retrospectively provide rough estimates on the numbers of SRs undertaking either telephonic or home visits or both.
2 Proximity of client homes, for instance
3 Threats to safety of SR personnel, for instance.
4 This should include information on frequency, content, number of participants, and the type of facilitator

for lobbying and advocacy, it is suggested that both PRs and SRs make use of PEP adherence and completion data to illustrate why integrated care promotes health outcomes.

Despite efforts to ensure survivors sign letters of informed consent, in instances where no clear relationship can be established with DoH around the sharing of client/patient information, an alternative solution to this may be to request that survivors sign a form at intake which notes their informed consent to be contacted by the SAW/FR or SW regarding information related to HIV testing and PEP initiation. This will ensure the best interests of the survivor are upheld as they can provide voluntary consent to share this information with SR personnel As highlighted in the evaluation findings, it may, however, be difficult to verify the accuracy of this self-reported information provided telephonically by survivors.

7. Collaboration with TCC Partners and Stakeholders

It is recommended that the role of NGOs, and specifically the respective roles of SWs and SAWs/FRs be illustrated for DoH staff at all TCC sites. Clarifying these roles and mitigating tensions between NGOs, DoH and also the NPA may potentially be addressed in the following ways:

- **Developing provincial and district level MOUs[5] with DoH and NPA to clarify roles and responsibilities among all stakeholders[6]**. This should, preferably, be undertaken at the beginning of a proposed grant phase and the potential for longer implementation period should be considered as part of such a grant should future grants of this nature be enacted. Given that the TCC is an intersectoral environment and requires that all stakeholders work collaboratively to achieve quality service for survivors, it is important that DoH and NPA understand the scope of work of NGO staff before this collaboration begins so that their work can be properly integrated into the TCC system.
- **Meetings with these government departments** both on a provincial and site basis to strengthen partnerships, improve communication structures and increase information sharing.
    - Sharing information would also allow for government stakeholders to have a better understanding of what NGOs do and have achieved, which could be used for purposes of lobbying for more funds at parliament or with other donors.
    - This could be actioned by SR Directors and Programme Managers who, according to the NACOSA SOP, should play an important role in building strong working relationships with the NPA, DoH and other stakeholders to ensure that the NGO TCC programme is clearly articulated and well integrated into the existing structure, processes, and procedures at the TCC.

8. PEP Adherence and Follow-Up

Based on evaluation findings, the following recommendations are provided:

- **Strengthening facilitating factors for PEP adherence and completion**: Where these factors are within the control of SRs, these should be enhanced and implemented across SRs. Chief facilitators included:
    - Supporting the psychological well-being of clients throughout the 28-day treatment via techniques relating to motivation, treatment with care, and encouraging a sense of empowerment.
    - The inclusion of families in the PEP adherence support process to ensure that they understand what the PEP side effects are, and how they can support the survivor through the 28-day medication course. SRs should play a significant role for those who do not identify a social support system.
    - A further suggestion is to implement and facilitate support groups with other survivors that not only deal with their trauma, but also with managing PEP side effects. Connecting survivors would help to build their support system, and may prove to be effective given that they are experiencing the same difficulties

5 This recommendation is consistent with the recommendations provided in FPD's 2016 TCC Compliance Audit
6 It is noted that whilst PRs have secured MOUs at provincial level with the DoH, challenges have been experienced in the establishment of MOUs with the NPA.

and may live in nearby areas to offer each other more practical support as well.

  - Appointment of an SAW/FR as a dedicated PEP adherence officer based at SR officer who is solely responsible for telephonic follow-ups with clients. It is recommended that this position is implemented only by SRs working in TCCs with large catchment areas which inhibit them from undertaking home visits for the majority of clients.

- **Strengthen the mechanism for verifying PEP completion:** The methods through which PEP completion is currently assessed (i.e. self-report) need to be strengthened as this information often cannot be verified for accuracy. Should the above recommendation of increasing the involvement of families or other PEP supporters be implemented, SRs could attempt to triangulate perspectives on PEP completion with these supporters to verify the accuracy of survivors self-reports. It is understood that from the beginning of Year 3 of the grant, SRs began tracking the reasons why SAWs/FRs or SWs were unable to follow-up on clients' PEP adherence. Understanding factors that inhibited PEP follow-up may contribute to the strengthening of the mechanism for verification of PEP completion.
- **Provision of more comprehensive forms of support to clients on PEP.** This support is two-fold:
  - This support should ensure that further information and education is provided to survivors to ensure they have thorough knowledge and understanding of the drug regimen. Of particular importance is ensuring survivors have the ability to identify of side effects of the medication and possess the knowledge of how to access treatment for these
  - This support should integrate PEP treatment issues with issues of HIV more generally, as well as other sexual and reproductive health issues like gender-based violence and termination of pregnancy.

A great deal has been learned through the Global Fund grant about the provision of psychosocial services in the context of health facilities.

9. Sustainability

At the time of report finalisation, eight and a half months will remain of the Global Fund ZAF-C GBV grant. Given this time frame, it may be most strategic to focus on the continued life of NGOs' TCC services, rather than further developing services that may well be dismantled in the coming months. These recommendations focus on the narrow goal of sustaining existing NGO services in the TCCs:

- For shorter-term advocacy efforts, PRs and SRs should lobby the Global Fund Request for Funding to continue to support the funding of TCCs.
- The care work project housed by the Shukumisa Coalition has developed a strategy with partner organisations that seeks to influence how this money is allocated, which includes a focus on post-rape services. PRs should ensure continued involvement[1] in the project in order to provide support for this strategy.
- PRs should track the release of the Victim Empowerment Bill for comment. In theory, this Bill, once enacted, ought to institute a legislated commitment to the funding of services. As it has not yet been circulated for public comment it is not possible to comment on whether it actually does so. Every effort should be made to ensure that this Bill does indeed allow for the effective funding of post-rape care, as an aspect of victim empowerment.
- PRs should engage with the national Department of Health's proposals to expand health services to rape patients at clinic level. Even though unlikely to be able to financially support these services, a great deal has been learned through the Global Fund grant about the provision of psychosocial services in the context of health facilities. It is important that this knowledge be shared before grant close-out.
- Both this process, as well as making a case for the funding of psychosocial services, whether located at TCCs or other sites, would be considerably helped by the further analysis and sharing of PR considerable monitoring data. As a final recommendation in this section, PRs should consider establishing

1 AFSA provide funding to the Shukumisa Coalition through the Global Fund grant and both AFSA and NACOSA are members of the Coalition.

partnerships with research organisations in order to encourage the analysis of data to further understand the impact and use of the grant[2]. This could be used to show the value of NGO psychosocial services at TCCs to Treasury and would also benefit advocacy at provincial level around how the VAWC additions to the Provincial Equitable Share (PES) are allocated (see page 93 below for further detail on this).

10. Further Research and Evaluation

SRs and PRs are encouraged to make further use of monitoring data collected to demonstrate the impact and accountability of TCC services via statistical analysis. Suggested monitoring data for use in analyses includes:

- 24-hour service provision
- Short-term psychosocial support: containment and counselling
- Long-term psychosocial support
- HR issues: Including qualifications, training and support/supervision
- PEP adherence and completion rates

The effects of all of these factors could be assessed in relation to various programme outcomes. Examples of this may include questions such as:

- Do TCCs that offer a 24-hour service have better PEP initiation and adherence rates compared to those that do not?
- Do survivors who receive short- and long-term psychosocial support demonstrate better PEP adherence and completion?
- Do survivors who receive home visits as opposed to telephonic follow-up support demonstrate better PEP adherence and completion?
- Do personnel with qualifications deliver better quality psychosocial services than long-standing lay counsellors?

These analyses could be undertaken internally or PRs could additionally commission analyses and write-ups of data from external service providers. This could be done by leveraging research and training relationships with local universities as a further source of evidence, support and advice. This information could be used as a basis to argue for ongoing support to TCC services, to strengthen advocacy in the sector, for the development of comprehensive post-rape care, and ultimately to improve the confidence funders have in the TCC programme.

Longer-Term Recommendations for GBV Stakeholders

1. 24-Hour Service Provision

It is understood that the provision of a 24-hour service is largely outside of the control of SRs with DoH shortages in forensic doctors and nurse impeding SRs' ability to be present at health facilities after hours. Participants from a number of TCC partner departments (HCPs specifically) mentioned the need for increased staff numbers to run a 24-hour service. Whilst this is not something that is within the control of SRs or the Global Fund grant, it is important to note that this is likely to have an impact on the service provision and the outcomes of SRs and survivors. Since the provision of a quality 24-hour service requires strong support and commitment from hospital staff, it is recommended that SRs devise methods to garner or advocate for this support within the TCC system.

2. Long-Term Psychosocial Support

Weaknesses regarding follow-up constraints due to transport costs for survivors may be addressed via rallying provincial Departments of Social Development and Community Safety (or equivalent) to cover the transport costs of survivors as part of the VEP.

Participants from a number of TCC partner departments (HCPs specifically) mentioned the need for increased staff numbers to run a 24-hour service.

3. Collaboration with TCC Partners and Stakeholders

Further action for mitigating tensions between NGOs, DoH and also the NPA may be addressed in the following ways:

- **Revision of the TCC Blueprint.** Since the Blueprint lacks guidance on many key factors in relation to the work of NGOs at TCCs, SRs should lobby the NPA to update the TCC blueprint in order to minimise implementation gaps, ensure intersectoral coordination and

2 Qualitative findings of this evaluation clearly demonstrate the value of the services provided by NGOs at TCCs. Not only do NGOs fill critical gaps in NPA and DoH services, they are also reported to assist in reducing secondary victimisation at TCCs. Since this is a key aim of the TCC model, it remains an important argument in ensuring the sustainability of NGO services at TCCs.

ultimately standardise the care provided to survivors. The revised protocol could be developed from NACOSA Guidelines, DoH guidelines, and DSD guidelines in order to guide stakeholders and assist with better service delivery. All TCC stakeholders should be involved in the development of the revised blueprint and should all receive training on its implementation thereafter.

- **Cultivating systemic thinking.** There is no single main figure in terms of accountability in the TCC model. The rendering of quality services hinges on all stakeholders collectively to make the system work. As such, a systemic thinking approach needs to be cultivated in terms of understanding the TCC. NGOs should lobby other governmental stakeholders to adopt this lens in order to produce a more functional operating environment for all TCC personnel. This could potentially be done on a platform like the quarterly national implementation meetings, where DoH and NPA personnel could also participate. PRs could use this as an opportunity to challenge TCC stakeholders and SRs to ensure that this happens and could use it as a way to leave some legacy in the system from the Global Fund grant.

4. Sustainability

The following recommendations provide actions for setting in motion the larger, longer-term goal of developing comprehensive approaches to post-rape care, implemented at a wider variety, and greater number of sites:

- As part of longer-term plans, one potential source of DSD funding that could be the immediate focus of advocacy is the additional R788 million allocated by Treasury towards the prevention and mitigation of violence against women and children over the next three-year medium-term expenditure framework (MTEF). This funding comes as part of the provincial equitable share (PES) which is distributed to provinces according to a formula (based on population and other factors). While Treasury recommended that fifty percent of these funds be allocated towards the Isibindi programme, equitable share funds are not ring-fenced – although it is expected that provinces will use any additional funds allocated in this way for the purpose it was motivated for and agreed to by all the provinces. However, the decision on how to allocate and spend these funds is taken at provincial level, in accordance with based on provincial priorities. The increased funding for VAWC is a permanent addition to provincial budgets and not an amount given for the three years specified in the MTEF alone. The MTEF is often misunderstood, even by departments[1]. These "additions" become part of the equitable share base amount in the following MTEF period, (i.e. this increased funding for VAWC becomes embedded in the amounts allocated to provinces[2] for all future funding years). This could ensure NGOs' TCC-based services.
- Comprehensive post-rape care need not only be provided from the TCCs and GBV stakeholders could initiate processes that seek to develop what such a model might look like in terms of the points made in the concluding part of the section on sustainability.

5. Further Research and Evaluation

Further research and evaluation can be undertaken by other stakeholders within the GBV sector via the following recommended activities:

- **Further research and evaluation on key populations and TCCs:** Although research exists in relation to key populations' perceptions of healthcare settings in general, future research or evaluation of the TCC system should attempt to include the perspectives of key populations in order to gain their perspective of the treatment received at TCCs. This would provide a clearer picture on whether TCC staff are as sensitive and accommodating of key populations as they reported themselves to be. While this group can be challenging to access, partnerships with other identified organisation suggested in previous sections may assist with this.
- **Further research on lack of awareness of TCCs:** This is required to understand why survivors generally lack knowledge of TCCs and the services they provide prior to accessing the facility. Despite 15 of the 18 sampled NGOs reportedly conducting some form of awareness raising in communities surrounding TCCs, the impact of these activities remains unclear. A randomised controlled trial impact evaluation undertaken by USAID on the "Increasing Services for Survivors of Sexual Assault in South Africa" program found community dialogues and service provider training to have no impact on TCC utilisation . The impact evaluation also found that community dialogues had no impact on broader community knowledge or attitudes on sexual assault, SGBV issues, and TCC services. This points to the fact that these kinds of activities may not be the most effective ways of addressing community attitudes on SGBV

1 It means that there is an additional R201m available in 2018/19, then an additional R85m in 2019/20 (i.e. the previous R201m plus an additional R85m to make R286m total addition) then an additional R15m in the third year (R201m plus R85m plus R15m makes R301m).
2 Considering the high level of political support required at a provincial level, it is important that the Office of the Premier is engaged across provinces in order to prioritise this as a key intervention for funding and implementation.

or increasing knowledge of TCC services. As such, further research is required to better understand the factors affecting the dissemination of information via campaigns aimed at changing attitudes and increasing knowledge within communities.

Photo courtesy of the Rape Crisis Cape Town Trust

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"I go just for support if you see the victim there, I am taken as a family member even if I go home to ask them to support them and they don't seem to want to help so when she sees me at the court she takes me as the aunt or sister or some family member they take me like that."

Social Auxiliary Worker

Notes

Networking HIV & AIDS Community of Southern Africa NPC
3rd Floor, East Tower | Century Boulevard | Century City | 7441
PO Box 33 | Century City | Cape Town | 7446
t. 021 552 0804 | f. 021 552 7742 | e. info@nacosa.org.za
NPO 190-030 | PBO 930056308 | NPC 2015/448924/08
Health & Welfare SETA Accredited HW591PA128468 | Level 1 B-BBEE Entity | VAT 4730273234

Nacosa.org.za