SEXUAL OFFENCES AND COMMUNITY AFFAIRS UNIT OF THE NATIONAL PROSECUTING AUTHORITY OF SOUTH AFRICA

REPORT ON THE

FEASIBILITY AND LOCATION OF A

THUTHUZELA CARE CENTRE

FOR MAMELODI

(Phase 1 of the National Audit)

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EXECUTIVE SUMMARY

This is a feasibility study that was conducted over a period of 3 weeks to establish what the rape incidence in Mamelodi and surrounding areas are. Once this data was obtained recommendations were to be made on the appropriate location of a Thuthuzela Care Centre (TCC), if the collected data proves such a need.

In order to do this a standardised audit tool was designed for data collection purposes. 5 Health care facilities, 8 police stations and 4 courts were audited. The health care facilities were identified as the current sites being accessed by police for the completion of medical examination and evidence collection in sexual offences matters. The police stations were identified as stations in close proximity to Mamelodi hospital and / or stations that previously accessed the Mamelodi TCC. The courts were identified as courts to which the police stations fed into.

The audit revealed that the Tshwane Crisis Centre (TsCC) was ideally equipped, capacitated and conducive to the victims needs. This site is however only operational during working hours and does not have sufficient staff to provide a 24 hour service. The other health care facilities encountered several problems *inter alia* lack of or insufficient forensic nurses, doctors dedicated to do sexual assault examinations and referral mechanisms for psycho- social services. It was further established that Mamelodi hospital currently sees no victims of sexual abuse as all these cases have been re-directed towards the other sites.

There is a disparity and inconsistency as well as an unaligned data collection system. The data collection systems in place serves only the needs of the respective role players and do not give a holistic picture of victim management and case tracking of the victims inception into the criminal justice system and beyond. In fact the data reveals that there are no mechanisms to support the victim after the cases have been finalised.

Considering the data revealed that only 3% of all cases reported on average amounts in a conviction, it is of grave concern that these victims are not supported throughout the system.

In proportion to the rape statistics for the area it is recommended that the site be established in Mamelodi, but this cannot succeed with infrastructural and capacity enhancements. It is noteworthy that there is currently a new hospital that has been built for Mamelodi. Occupation should take effect as from October 2008. A further recommendation is made that the MTCC be housed in this facility.

The report is structured as follows:

Part 1: The Introduction to the report sets out the history to the Thuthuzela Care Centre project, whilst the Background discusses the establishment of the Mamelodi TCC and explains the process which led to the culmination of this report.

Part 2: Research. This section succinctly looks at available research which has been conducted on sexual abuse, secondary victimisation and studies and or reports conducted / drafted regarding TCC's in South Africa. It briefly highlights certain developed indicators and or recommendations made to measure and maintain optimal performance of TCC's in general. It furthermore looks at Mamelodi itself, the population, the incidence of abuse and the available facilities. Moreover it evaluates national, provincial and local statistics provided by the South African Police Services as per the 2006 / 2007 Annual Report.

Part 3: This is a collation of the actual findings of the audit conducted. It furthermore discusses the status quo in light of the recommendations and or indicators that have been identified in Part 2 as a performance measure and evaluates the statistical data collected.

Part 4: Outcomes and recommendations.

Abbreviations used

FCS	Family Violence, Child Abuse, Sexual Offences unit of the South African Police Service
GCIS	Government Communications and Information Systems
HCF	Health Care Facility
IDMT	Inter Departmental Management Team
LC	Laudium Clinic
MTCC	Mamelodi Thuthuzela Care Centre
NPA	National Prosecuting Authority
PEP	Post Exposure Prophylaxis
PT	Pregnancy Testing
SAPS	South African Police Services
SB	Stanza Bopape Clinic
SC	Soshanguve Clinic
SOCA	Sexual Offences and Community Affairs
STI	Sexually Transmitted Infections
TCC	Thuthuzela Care Centre
TOP	Termination of Pregnancy
TsCC	Tshwane Crisis Centre (Pretoria Academic)

1. INTRODUCTION

In 2000 Cabinet instructed the Heads of the Departments of Health and Social Development to develop the Anti Rape strategy as a response to the alarming rape statistics. In 2002 this process was transferred to the Department of Justice and Constitutional Development when the IDMT was established. This is a national management team chaired by the SOCA Unit. The IDMT comprises of representatives of the following national departments:

Department
1. Justice and Constitutional Development a. National Prosecuting Authority (Sexual Offences and Community Affairs Unit): Chairperson
2. Health
3. Social Development
4. Safety and Security
5. Correctional Services
6. Education
7. Treasury
8. GCIS

The initial work of the IDMT entailed a data driven yet action orientated approach (with the assistance from Monitor Group, a leading global strategy firm). A total of 166 interviews involving all IDMT departments were conducted and this included the involvement of line function departments at provincial and local levels.

The research into the development of the strategy found *inter alia* that in order to holistically address the scourge of rape a multi – disciplinary approach was required. The research proved that there was no silver bullet to address the rampant incline of sexual offences in South Africa. In essence not all offences were the same, nor all victims alike and each offender required a different approach to rehabilitation. This matrix for action accordingly viewed what is good, what is bad and what is missing which in turn informed the three pillars of Prevention, Support and Reaction to rape care management.

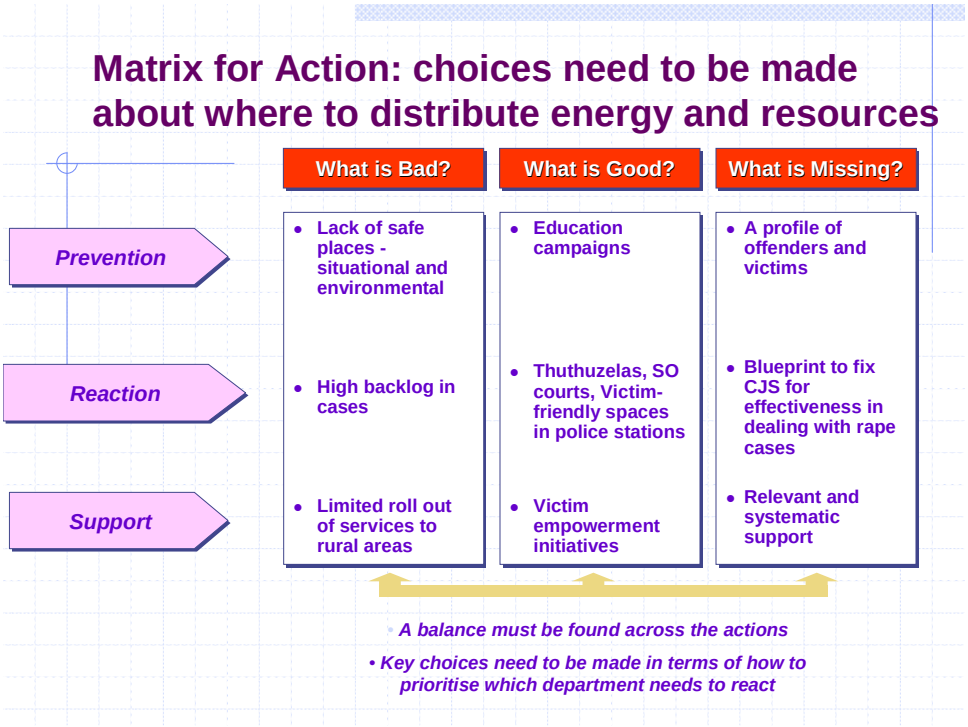


Figure 1

Matrix for Action

As one of the initiatives to address rape care management the IDMT developed the Thuthuzela ("*To Comfort*" in isiXhosa) Care Centre (TCC) model. The TCC model is accordingly a culmination of empirical research which places the victim at the forefront of service delivery. This victim centered approach not only allows for victim empowerment but journeys the victim through the criminal justice system, so transforming him or her from victim to survivor and ultimately a more empowered witness in the criminal process.

Hence the aim of the Project is two-fold:

- To improve the care and treatment of rape victims at *all* points in the criminal justice system hence reducing secondary victimisation; and
- To ensure speedy, effective investigation and prosecutions of rape cases, a reduction in cycle times and increase in conviction rates.

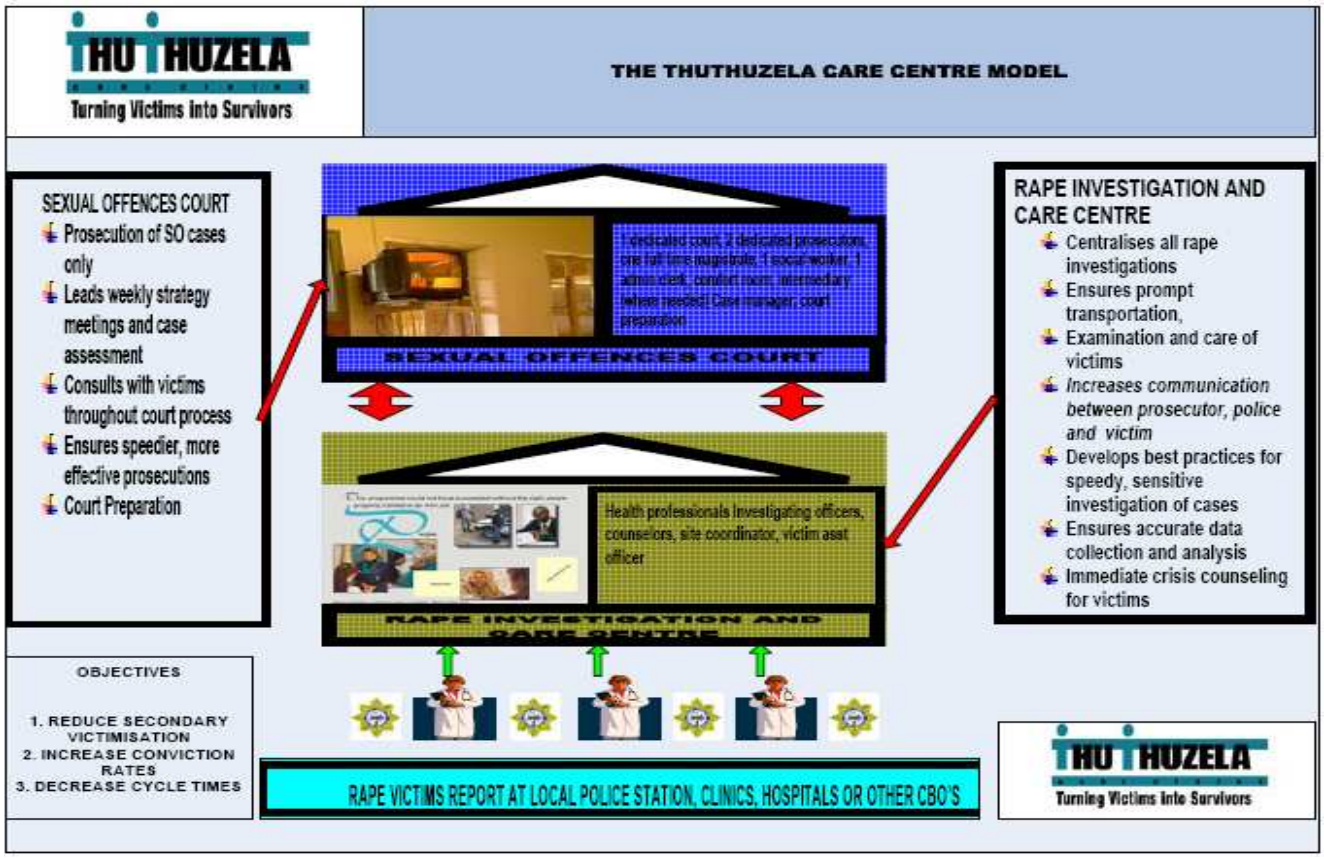


Figure 2

Thuthuzela Care Centre Model

There are currently 9 operational TCC's (Feasibility Study on the reopening and appropriate placement of Mamelodi addressed in this report).

Rural Areas
1. Mafikeng
2. Mdantsane
3. Libode
Urban Areas
4. Mannenburg
5. Baragwanath
6. Natalspruit
7. Kimberly
8. Umlazi
9. Phoenix

Sub - Projects to the TCC Project that have been undertaken:

a. The IDMT has commissioned research into the TCC's in relation to processes followed at the sites from a legal, psycho-social and health perspective and developed monitoring and evaluation tools for all role players within the model. These tools were developed by ECI Africa (PEP services) and Southern Hemisphere (all other services).
b. In an attempt to define and formalise roles and responsibilities the specific sites has developed a Protocol. These Protocols contain *inter alia* the Standard Operating Procedures for each site.
c. In order to address accountability operational plans were developed. These included *inter alia* activities for the year on three areas of Governance, Delivery and Resourcing.
d. To address uniformity the SOCA Unit has undertaken a mapping process which was informed by *inter alia* the Protocols.

Other projects undertaken by the IDMT

The development of the 365 Day National Action Plan to address violence against Women and Children. This is a comprehensive collaborative plan developed by various government departments and civil society organisations.

2. BACKGROUND

In 2002 an organisation known as the "Bulletin" approached the NPA indicating that they had funds available to assist in the establishment of a Thuthuzela Care Centre in the Mamelodi region. The reason for choosing the region was as a result of the high rape statistics in the area. At this point in time certain discussions ensued between the NPA and the hospital management. Subsequently the relationship between the Bulletin, NPA and hospital management were faced with challenges as no clear roles and responsibilities of the donor were identified, the Bulletin withdrew and Vodacom consequently funded the project. [1]

In 2002 a Site Coordinator, Ms Refiloe Bahula was appointed to assist in the running of the centre and to ensure that the centre was indeed set up in accordance with the Blue Print. It appears that the centre was set up based on a verbal agreement between the NPA and the hospital management at the time.

According to Gauteng Department of Health (GDOH) they have no recollection or records of any meetings that took place in relation to the establishment of the site between themselves and any other parties. They came to hear about the existence thereof in 2006 (at least two years after its inception). It is noteworthy that the Mamelodi Hospital was indeed a crisis centre at according to GDOH but not identified as one that follows the TCC model.[2]

It is furthermore essential to note that there may have been discussions between District and Regional health regarding the establishment of the MTCC, but no records have been found in this regard. However there has been a change of management at District, Region and Hospital levels. There has been no change of management at NPA however the Victim Assistant Officer / Site Coordinator is no longer in the employ of the NPA. She was instrumental in the set up, running and data collection for this audit. No verifiable evidence as to the agreement, reasons for establishment, and parties to the agreement could be obtained.

In May 2007 the Special Director of Public Prosecutions Adv Thoko Majokweni decided to relocate the site coordinator to Head Office as the centre was no longer operational. This occurred as a result of cases being redirected to other hospitals / clinics for sexual assault examinations and insufficient staff to resource the centre. Simultaneously Mamelodi saw an increase in number of rape statistics in the Mamelodi area.

[1] Adv P Smith and Ms P Mafani SOCA Unit
[2] Mr. Mohau Makhosane Gauteng Department of Health

It soon became evident that the Mamelodi centre was experiencing a myriad of challenges and an urgent meeting was convened in September 2007.

At this meeting a decision was taken to conduct a feasibility study in the Mamelodi area to address the following questions:

1. Is there a need for a TCC in Mamelodi?
2. If so where would the appropriate location of the site be?
3. What are the current best practices in the surrounding vicinity?
4. What challenges prohibit the success of a TCC in Mamelodi or elsewhere?
5. What is the best way forward?

In order to action this instruction a reference team was created to conduct such a feasibility study and draft recommendations.

This team comprised of the following:

Name	***Organisation***	***Rank***
To conduct audit at Health Facilities		
Adv Brandon Lawrence	NPA (SOCA) Unit	Senior State Advocate & Operational Manager MTCC
Sister Cindy Mosehana	Department of Health	Forensic Nurse: Coordinator Soshanguve Rape Crisis Centre
Const MS Mdluli	South African Police Services	
To conduct audit at Police Stations		
Ms Refiloe Bahula	NPA (SOCA) Unit	Site Coordinator MTCC
Mr. Sipho Mkonza	NPA (SOCA) Unit	Site Coordinator Natalspruit Thuthuzela Care Centre
Cpt S Mawila	South African Police Services	
To conduct audit at Courts		
Mrs. Sanette Jacobs	NPA (SOCA) Unit	Senior Public Prosecutor: Project Manger Monitoring and Evaluation

Dr J Du Toit	Mamelodi Hospital	Medical Doctor
To draft report		
Adv Brandon Lawrence	NPA (SOCA) Unit	Senior State Advocate & Operational Manager MTCC

The team was accordingly required to develop an audit tool to conduct the feasibility study, conduct the actual audit and make recommendations to answer the aforesaid questions.

3. RESEARCH

A national survey conducted by the Institute for Security Studies in 2002[3] found that a majority of services offered by various service providers addressed the response to victims of sexual abuse as an urgent matter. The surveyed 1000 women- from all nine provinces - key findings included the fact that victims who have been sexually abused felt angry, isolated, depressed, experienced feeling of self blame and guilt, and in certain instances, victims felt suicidal. It was accordingly found that there is an urgent need for psychological intervention for victims of sexual abuse.

On medical assistance the findings revealed *inter alia*:

1. Less than half the women surveyed (42%) sought medical help following the most serious incident of abuse.
2. There is often a delay between the time of the abuse and the time that women seek medical assistance: 20% of all survivors said they were examined within an hour, 46 within a few hours and 30% said they were examined within a week of the incident.
3. The lack of transport was the most common reason why women delayed seeking medical treatment.
4. In the vast majority of cases, the medical personnel did ask survivors who had abused them. Almost all the women provided truthful information about the identity of the abuser. This confirms that health care providers have an opportunity to identify and help abused women because of their ongoing contact with women. They can perform an important service simply by breaking the silence surrounding abuse and putting women in contact with individuals and groups better prepared to deal with their problems.

On psycho – social service the findings revealed *inter alia:*

1. Only 46% sought help of a psycho – social service provider after the most serious incident.
2. Women who were physically abused were less likely to access this service.
3. Social workers employed by the government were found to rely heavily on civil society sectors for counseling but rarely followed up on this referral.

On Police the key findings revealed *inter alia*:

1. Although most women believed that the worst incident of abuse was a crime only 46% reported the matter to the police. Only 39% of the sexual abuse cases perpetrated by relatives and less

[3] Violence Against Women, A National Survey, ISS, Rasool S *et al* Pretoria, 2002

than half (45%) of those perpetrated by spouses or partners were reported to the police. By comparison 69% of sexual abuse cases perpetrated by strangers and 70% perpetrated by friends or acquaintances were reported.

On legal services the study found that:

1. Of the cases that were reported only 13% said that their abusers had not been charged.
2. 8% asked for the charges to be dropped
3. 7% said the abusers had not been arrested
4. a 2% conviction rate ensued

A research paper[4] conducted on the TCC model in December 2006 evaluated services offered by the TCC model and made recommendations on the improvement and or sustainability of the model. These included *inter alia*:

1. Develop and implement minimum standards to assure that services are consistently and uniformly delivered.
2. Ensure that all TCC's operate 24 hours, weekends and on holidays.
3. Consistently take statements *after* victim has seen an intake counselor and undergone a medical examination.
4. Consistently record the same type and quality of information in each police report.
5. Ensure child friendliness at all TCC's
6. Provide psychological debriefing for all staff interacting with victims of sexual violence
7. Create and maintain a national database.
8. Ensure NGO participation in the model

For purposes of this report the current status quo will be discussed in light of these recommendations.

The South African Police Services Annual Report[5] identified contact crimes as amounting to 33.3% of all crimes committed in South Africa. These crimes include rape. The report indicates that contact crimes invariably result in death, bodily injuries of varying degrees and psychological trauma, which in many cases, is of a permanent nature. The report further indicated that 76% of rapes were social contact crimes (perpetrated by friends, acquaintances or relatives). For 2006/2007 the incidence of rape per 100 000 of the population was recorded as 111, a reduction from the 2005/2006 year (117.1). It is noteworthy that the report highlights poverty and unemployment as a major catalyst for social

[4] Sexual Offences Courts and the Thuthuzela Care Centre Model: Evaluating South Africa's Innovative Response to Sexual Assault, Abrams E, Harvard Law School, Dec 2007

[5] Annual Report of the South African Police Services 2006/2007

contact crimes. A context study done in lieu of a MAcrh degree at the University of Pretoria[6] revealed that alcohol is one of the major contributors to crimes such as rape in Mamelodi. Furthermore at least 40% of the Mamelodi population lives below the poverty line. The SAPS report states that

> "Such conditions [poverty] usually stimulate the development of a macho – man image. This manifests in a subculture in which the male is always right and dominant, the female is considered as a sex object and liquor and drugs provide an escape from the realities of life."

The report further states that a study in Mamelodi revealed a growing number of child families and found that child rape is closely associated with families that are child headed.

The Crime Information Analysis Centre of the South African Police Services conducted a docket analysis, which revealed the following:

Crime	% of perpetrators known to victim	% of perpetrators being relatives, friends or acquaintances to victim	% relatives as perpetrators
Rape	75,9	56,9	16,2

For the 2006/2007 year the SAPS annual report found that Gauteng was ranked as the province with the forth highest rape ratio per 100 000 persons (120.7) and first with "raw rape crime figures" (11 114).

Of the 116 top 40% (highest recorded rape figures) police precincts in the country, Mamelodi ranked 26th (6th highest in Gauteng) and Mamelodi East 75th (15th highest in Gauteng).

The crime statistics[7] released for Mamelodi and Mamelodi East[8] for the 2006/ 2007 are exorbitantly high.

Crime	**Mamelodi**		**Mamelodi West**	**Mamelodi East**	**Total**
	April 2004 to March 2005	April 2005 to March 2006	April 2006 to March 2007	October 2006 to March 2007	April 2006 to March 2007
Rape	396	347	213	150	**363**
Indecent	13	28	31	17	**48**

[6] GOLOFELO -"we are hoping" Rheeder A, March, Master's Dissertation 2004-11-30

[7] http://www.issafrica.org/cjm/stats0906/_pdf/provinces/gauteng/mamelodi.pdf

[8] Established October 2006

Assault					
Total Sexual Offences	**409**	**375**	244	167	
			Combined totals Mamelodi 2006 - 2007		**411**

In September 2006 ECI Africa was commissioned by the IDMT to conduct a national survey that tested compliance with the National Health Guidelines at the TCC's. The objectives of the ECI audit was follows:

- To assess the provision of post exposure prophylactic services with the National Guidelines
- To assess existing monitoring and evaluation systems and instruments for health care at Thuthuzela Care Centres
- To identify and review selected monitoring and evaluation tools currently available for provision of use for health/medical care
- To consult with key stakeholders to determine their needs with respect to monitoring and evaluation
- To modify existing processes and develop a set of recommendations for a cost-effective and sustainable monitoring and evaluation process for health care
- To develop monitoring and evaluation tools for use in all Thuthuzela Care Centres for health care

The study (See Annexure 1) revealed that MTCC was 20% compliant with the National Health Guidelines. On the provision of these services, the findings were reflected as follows:

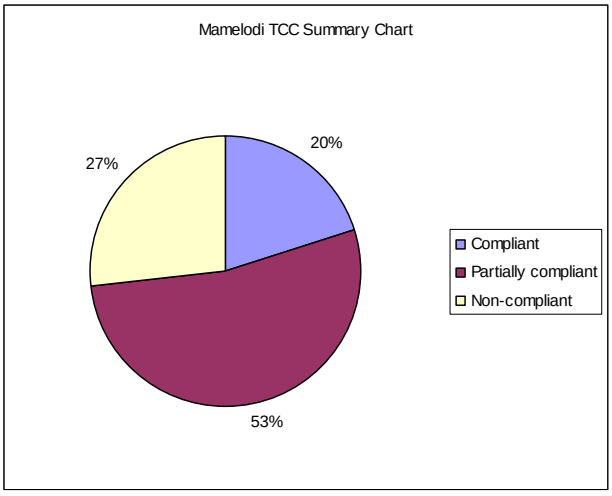


Figure 3

MTCC Compliance

In December 2006 the NPA mandated Southern Hemisphere, a consultancy, to assist with improving the monitoring and evaluation and reporting system for the TCC model. This monitoring and evaluation and reporting system would then ensure that the model is working as intended and that it was learning from implementation and achieving the desired results and outcomes. Accordingly they were required to develop performance indicators for various outcomes. For purposes of this report only certain indicators are listed below.

Goal	Outcome	Indicator
Turning victims into survivors	Reduce Secondary Victimisation	1. No and % or victims who withdraw
	Effective, Efficient, Expeditious Prosecutions	1. No and % of cases finalized with 6 months 2. Average cycle time 3. Average conviction rate 4. No of cases postponed per month 5. No of cases withdrawn per month 6. No of arrests effected within 48 hrs 7. No of Non Arrest Docket Forms converted to arrest dockets
	Comprehensive Multi – disciplinary Service	1. No of victims received at centre 2. 24 hour service 3. client record keeping 4. No and % tested for HIV 5. No and % received PEP etc
	Integrated referrals	1. No and % of victims referred for psycho social services 2. No and % of cases followed up

These indicators will be used as a guideline to evaluate the current services.

4. METHODOLOGY

After meeting, the team identified the following sites (Column 1) to conduct the audit for reasons in Column 2.

Health Care Facilities	
Mamelodi Hospital	As the hospital where the TCC was initially established
Stanza Bopape Clinic	Currently cases are referred to this site after hours: Establish why cases are being referred here [what is good, what is bad and what is missing]
Tshwane Crisis Centre (Pretoria Academic)	Currently cases are referred to this site working hours Establish why cases are being referred here [what is good, what is bad and what is missing]
Laudium Clinic	Police are accessing the services at this site Establish why cases are being referred here [what is good, what is bad and what is missing]
Soshanguve Clinic	Police are accessing services at this site Establish why cases are being referred here [what is good, what is bad and what is missing]
Police Stations	
Mamelodi East	As the police station in the Mamelodi district [Establish extent of reporting and concerns]
Mamelodi West	As the police station in the Mamelodi district [Establish extent of reporting and concerns]
Cullinan	Police from this region previously accessed the MTCC and currently access some of the sites listed above [Establish extent of reporting and concerns]
Boschkop	Police from this region previously accessed the MTCC and currently access some of the sites listed above [Establish extent of reporting and concerns]
Silverton	Police from this region previously accessed the MTCC and currently access some of the sites listed above [Establish extent of reporting and concerns]
Eersterust	Police from this region previously accessed the MTCC and

	currently access some of the sites listed above [Establish extent of reporting and concerns]
Bronkhorstspruit	Police from this region previously accessed the MTCC and currently access some of the sites listed above [Establish extent of reporting and concerns]
Kameeldrift	Police from this region previously accessed the MTCC and currently access some of the sites listed above [Establish extent of reporting and concerns]
Courts	
Pretoria Regional Court	This is a referral court and certain cases reported at the Mamelodi police stations are tried at these courts [Establish statistics and concerns]
Pretoria North Regional Court	This is referral court and sexual offences cases reported at Mamelodi are tried at this court [Establish statistics and concerns]
Mamelodi District Court	This is the court of first appearance for cases reported in the Mamelodi district [Establish statistics and concerns]
Cullinan	This is both a court of first appearance and trial court for sexual offences cases. [Establish statistics and concerns]
Bronckhorstspruit	This is both a court of first appearance and trial court for sexual offences cases. [Establish statistics and concerns]

A standardised audit tool was developed for data collection purposes.[9] The tool establishes what medical, court, psycho – social, shelter and other services exist in the Mamelodi and surrounding areas. It furthermore addressed data collection to establish the number of victims seen at the various health care facilities in relation to the number of reported cases, arrests and matters reported to the various courts. It furthermore looks at training and crime prevention initiatives.

In order to establish whether the health care facilities are blue print compliant[10] a checklist for infrastructure, equipment and sundries was developed. The tool also looks at referral mechanisms in place to measure the levels of coordination of services.

[9] Not attached but available on request.
[10] Annexure 3

The various persons were interviewed at the following sites:

Service	Site	Respondent
Health Care Facilities	Mamelodi Hospital	Dr Du Toit
	Soshanguve Clinic	Sister Cindy Mosehane and
	Tshwane Crisis Centre (Pretoria Academic)	Dr Seller and Sister Betty Mosima
	Laudium Clinic	Sister Nancy Nkopane
	Stanza Bopape Clinic	Dr Lerumo and Sister Moselane
Police Stations	Bronkhorstspruit	Unknown
	Mamelodi East	Unknown
	Mamelodi West	Unknown
	Eersterust	Unknown
	Silverton	Unknown
	Kameeldrift	Unknown
	Boschkop	Unknown
	Cullinan	Unknown
Courts	Pretoria	Mr. Ismail Motaung
	Mamelodi	Mrs. Minette Wilsenhach
	Cullinan	Mr. Gustav Nauhaus
	Bronkhorstspruit	Mrs. Elize Schoeman

5. AUDIT OF HEALTH CARE FACILITIES

8.1. Governance: Protocols and or Service Level Agreements

Respondents were required to indicate what protocols and policies are in place and had to verify this information by either providing the policy to the interviewer. Alternatively the respondents were able to indicate what they were verbally. Furthermore they were required to show the accessibility of such policies and or protocols.

Respondents were further requested to indicate if any memorandums of understanding, service level agreements or other agreements were in place.

They were also required to state whether the HCF meets the following objectives:

1. Reduction of secondary victimisation
2. The reduction in the cycle times of cases and
3. The increase in conviction rates

Of the 5 sites only one has a centre specific protocol, namely TsCC. All the other sites operate on the National Protocol for Sexual Offences Management. All sites except Mamelodi could produce the protocol.

No SLA's or MoUs have been entered into between either civil society organisations or government departments. All agreements between different role players are verbal.

Whilst Mamelodi has not seen any victims in the past year as all are referred to the other sites an indication was given that whilst it was operating the centre did have the aforesaid objectives. TsCC, SC and LC ensures the reduction of secondary victimisation. Whilst its objectives do not specifically spell out the increase of conviction rates the medical examinations are conducted with this in mind.

All sites except Mamelodi were able to produce policies on PEP, STI and Pregnancy Testing.

Regarding the accountability of ensuring that the PEP, STI and pregnancy testing protocols are followed. SC and TsCC accountability leis with the forensic nurse. There is a formal process in place and recording thereof. At SB whoever examines the victim takes responsibility for it. There is however

no formal monitoring system in place. At SC and LC an indication was given that the facility manager monitors the process.

5.2. Role Players

1. Respondents were required to indicate which role players provided services at the centre and which department / organisation funds the project?

At all sites the Department of Health provided services inclusive of medical examinations, evidence collection, emergency care etc. None of the sites had role players from the Department of Social Development, SAPS nor the NPA. None of the sites had any civil society organisation based at the site although TsCC and SC did refer to organisations for counseling services. None of the sites offer court directed services such forensic assessments, court preparation, court support etc.

Mamelodi hospital's funding comes from the central hospital budget. SB comes from the clinic budget. LC and TsCC are funded by Regional Health. SC is funded by HAST and the clinic budget.

8.1. Victims

Respondents were required to indicate which class of victims of crime is examined at their site.

Mamelodi currently sees no victims of sexual abuse these victims are referred to other sites for medical examination and evidence collection. They do however see all other victims of violent crimes. TsCC sees victims of sexual assault as well as, common assaults and Domestic Violence, whilst SB, SC and LC see all victims of crime. The centre at SC however sees victims of sexual assault in a separate facility to the other victims of crime and drunken driving accused during office hours.

8.1. Personnel

Respondents indicated that no formal training was given for medical doctors performing sexual assault medical examinations other than as part of their medical training towards the MBCHB degrees. Forensic nurses are employed at the SC and TsCC's only. These nurses have accordingly received formal training on rape care management, evidence collection, medical examinations and HIV management. Although only the nurse at SC performs medical examinations. Doctors do the examination at the other sites (all sites except Mamelodi). There is roster of doctors on call available.

TsCC and SC had a forensic nurse who is allocated to the site. None of the sites except for TsCC had dedicated doctors assigned to the sites. The remaining sites relied on sessional doctors to examine and collect evidence. A nurse is responsible for the implementation of PEP services.

8.1. Services Offered

Respondents were requested to indicate whether there were psycho – social service providers available at the centre or if this was a referral service.

Mamelodi sees no victims of sexual assault and accordingly no psychologists are used for this purpose. An indication has been given that the victims could be referred for psychological support services. TsCC, LC has a psychologist that provides services from the centre for two and a half days a week. SC has a psychiatrist and psychologist based at the hospital who can assist. There is however no formal referral system in place. SB is serviced by one psychologist that services the entire Mamelodi area. This service is not offered automatically. The nurses are trained in managing acute trauma but this is not always monitored effectively. If the assigned nurse is not available then the acute trauma debriefing is not done. Furthermore the services of the psychologist are only accessed if the victim requests it.

PEP services are offered at all sites except for Mamelodi. Although Mamelodi indicated that the services could be offered at the hospital as the nurses are trained in this.

In relation to emotional support, psychological support, therapy, VCT counseling and safety planning: TsCC, LC and SC provided all of the services. None of the sites had any shelter services but indicated that the police together with the Department of Social Development arranged this if it were required.

8.1. Equipment and sundries

All facilities conduct medical examinations on an examination couch. Only the TsCC facility has a colposcope with an attached digital camera, which is attached to a monitor and printer.

At the TsCC, SC and LC victims are provided with comfort packs. SC indicated that these comfort packs were previously provided by FCS units but this no longer happens since the disbandment of their disbandment. Both these sites have a photo copy machine, fax machine, telephone and computers available at the centre itself. Whilst LC only has a telephone and computer and a general photo copy machine. Mamelodi indicated that none of the above except for telephones and computers were available at the centre.

8.1. Facilities

Mamelodi does have a site identified from which medical examinations of victims can be conducted. This area has a shower facility directly linked to the medical examination area. This is however not conducive to the victims needs as there is only a glass door separating the area where the examination is done and where she/he would shower. Thus if another victim were to come in the examination area whilst she is showering this could be a cause for concern. Whilst it has a separate waiting area there is no separate facility for victims awaiting further services other than in this area. There is furthermore no facilities to keep children occupied whilst waiting.

The Mamelodi hospital will however be moving to a new facility at which space is provided for a crisis centre. It is unsure whether it can house a site coordinator, nurse, psycho – social service provider and a SAPS member.

TsCC is housed within the Pretoria Academic Hospital premises but is a separate facility altogether. The site has ample space for the statement taking purposes, although the statement taking is not done at the site but at the police stations. The site is aesthetically pleasing and ensures that the victim is safe, secure and has bathing facilities that are conducive to the victims needs. The site has at least two medical examination areas that ensure privacy. It furthermore has office space and a boardroom and separate waiting facilities that are both victim and child friendly. Whilst the facility is not housed in or adjacent to a casualty section these services can be easily accessed.

The area in which the SB clinic conducts its medical examination exacerbates trauma of sexually abused victims. Victims are examined in a general examination area and are separated from other members of the public by a curtain that is suspended with a gap of at least 30 cm from the floor. Thus if anyone were to bend down they would be in a position to see what was happening behind the curtain. When questions are asked about the rape it should be easily heard by persons in the examination area. Thus confidentially and embarrassment cannot be averted at this site.

The SC is a separate facility that is housed within the clinic premises. The medical examination area and waiting areas are conducive to the victims needs as it keeps victims separate from other members of the public and the medical examinations are conducted in a separate private area. The bathing facility is not part of the centre. The victim needs to exit the centre into the passage and enter the bathing facility that is adjacent to the centre. Whilst this bathing facility is not too far from the centre it is

nonetheless not ideal as the victim has to exit the site and walk in an area accessed by the public. After hours victims are examined in the causality section which is not a victim friendly facility.

At LC the victim is examined in a separate medical area, but has to wait in an area that can be accessed by the public. Whilst this area is a restricted access area there appears to be no measures to ensure that members of the public do not access the area. There is a shortage of staff to monitor this process. The area where the medical examination is conducted is not aesthetically pleasing but ensures confidentiality nonetheless. The site does not have a child friendly waiting area.

8.1. 24 Hour service

SB only sees clients after 4pm. Between 8am and 4pm these victims are seen at the TsCC. Thus all PEP medical examinations etc are not done during office hours. This is disconcerting considering that the TsCC is ideal to address the needs of victims. TsCC is also closed on weekends and public holidays, which is the period when sexual offences occurrence peaks.

LC is a 24 hour service. SC operates office hours. After hours victims are examined in the casualty section of the clinic.

8.1. Coordination of services

Only TsCC and SC have referral mechanism in place for psycho – social services. These are recorded. However no follow ups are done to ensure that the victim did in fact access the services. Mamelodi is currently not offering any of the services below. Accordingly reference to all sites exclude Mamelodi.

1. Medical examinations for purposes of sexual assault and or domestic violence: All sites except Mamelodi conduct these examinations. Serious trauma for the TsCC is referred to Pretoria Academic hospital.
2. Sexual assault evidence collection and safeguarding of medical evidence: All sites except Mamelodi
3. Provision of PEP: All sites. SB has indicated that this is only done after hours when the TsCC is closed.
4. VCT : All sites. SB has indicated that this is only one after hours when the TsCC is closed
5. STI testing : All Sites
6. ARV’s : All sites
7. Hepatitis B vaccine: All sites except TsCC

8. Tetanus toxoid vaccine: All sites except TsCC. LC indicated that sometimes this is done at Skinner
9. Pregnancy prevention (this refers to emergency contraception only): All sites
10. Pregnancy testing: All sites
11. Dispensing of medication: All sites
12. Emergency medical care: All sites
13. TOP: TsCC refers to Skinner clinic. LC and SC refers lab specimens to George Makhari. SB forwards lab specimens to Mamelodi day labs.

Although Mamelodi did not offer any of these services, it was indicated that if emergency care would be required they can access the trauma / causality section of the hospital. SB also refers serious trauma cases to Mamelodi.

5.11. Debriefing

4.7.1. Health Care Facilities: No debriefing

4.7.2. South African Police Services: No debriefing

4.7.4. Courts: no debriefing but prosecutors can access the Employee Wellness Programme offered by the NPA at no costs.

6. AUDIT OF POLICE STATIONS

8 police stations were audited. This required site visits to the police station to view the station and facilities as well as to collect statistical data.

All statements were taken at the police station. Accordingly the statements are not taken after the victim has had a chance to bathe and change clothing. This is done because of the fact that the statement is taken prior to the medical examination. The respondents indicated all the statement taking officers are trained in statement taking but not necessarily how to obtain evidence from the child witness and monitoring the chain of evidence. Only Mamelodi, Silverton and Eersterust had experienced officers from the FCS unit. At other stations it appears that the statements are sometimes taken by inexperienced officers, but this is an exception to the rule. Bronkhorstspruit, Kameeldrift and Cullinan rely on experienced investigating officers based at their stations.

Cullinan and Bronkhorstspruit make use of doctors in Bronkhorstspruit, but also SB. Eersterust, Silverton and Mamelodi access LC, SB and TsCC dependent on where there are doctors available. Accordingly there is no system to monitor where the cases are examined as they access a medical facility based on the time of day and availability of doctors.

There are victim friendly facilities available at Mamelodi East, West, Cullinan, Bronkhorstspruit and Silverton police stations. There were only victim friendly statement taking rooms at the Eersterust, Mamelodi East and West and Bronkhorstspruit police stations. At the other stations statements are taken in an office which is often interrupted by other staff members whilst the statements are taken.

Statistics regarding the breakdown of adult vs. child victims of sexual offences could not be obtained as these statistics are not collected. An inference could however be drawn from the Mamelodi Court statistics as discussed hereunder.

7. AUDIT OF COURTS

The Mamelodi East and West police stations feed into the Mamelodi District Court, which in turn feeds into the Pretoria Regional Court. The Bronckhorstspruit and Cullinan cases feed in Cullinan and Bronkhorstspruit respectively. In indication was however given that the matters are transferred between the two Regional courts dependent on the availability of the magistrate in relation to the court roll. Thus partly heard matters are shared between the two courts to ensure speedier Finalisation of matters. The statistics could therefore not give an accurate reflection of which station's cases were finalised accordingly. All other stations also feed into the Pretoria courts.

Only Pretoria courts have a regional court dedicated to sexual offences. These courts however only hear sexual offences perpetrated on children and mentally challenged witnesses. All other sexual offences matters are distributed amongst the other regional courts. Data collected at the Pretoria courts reflect sexual offences perpetrated on children from the Mamelodi stations. It is indicated that the Mamelodi cases approximately make up one third of all cases on the roll at these courts.

The Cullinan and Pretoria Courts are equipped with intermediary facilities and have separate waiting areas for victims. Cullinan does however not have any court preparation officers based at the centre as this is left for the prosecutor to do. The court preparation facility at the Pretoria courts have separate waiting and ablution facilities, a separate consultation room for prosecutors and victims do not have to pass the general public to get to the court room for testimony, unlike with Cullinan.

Only the Pretoria court has a case manager who does the initial interview with witnesses. This is however not done for the Mamelodi cases as these cases do not appear at the Pretoria courts for first appearances and she can accordingly not monitor the intake of cases. She screens cases that are brought to the regional courts, interviews complainants and then distributes the cases. The follow up on investigation is left to the prosecutor. Mamelodi cases are generally transferred to Court 12.

Cullinan has three prosecutors for the one regional court. Pretoria has 1 prosecutor per court and relies on the other prosecutors of the normal regional courts to rotate in these courts to ensure one week in one week out of court for consultation purposes.

Initially Pretoria North Courts were also included in the audit. No statistics were however forthcoming and this court is accordingly excluded from this audit report.

8. STATISTICS

8.1. Health Care Facilities (As there was no health coordinator for the Tshwane district at the time of the audit, the statistics could not be obtained at that time. These were however provided by Dr Poshoko (newly appointed coordinator). It should be noted that not all the centres data is reflected for the entire period as certain centres did not submit data for months as reflected (#) below.

It is important to note that none of the centres could give an indication as to the number of cases that were examined as per the police stations. The data reflected below accordingly includes *inter alia* police stations in the greater Pretoria, Atteridgeville, Soshanguve, Laudium, Erasmia stations etc and the data cannot be interpreted to establish the correlation between the number of reported and or arrested cases.

The closest indication as to the aforementioned is Stanza Bopape Clinic statistics as it is situated in Mamelodi. What is noteworthy of these statistics is that SB only sees victims after hours and yet has seen an alarming 115 victims in a 6 month period (No statistics available for December 2007).

Statistics regarding PEP services are not available.

Medical Statistics	MAMELODI	TSHWANE	LAUDIUM	SOSHANGUVE	STANZA BOPAPE
June	0	35	47	13	14
July	0	33	60	#	13
August	0	30	43	#	17
September	0	25	60	44	18
October	0	52	44	38	31
November	0	27	48	31	22
December	0	30	70	48	#
Total	**0**	**232**	**372**	**174**	**115**

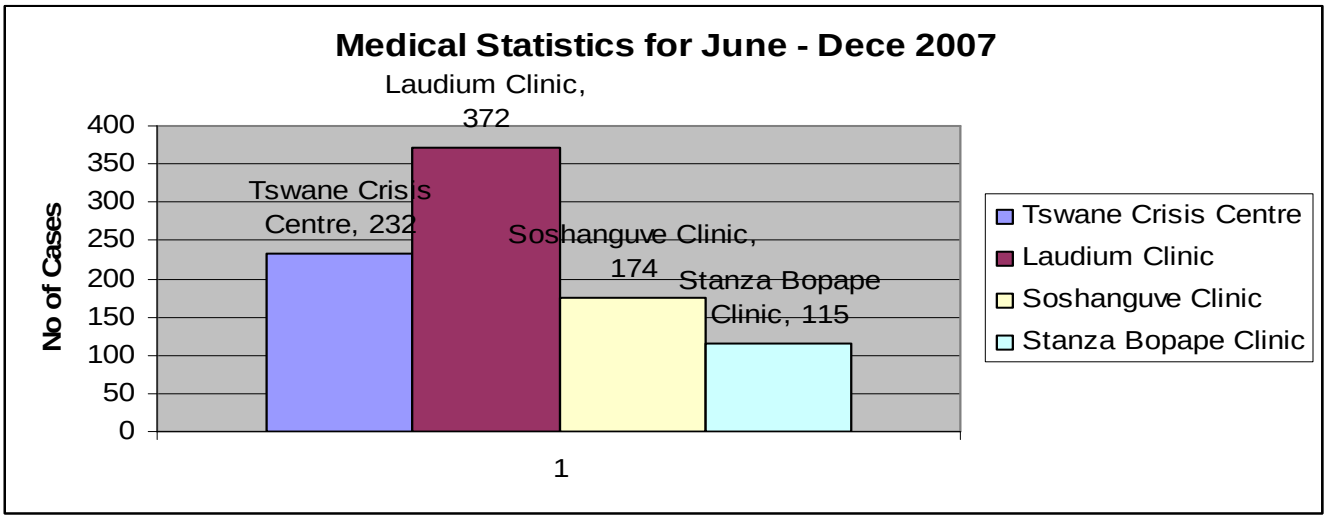


Figure 4

Medical Statistics

8.2. South African Police Services and Courts

The following stations feed into the following courts:

Station	Court of 1st appearance (District)	Trial Court (Regional)
Cullinan	Cullinan	Cullinan
Boschkop	Cullinan	Pretoria
Kameeldrift	Pretoria	Pretoria
Eersterust	Pretoria	Pretoria
Silverton	Pretoria	Pretoria
Mamelodi East	Mamelodi	Pretoria
Mamelodi West	Mamelodi	Pretoria
Bronkhorstspruit	Bronkhorstspruit	Bronkhorstspruit

A total amount of 354 sexual offences cases were reported at these police stations between the period June to December 2007. Prior to the audit it was established that these were the police stations that accessed the Mamelodi site prior to its temporary closure. Accordingly this means that a potential of 354 victims could have benefited from a TCC. The new cases reported for the period June 2007 to December 2007 per stations is reflected as follows:

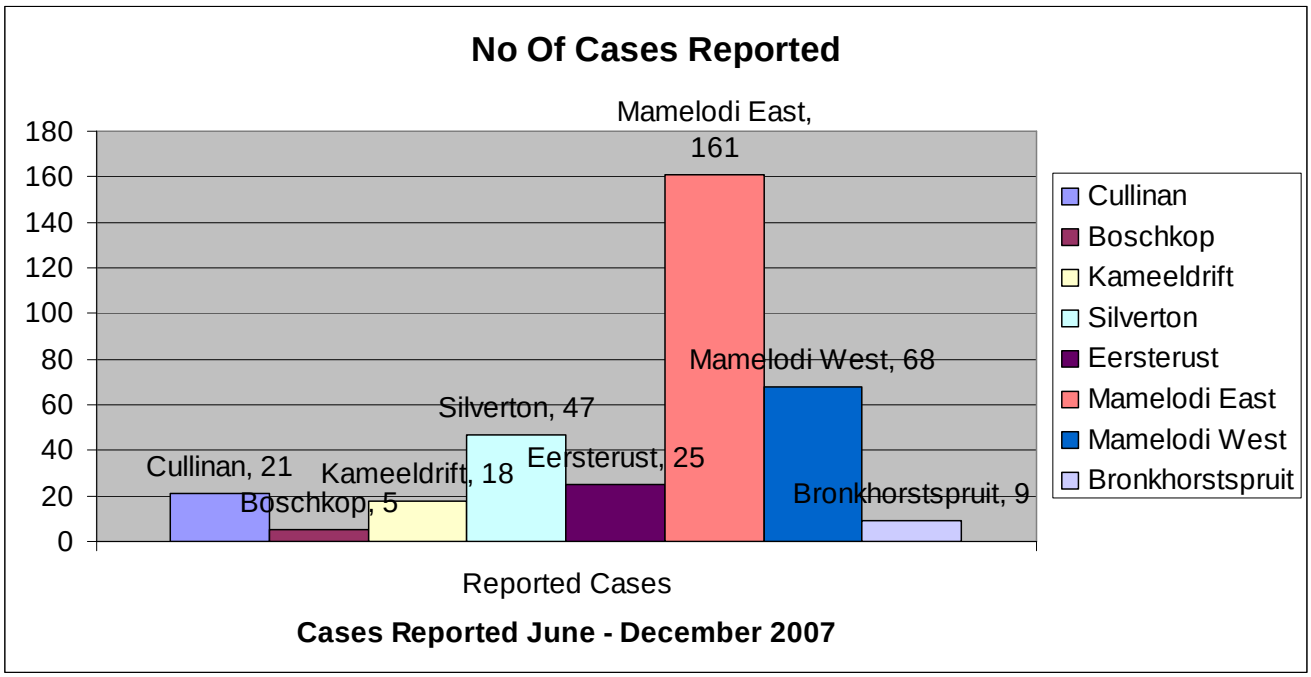


Figure 5

Police Statistics Reported Cases

Of the 354 cases reported at the stations 214 arrests were effected. The illustration below excludes a monthly breakdown due to computer malfunctions at the time of the audit.

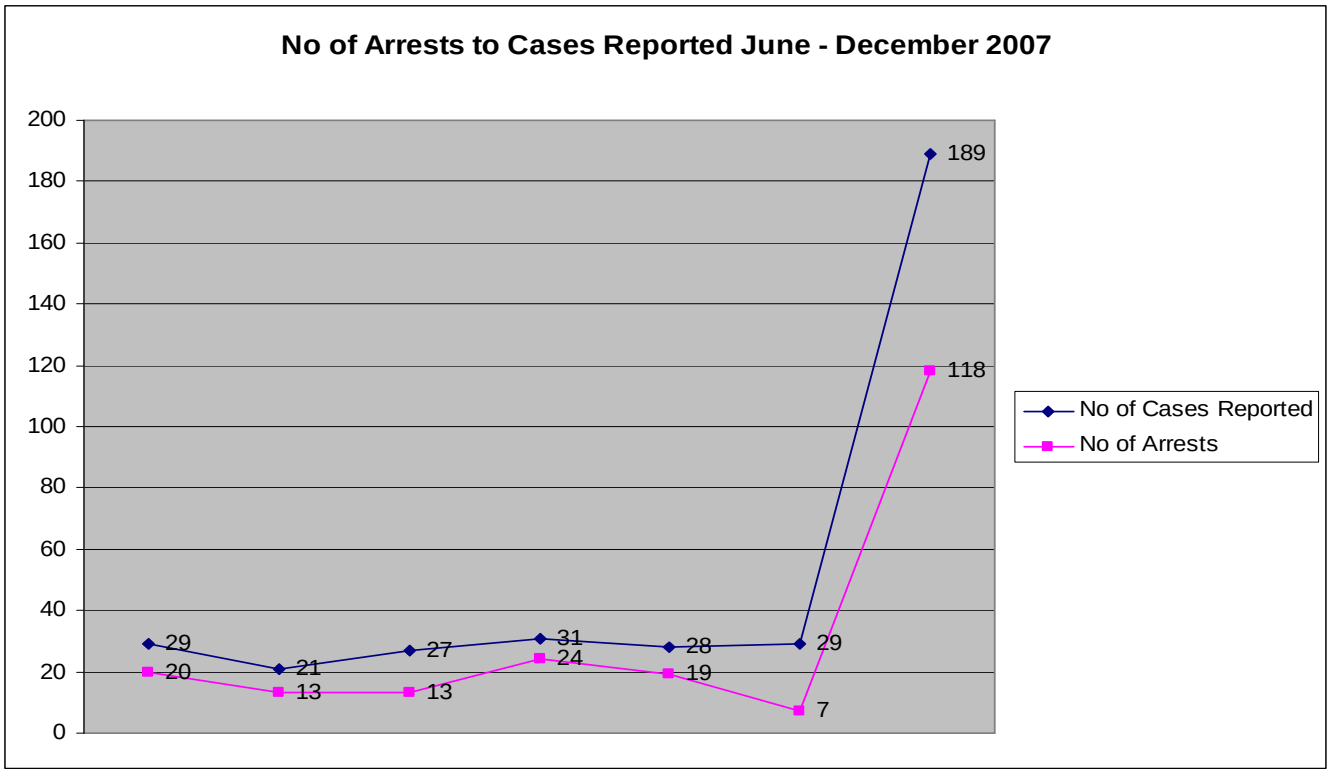


Figure 6

Mamelodi Reported vs. Arrested

Accordingly only 60% of cases reported amounted to arrests. Reasons for non arrests include accused unknown, officers having a heavy workload and cannot effect arrests immediately. On inspection of 10 dockets it transpired that the perpetrator was known to the victim. This study could not be done in detail due to time constraints and requires a total separate audit to gather the most reliable data.

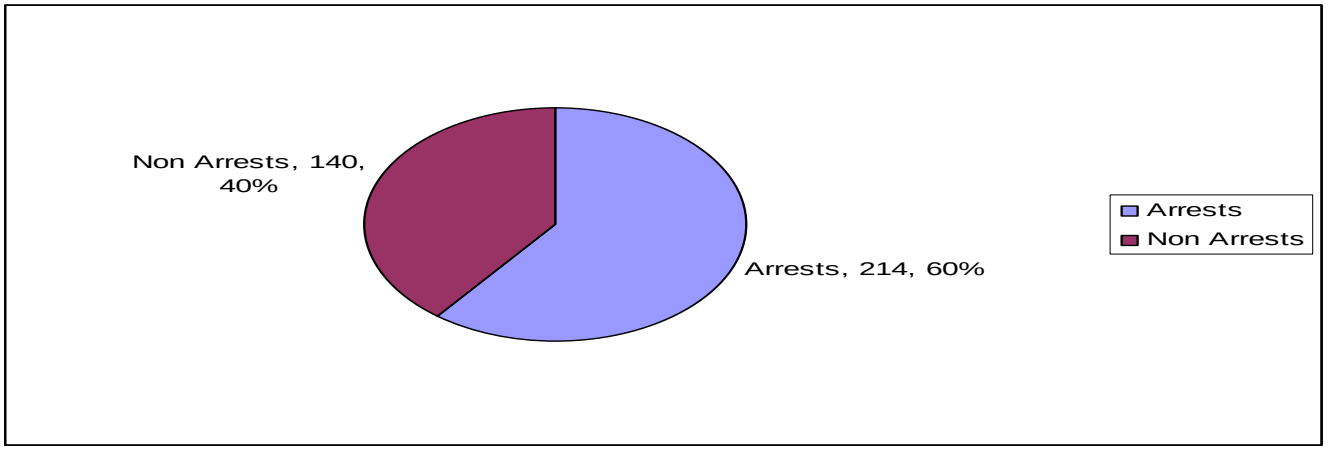
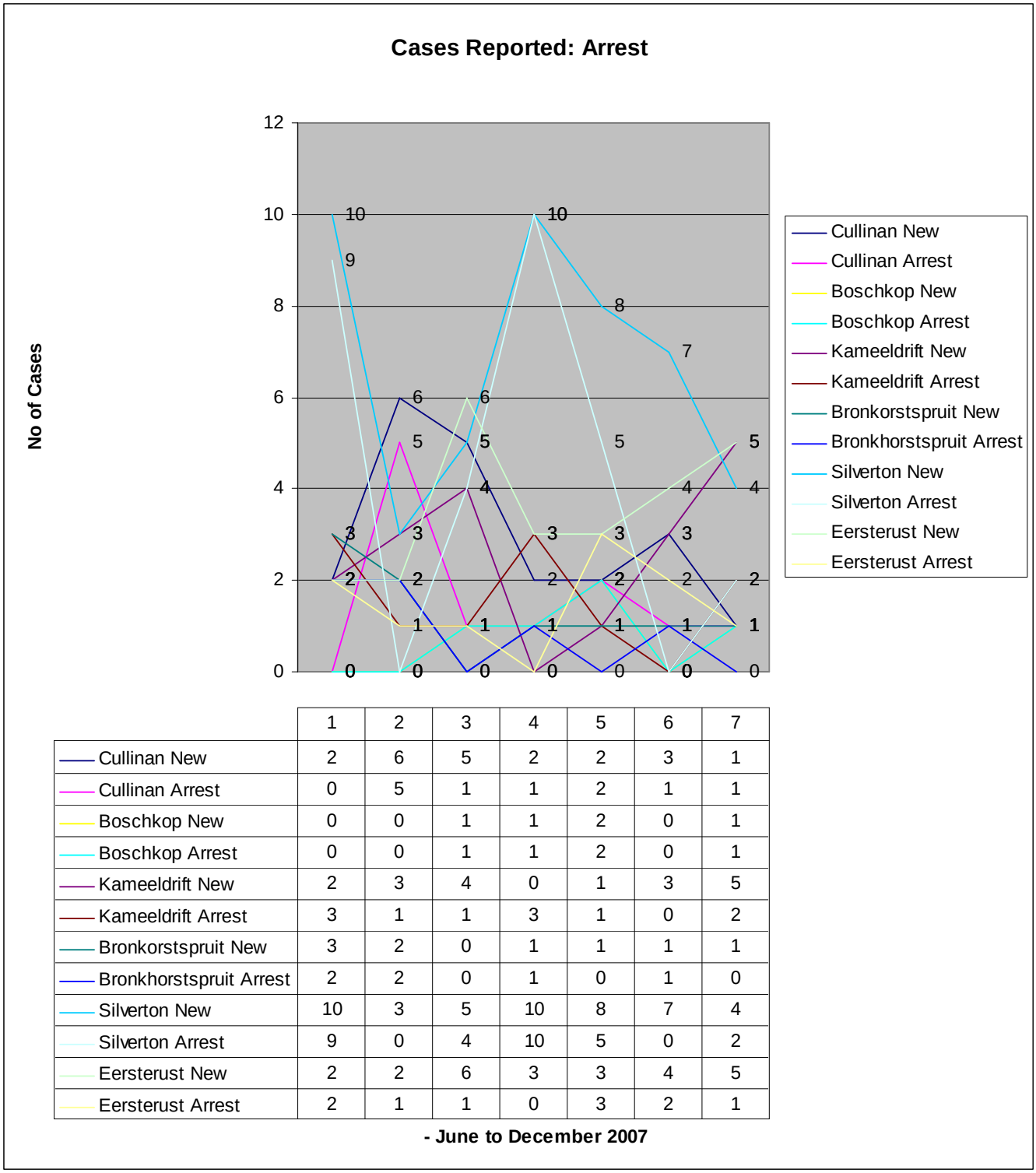


Figure 7

Reports to Arrests

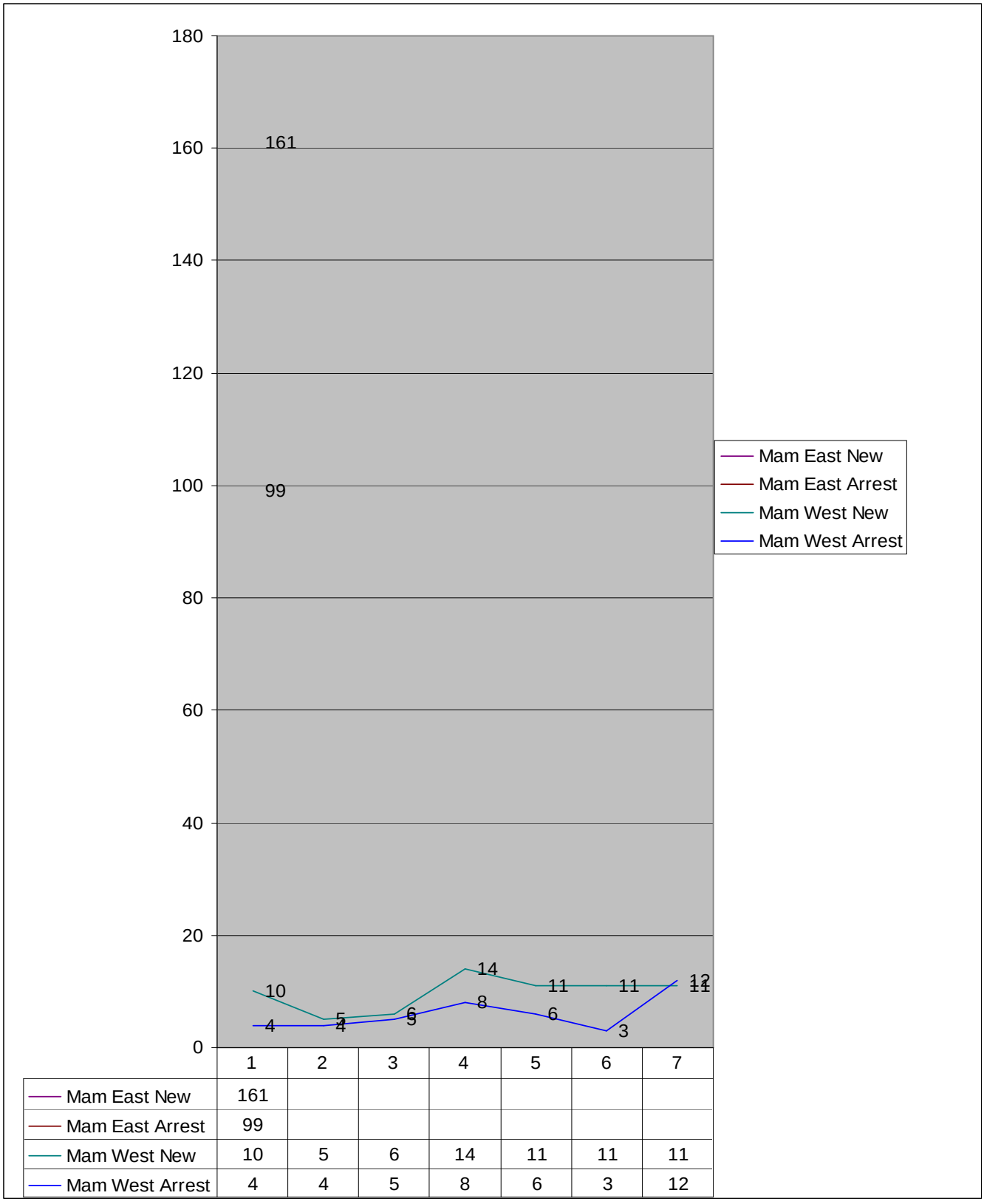
Broken down to station level (excluding Mamelodi East and West, the following is reflected.



	1	2	3	4	5	6	7
Cullinan New	2	6	5	2	2	3	1
Cullinan Arrest	0	5	1	1	2	1	1
Boschkop New	0	0	1	1	2	0	1
Boschkop Arrest	0	0	1	1	2	0	1
Kameeldrift New	2	3	4	0	1	3	5
Kameeldrift Arrest	3	1	1	3	1	0	2
Bronkorstspruit New	3	2	0	1	1	1	1
Bronkhorstspruit Arrest	2	2	0	1	0	1	0
Silverton New	10	3	5	10	8	7	4
Silverton Arrest	9	0	4	10	5	0	2
Eersterust New	2	2	6	3	3	4	5
Eersterust Arrest	2	1	1	0	3	2	1

Figure 8

Reports to Arrests



	1	2	3	4	5	6	7
Mam East New	161						
Mam East Arrest	99						
Mam West New	10	5	6	14	11	11	11
Mam West Arrest	4	4	5	8	6	3	12

Figure 9

Reports to Arrests

Mamelodi West reflects a 62 % arrest rate.

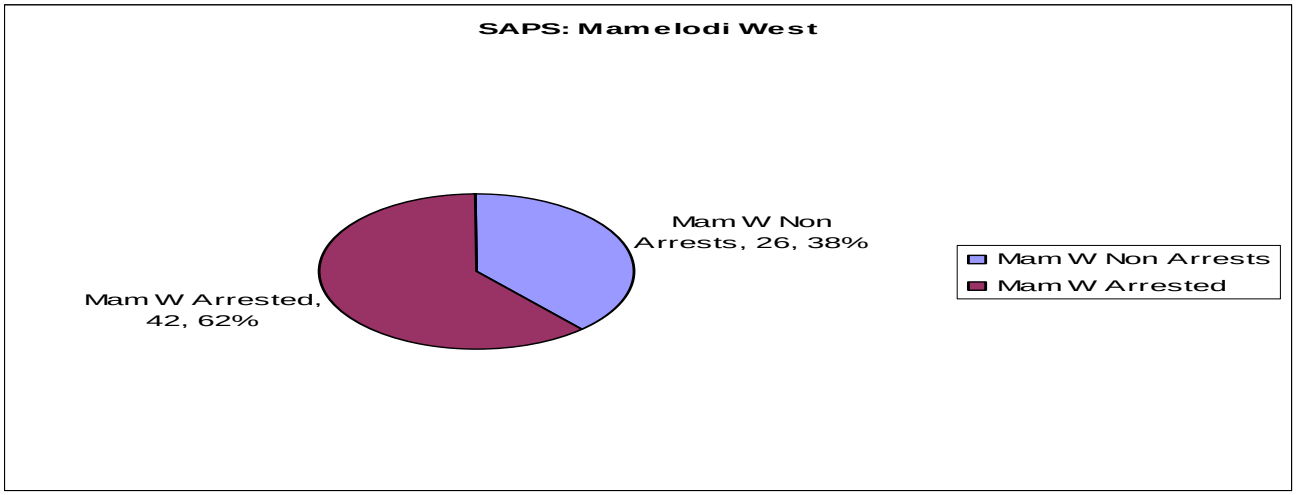


Figure 10

Reports to Arrests

Whereas Mamelodi East reflects a 58% arrest rate.

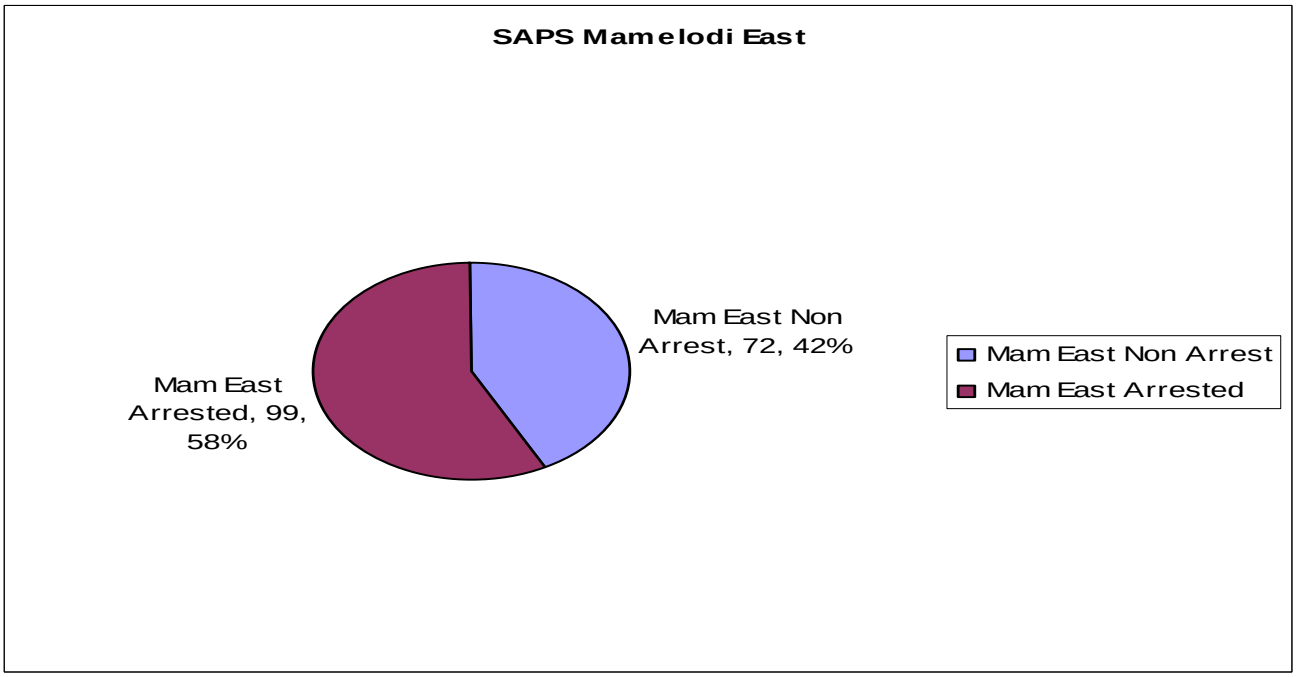


Figure 11

Reports to Arrests

As stated above the Mamelodi court feeds into the Pretoria regional court. SAPS Mamelodi statistics indicated that there was a total of 229 cases reported at the Mamelodi East and West Stations. The court statistics reflect that for the same period a total of 88 cases were reported at the Mamelodi courts as first appearances. I

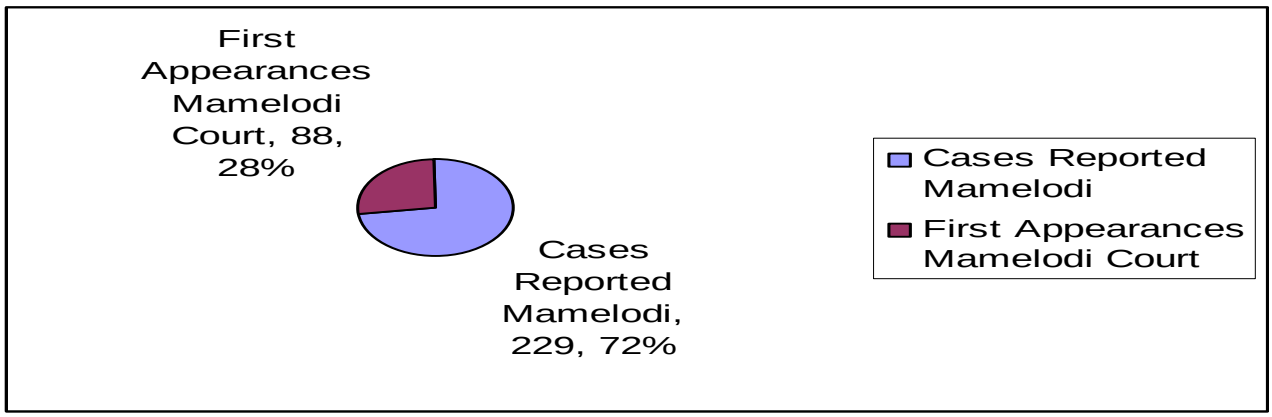


Figure 12

Reported to First Appearances Mamelodi

For the same period a total of 94 matters were transferred to the regional court, of which, 55 were transferred to the Pretoria Sexual Offences Courts. This court entertains matters where perpetrated on children and mentally disabled victims. 1 matter was withdrawn at District court level. For the same period though the Pretoria Court reflects 90 first appearances. It can be inferred that matters were also transferred outside of the reporting period for this audit.

It is nonetheless concerning that of the 229 cases that were reported only 28% of these cases reflected on the court rolls as first appearances.

Regarding the data of the adult victim's cases that were transferred to the normal regional courts at Pretoria could not be obtained. The other remaining stations (excl. Cullinan and Bronkhorstspruit) also feed into the normal regional courts.

Mamelodi Court	First Appearance	Child	Adult	No of Cases TTRC Child	No of Cases TTRC Adult	SAPS M West: Reported Cases	Mam W Arrested	SAPS M East Reported Cases	Mam East Arrested
June	13	10	3	8	4	10	4	#	#
Jul.07	11	9	2	10	2	5	4	#	#
Aug. 07	14	6	8	9	9	6	5	#	#
Sept. 07	8	3	5	5	6	14	8	#	#
Oct. 07	18	13	5	11	2	11	6	#	#
Nov. 07	15	7	8	10	8	11	3	#	#
Dec. 07	9	2	7	2	8	11	12	#	#
TOTAL	88	50	38	55	39	68	42	161	99

Accordingly 57% of the cases that were enrolled as first appearances in the Mamelodi district court were perpetrated on children (under the age of 18).

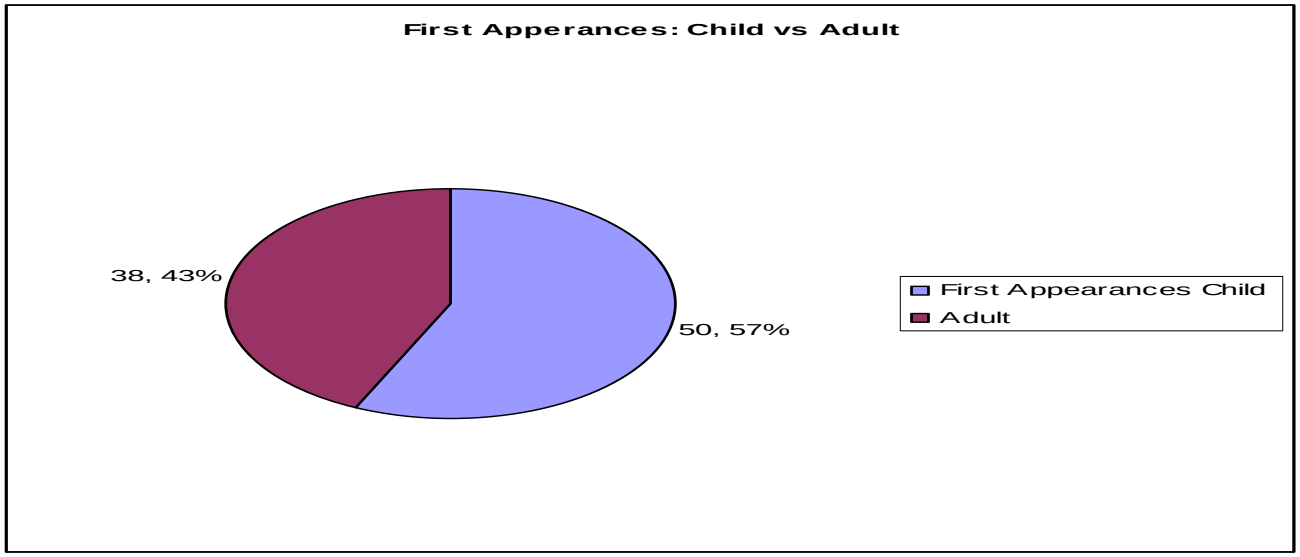


Figure 13

Adult vs Child

It should be noted that it could not be determined if the cases as reflected in the police statistics are indeed the very same cases reflected in the court statistics. The most accurate reflection is the aforesaid data regarding arrests and first appearances in the Mamelodi district court. What is of concern is the fact that a total of 39 Mamelodi matters were withdrawn. Reasons for the withdrawal could not be obtained as this data is not captured. Mrs. Wilsenhach (Control prosecutor for the sexual offences courts) gave an indication that on a rough estimate the Mamelodi cases make up approximately 25 – 30 % of the cases on the court roll. She states that Mamelodi cases are generally transferred to court 12. However in order to ensure an even spread of cases amongst the 3 sexual offences courts, some matters from Mamelodi are transferred to the other courts. Court 12's court roll consists only of sexual offences cases.

For June to December 2007 the courts nonetheless reflect that for the same period as the audit, at least 139 cases were on the roll for further investigation. Moreover whilst 90 new matters were received (an average of 12.8 per month) 13 matters were finalized with a verdict (an average of 1.8 per month). Under investigation hereunder also includes other matters such as postponements for legal representation, awaiting an outcome of a representation etc. All courts combined had a total of 325 outstanding cases on the roll of which 202 were on the roll for longer than 6 months, court 12 had 88 matters on the roll that were older than 6 months. Hence 63% of matters on the court roll are older than 6 months.

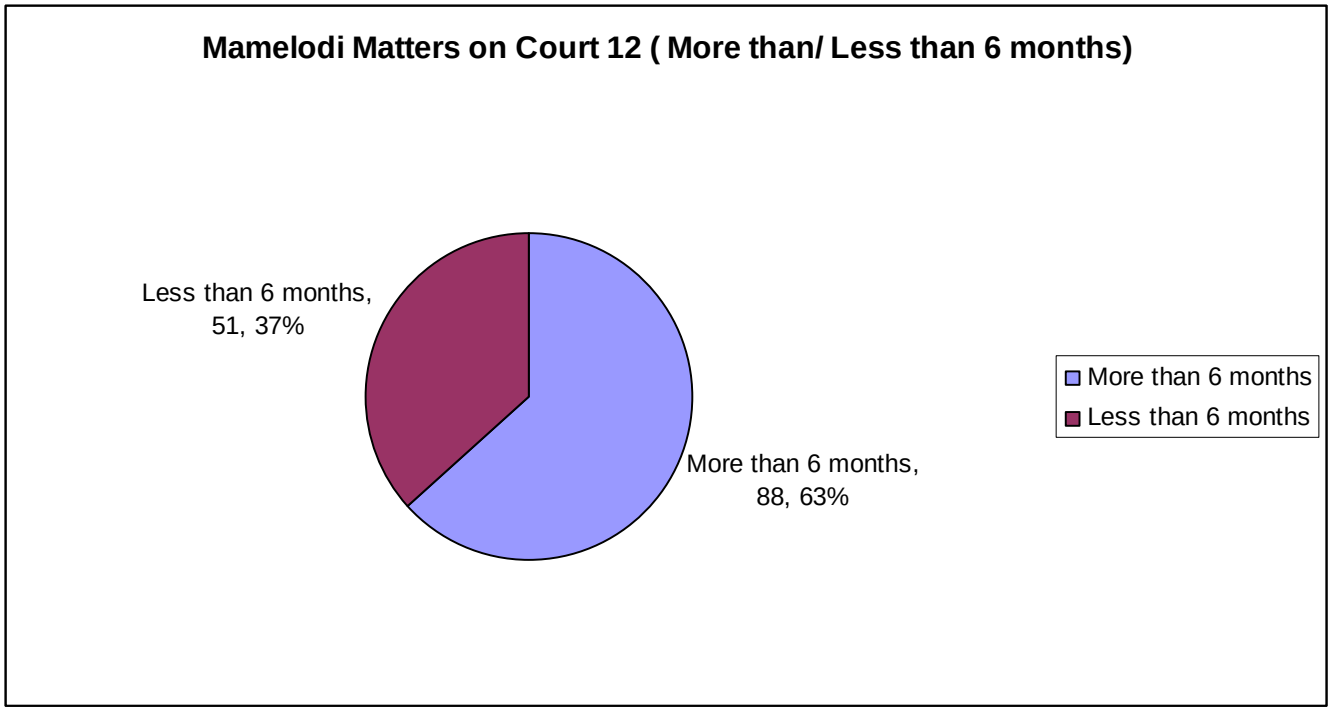


Figure 14

Cycle Times

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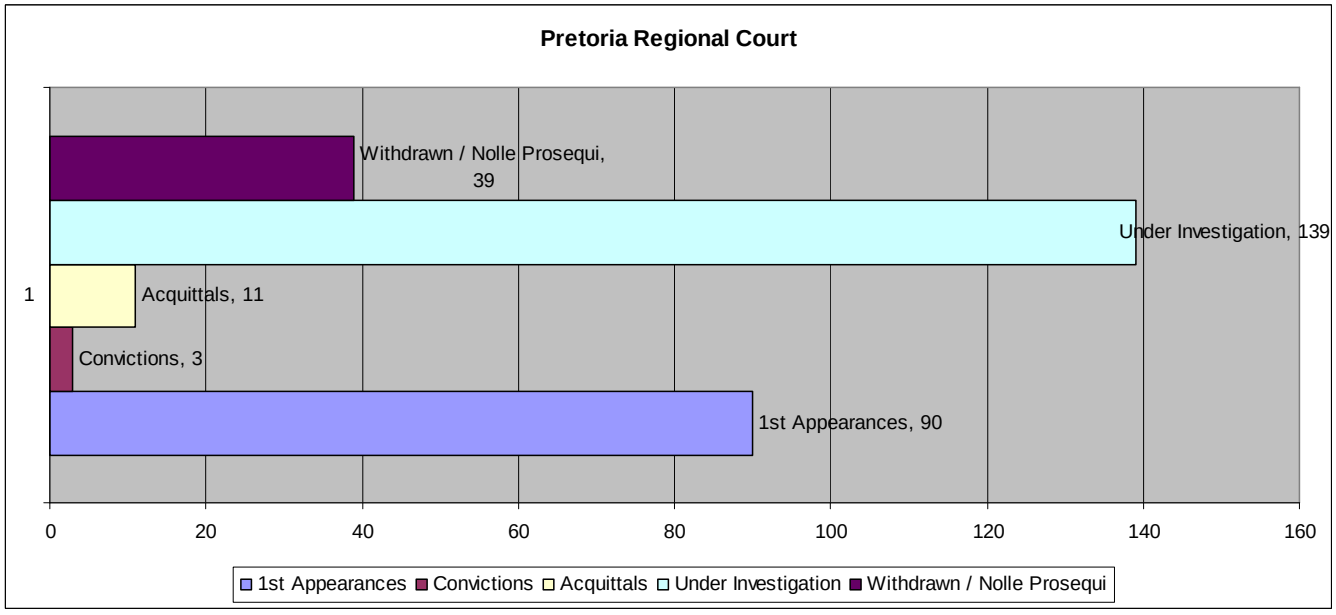

Figure 15

Pretoria Court

Mrs. Wilsenhach raised the following challenges regarding the Mamelodi cases.

1. Bail: in serious cases bail is generally granted at the district court level and a request has been made by the police to place the matters on the roll at the Pretoria regional court from the start in order to alleviate this situation.

2. It is evident that case management is a difficult task at the courts and accordingly monitoring of outstanding investigation is not done effectively. Dockets are brought to court a day or two prior to the appearance at which time prosecutors discover that investigation is not complete. She states that turn around times on cases can be reduced. Some of the problems experienced are that additional statements are not obtained timeously. It appears though that this is because of the fact that the investigating officers are overworked.
3. It is further evident that corroborating evidence for children are not obtained. Some of the examples cited include obtaining bed linen for DNA, going to the scene of the crime to verify the child's evidence relating to descriptions of a room, objects etc.

It is noteworthy that whilst the Pretoria Regional Courts are receiving a minimum of 50 cases in the 6 month period they were only able to finalise 14 matters over the same period (3 convictions: 11 acquittals). It appears that they have an excess of at least 130 cases on the roll.

The following is a depiction of sexual offences recorded for the period April 2006 to March 2007 (Annual SAPS Report) in relation to cases reported for the June 2007 to Dec 2007 period.

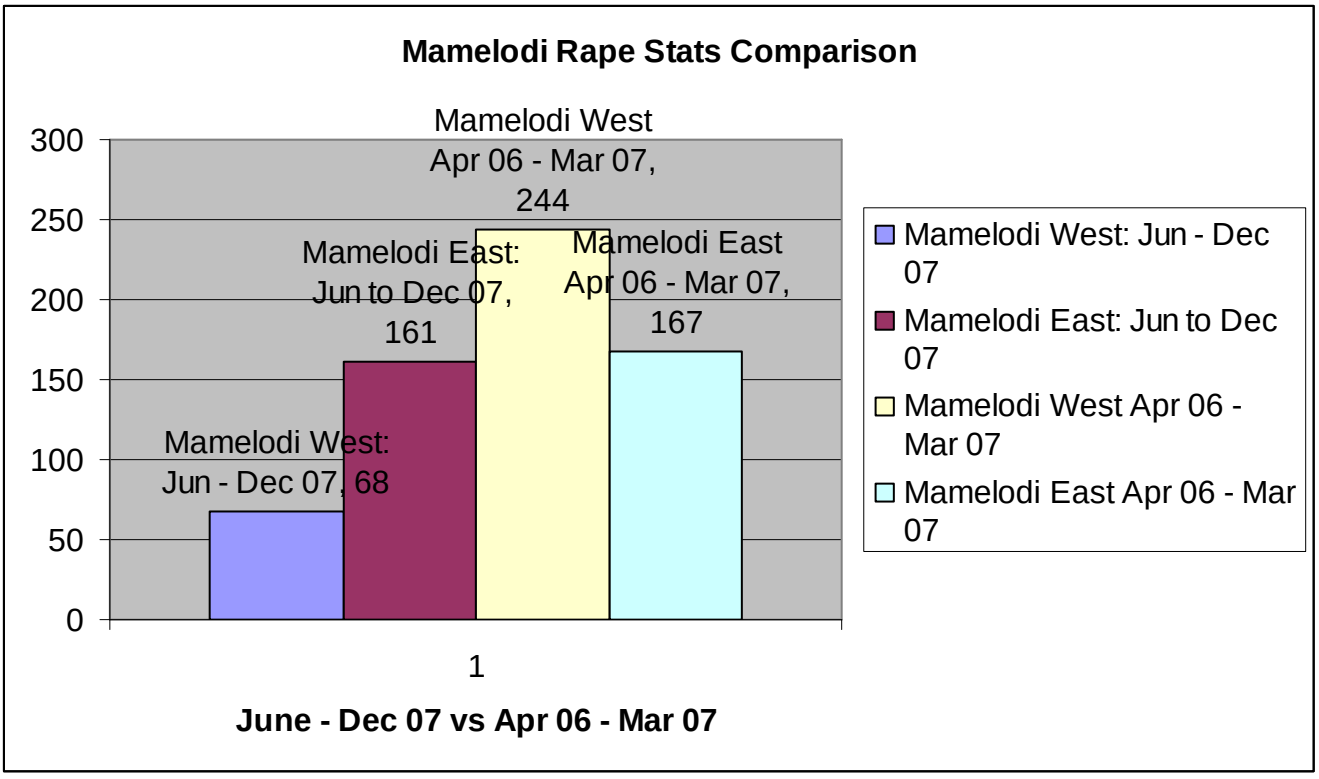

Figure 16

Annual vs. 7 month comparison: SAPS stats

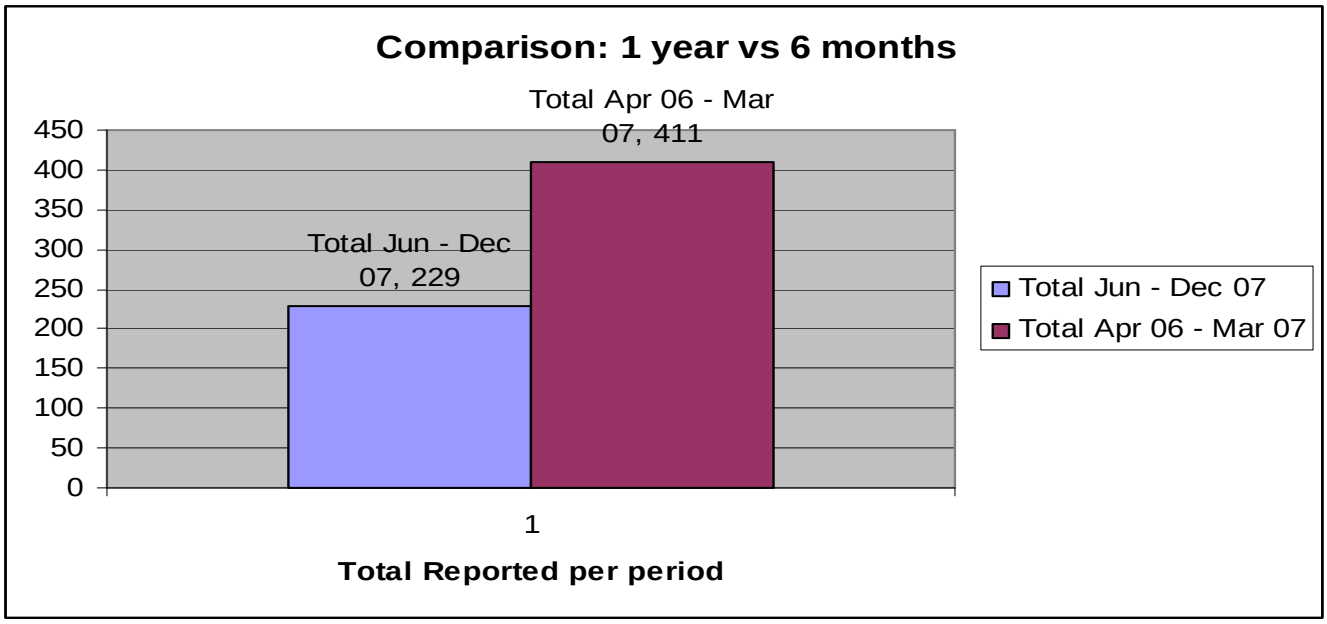

Figure 17

Annual vs. 7 months

If one were to compare the statistics for these months to the annual period it appears that Mamelodi has within 7 months already reached 56% of the annual rape statistics for the 2006 / 2007 year.

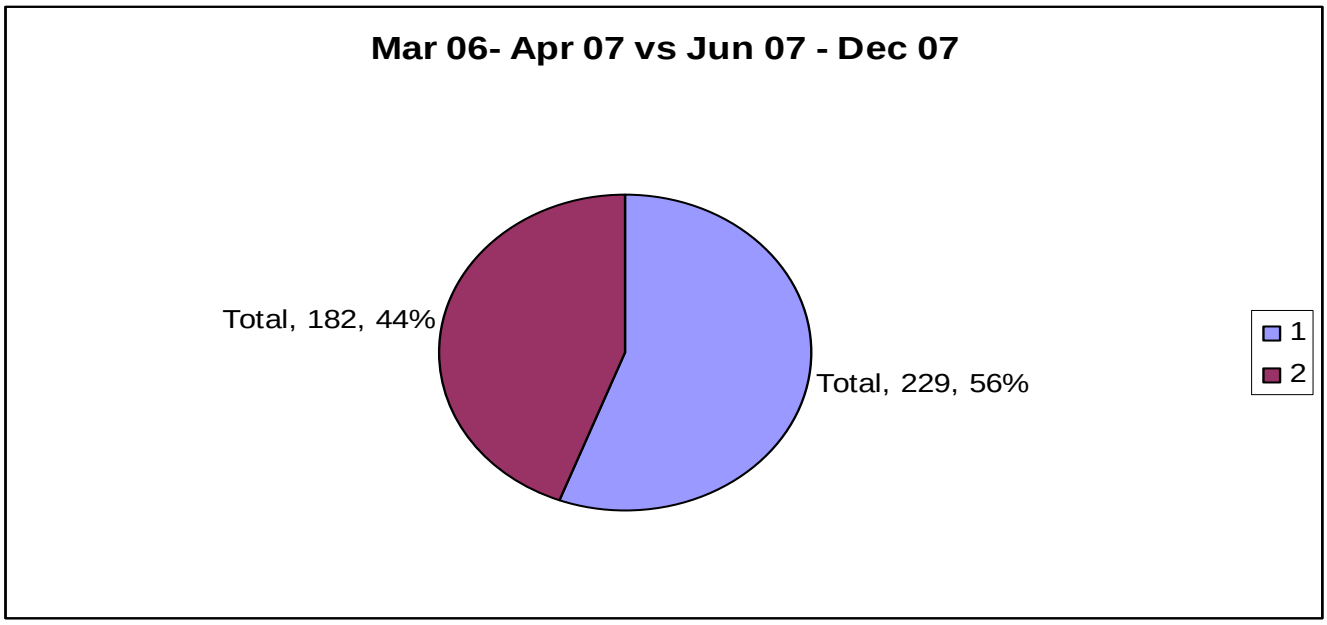

Figure 18

Annual vs. 7 Months

The total of 354 cases at the stations audited translates to a monthly average of 50.57 cases. This accordingly means that a total of 606 cases could be reported for the entire region in a period of one year. Thus a minimum of 606 victims that could access a multi – disciplinary service for rape care management.

Comparative Analysis for the relevant courts that would benefit from a TCC :

Of the 354 cases that were reported for this period of June to December 2007 214 arrests were effected. Of the total no of cases reported 53 cases were withdrawn due to insufficient evidence, completion of investigation or on request of the complainant etc.

Whilst there are a host of extraneous variables that may affect the finalisation outcomes of a case the following is nonetheless noteworthy. 16 matters resulted in an acquittal and 12 convictions were reported in this period. It is important to note though that the matters that have been finalised are not necessarily of the same class of matters that were reported. Currently the three courts finalise cases on an average of 18 months. This reflection accordingly shows that considering the amount of cases reported on a monthly average (59) an average of 4.66 cases are finalised for the same period which translates into 2 convictions on average. This accordingly means that the rate of new cases entering the court system is far exceeded by the rates of finalisation. As a result of the cycle time of cases it means that for the period of this audit none of the cases that were reported were finalised.

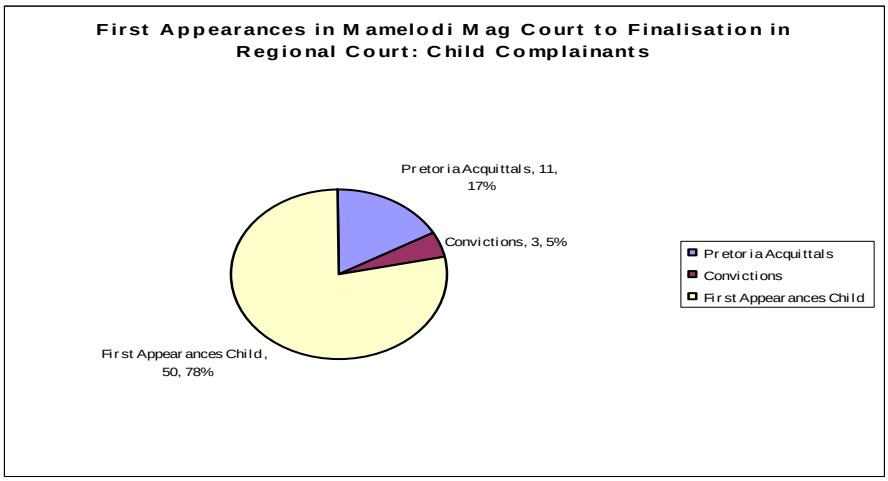

Figure 19

Finalisation from First appearance in Mamelodi to finalisation in the Regional Court

If this snapshot were to be used as a reflection on the performance of courts on sexual offences courts the following is illustrated.

No of Cases Reported	No of Convictions	No of Acquittals	No of Cases withdrawn
354	12	16	53

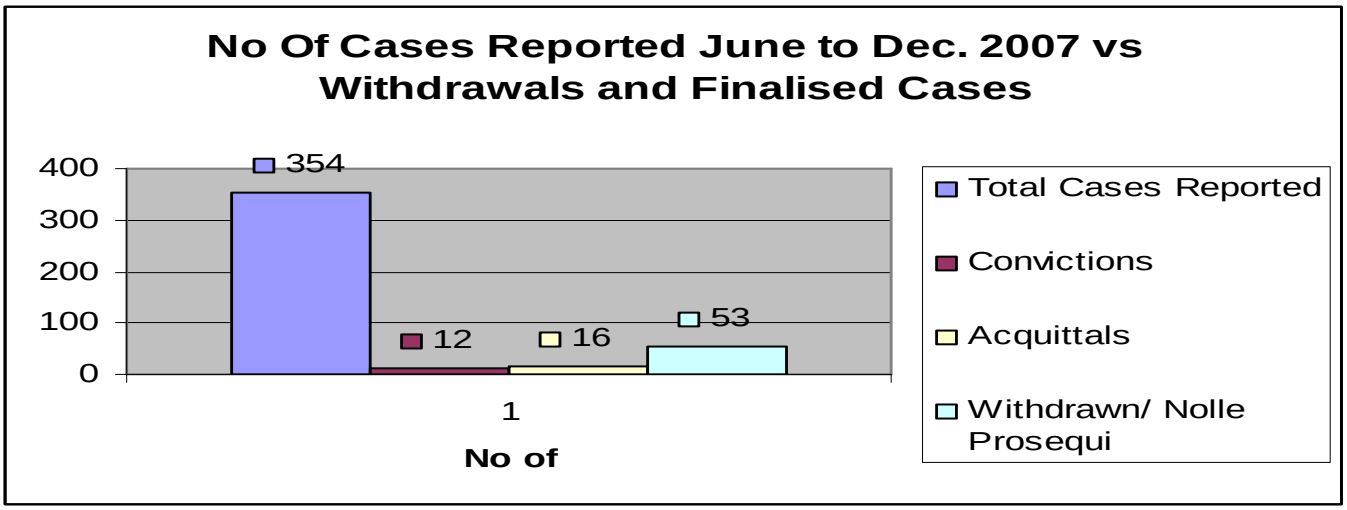

Figure 20

Reported to Finalisation

It appears that the conviction rate appears to be a constant average over a period of 1 year. Accordingly this translates that a mere 3% of cases reported in the region ends in a conviction.

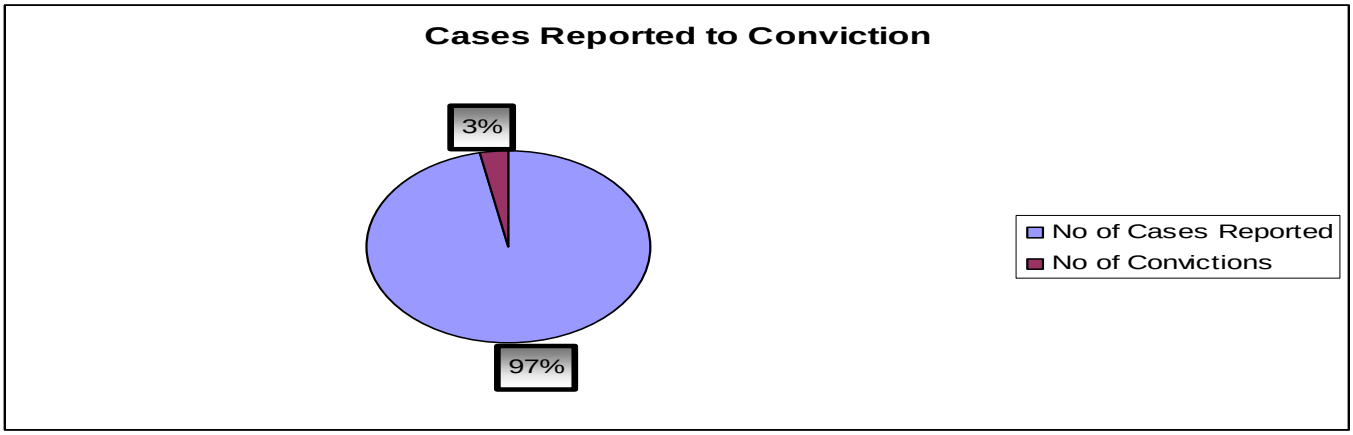

Figure 21

Reported to Conviction

9. OUTCOME

9.1. Best Practices Identified

The TsCC and SC are centres that ensure the reduction of secondary victimisation. It is unfortunate that these centres are only operational during working hours. After hours victims are referred elsewhere. Both the TsCC and the SC are clearly well managed with a good monitoring system in place to ensure that national guidelines and or protocols are observed and implemented. The centres are aesthetically pleasing and structured in such a manner that it can ensure that victims feel safe, at home and comforted. The availability of the forensic nurse at these sites adds credence to the fact that victims receive the appropriate PEP services. As there is a full time doctor at the TsCC it ensures that victims do not have to wait for long periods at a time for examinations. As the forensic nurse conduct the medical examination at the SC the same results are found. No statistics were provided and the verbal indications, verification of policies etc given inform this.

9.2. Gaps Identified

It is a concern though that the sites require other doctors that are not dedicated to sexual offences in which cases, victims as seen by doctors performing duties in the casualty sections. Accordingly rape victims do not receive preference in relation to other cases that are examined.

At all sites except for TsCC staff shortage is a major concern. At SB and LC it was reported that victims can wait up to 5 hours if not more. This is a disconcerting factor considering that police call the sites to find out where victims will not wait for too long. This process clearly does not work well. In hindsight if the TsCC were given additional staff they might be in a position to operate all hours.

Mamelodi, SB, LC facilities exacerbate trauma. Furthermore these centres are not well equipped and have no manageable link to the courts other than being informed of a date for testimony. There is no follow up system in place to ensure that victims access services to which they may have been referred to. At all sites doctors and forensic nurses complained about the inefficient services they receive at courts. They indicated that they often have to wait for hours and are consulted with in at least 1 in very 4 to 5 cases. This has caused some doctors to feel that they do not want to do medical examinations to prohibit the risk of negative exposure at the courts. They do not receive details of the victims names, dates etc in order to prepare their testimony from the hospital files.

It is evident that there is only effective victim management that takes place at the SC and TsCC sites. There are referral mechanisms in place, but these mechanisms can be enhanced.

The shortage of staff at the Mamelodi site is of grave concern. Without the requisite staff a centre at the Mamelodi hospital would defeat the objectives of the TCC Model. In fact reopening the centre in the current situation will drastically affect the victims well being. Without the requisite staffing and referral mechanism in place the victim would be lost within the criminal justice process.

The facility at SB is manifestly not conducive to the victims needs. The location of the examination area is open to all members of the public; there are no control measures to ensure that a victim and the perpetrator do not come into contact with each other. It is neither staffed sufficiently to deal with the influx of cases.

As is evident from the aforesaid there is no logical, consistent, uniform data collection system in place at the health care facilities. Whilst statistics are available for the number of victims seen. This data cannot be interpreted to assist in an analysis of the efficacy of the services offered. E.g. Data as to sero conversion rates are not kept at any of the centres. No exit interviews or service evaluation is collected and where it is (SC) and TsCC it is not uniform. There is no manner in which cases are tracked throughout the criminal justice system as each stakeholder collects data for its own purposes and none of the data is strategically aligned to address a common goal, namely victim support, reduction of cycle times, reduction of secondary victimisation and an increase in conviction rates.

The data collection in fact only serves the relevant stakeholder, but this data appears to be collection as to numbers and is not strategically aligned to inform victim management, victim empowerment, needs and concerns.

Concerns were raised about the fact that the flagship centre (TsCC) has all the requisite equipment, staffing and ideal facilities but only operates office hours. SC, SB and LC have all indicated that the bulk of cases are seen after hours, over weekends and public holidays especially so during school holidays, Easter and Christmas. One respondent was especially concerned that between the 23rd and 28th of December the TsCC could not be accessed, a time when the numbers of victims doubled. It was a site with ideal facilities that is not available at a time when victims need it most.

Police have indicated that they currently experience a shortage of transportation and that it is difficult to transport victims to the other centres outside Mamelodi, especially in light of the high volumes of cases reported. In certain instances victims are informed to go to the medical facilities on their own and there in no manner of monitoring if this has taken place.

The LC, SB and Mamelodi centres can learn from the SC and TsCC sites in reducing secondary victimisation.

It is a further point of concern that the NPA has invested R200' 000, 00 into structural renovations at the Mamelodi hospital, equipment and furniture and this has now become a wasteful expenditure as the hospital refers all cases to other health care facilities. Nonetheless in light of the aforesaid the infrastructural enhancements may still induce a certain amount of trauma.

The shortage of forensic nurses is an area that can be addressed as a matter of urgency. An indication was given that some of the forensic nurses do not want to do these cases because of the fact that they do not want to testify[11].
A research paper[12] conducted on the TCC model in December 2006 evaluated services offered by the TCC model and made recommendations on the improvement and or sustainability of the model. These included *inter alia*:

Recommendations of the Abrams report *supra*

1. Develop and implement minimum standards to assure that services are consistently and uniformly delivered.

One of the deliverables for the Thuthuzela project is the finilsation and approval of the Protocol for Thuthuzela Care Centres. This is an activity that has been done for all TCC's and will be approved at Provincial level so as to ensure standardisation of services within the TCC's In Gauteng.

2. Ensure that all TCC's operate 24 hours, weekends and on holidays.

In order to implement this recommendation sufficient staff needs to be allocated to the TCC.

3. Consistently take statements *after* victim has seen an intake counselor and undergone a medical examination.

Once the model is implemented this will be addressed in the finalization of the Protocol.

4. Consistently record the same type and quality of information in each police report.

Once the model is implemented this will be addressed in the finalization of the Protocol.

[11] Telephonic interview with Dr Poshoko
[12] Sexual Offences Courts and the Thuthuzela Care Centre Model: Evaluating South Africa's Innovative Response to Sexual Assault, Abrams E, Harvard Law School, Dec 2007

5. Ensure child friendliness at all TCC's

This would require infrastructural changes to the existing centre. A plan needs to be drafted for the Department of Health to accommodate or house the TCC in the new hospital structure.

6. Provide psychological debriefing for all staff interacting with victims of sexual violence

The NPA provides such Employee Wellness Services to staff at the TCC's and such service can accordingly be accessed if a TCC is established

7. Create and maintain a national database.

By ensuring the aligned data management system is in place, consistent and uniform structured data can be obtained.

8. Ensure NGO participation in the model

This will be addressed by the finalisation of the Protocol which seeks to ensure a formal referral mechanism is in place.

For purposes of this report the current status quo will be discussed in light of these recommendations.

10. CONCLUSION

In proportion to the number of reported cases it is suggested that a site is required in the Mamelodi area. It is further recommended that it be placed at the Mamelodi hospital. This can only e achieved with the appointment of additional medical staff. As the new hospital is currently being finalised it would be appropriate to have it placed in this facility. Further office space would however be required for police, a site coordinator and a victim assistant officer. A final date could however not be obtained for full implementation of services from this site.

If the centre were based at the Mamelodi hospital it would also ensure that victims, who require emergency medical treatment, receive such immediately.

Services can benefit form a cases manager to monitor the cycle time, report to arrest and cases.

A uniform, consistent and informed data collection system needs to be developed. There is clear disparity and inconsistency as well as unaligned data collection. The data collection systems in place serves only the needs of the respective role players and do not give a holistic picture of victim management and case tracking of the victims inception into the criminal justice system and beyond. In fact that data reveals that there is no mechanism to support the victim after the cases have been finalised.

Considering that the data revealed that only 3% of all cases reported on average amounts in a conviction, it is of grave concern that these victims are not supported throughout the system.

In proportion to the rape statistics for the area it is recommended that the site be established in Mamelodi, but this cannot succeed with further infrastructural and capacity enhancements.

One of the recommendations made by respondents was that the centre be placed in the Gateway Clinic. This is a vision that the existing hospital becomes a gateway clinic in that all first reports would come from this site. A response hereto was that this has not been finalised and no strategy in this regard exists. Accordingly it was recommended that the centre be based at the new Mamelodi hospital.

10.1. Is there a need for a TCC in Mamelodi?

The statistics reveal an alarming amount of sexual offences cases reported in the 6 month period. This translates that a total of at least 350 victims could have accessed the services and benefited from the services of a TCC in the June to December 2007 period alone. This means that an average of 60 victims could have been empowered.

Moreover the loss of cases within the system is of grave concern as it would exacerbate trauma. This factor is especially disconcerting in light of government's plight to fight sexual offences.

The lack of effective victim management, case tracking, strategically aligned initiatives, lack of stakeholder cooperation to ensure a seamless service provision, shortage of staff and training alone is grounds for motivation for a TCC. This factor together with statistical data is an overwhelming motivation for the need of a TCC.
The following indicators apply to Mamelodi services only.

Outcome	Indicator	Audit Outcome
Reduce Secondary Victimisation	1. No and % or victims who withdraw	The reasons for withdrawals are not available but the number of cases withdrawn amount to 38 for the June – December 2007 period.
Effective, Efficient, Expeditious Prosecutions	2. No and % of cases finalized with 6 months	No cases were finalized within 6 months
	3. Average cycle time	Average cycle times of cases appear to be more than 6 months in the regional court + an average of 3 months in the District Court. Accordingly the average time is more than 9 months
	4. Average conviction rate	3%
	5. No of cases postponed per month	Average of 130 cases rolled over per month
	6. No of arrests effected within 48 hrs	Information not available
Comprehensive Multi –	7. No of victims received at centre	0 victims seen at Mamelodi Hospital but 115 at SP

disciplinary Service	8. 24 hour service	SB 24 hours
	9. No and % tested for HIV	Information not available
	10. No and % received PEP etc	Information not available
Integrated referrals	11. No and % of victims referred for psycho social services	No referrals at Mamelodi and SB
	12. No and % of cases followed up	No follow ups

The aforesaid 12 performance indicators can be enhanced by the establishment of a TCC.

10.2 If so where would the appropriate location of the site be?

It is recommended that Soshunguve be considered as a possible site for the establishment of a TC. This would however require substantial infrastructural changes and appointment of staff to ensure 24 hour operations.

As a result of the shortage of vehicles and availability of services outside of the Mamelodi victims are required to go to the health care facilities when no transport is available. This amounts in several cases being withdrawn. Victims might not have the required transport of funds to access the centres that are outside of Mamelodi. Accordingly medical examination details are not recorded in the dockets. This is one of the factors that adds to the higher withdrawal rates.

The services at SB are clearly not conducive to the victims needs and it can be inferred that the site is a cause for victims not to want to report sexual abuse.

It is accordingly recommended that the ideal location for a TCC would be in Mamelodi either at the existing hospital or at the new hospital. Dr Poshoko has stated that the occupation of this new hospital was initially scheduled for October 2008. This has however been delayed due to a shortage of staff, equipment etc.[13]

10.3 What are the current best practices in the surrounding vicinity?

See discussion above regarding the TsCC and SC.

[13] Telephonic interviews with Dr Poshoko and Dr Ribeiro

10.4. What challenges prohibit the success of a TCC in Mamelodi?

1. Shortage of staff
2. Lack of equipment
3. Inadequate infrastructure
4. Lack of alignment of data collection methods and priorities
5. Inexperienced staff taking statements
6. Informal to no referral mechanisms

11 RECOMMENDATIONS

Challenge	Recommended Activity	Responsible Organisation	Deadline
Staff Shortage	Securing forensic nurses	DoH	To Be Identified (TBI)
	Securing of additional doctors	DoH	TBI
	Secure space at the new hospital	DoH and NPA	TBI
	Appoint Case manager, Site coordinator and Victim Assistant Officer	NPA	TBI
	Secure psycho – social service providers to assist at the centre	DSD	TBI
Inexperienced staff taking statements	Training of all service providers	NPA, DoH and SAPS	TBI
Lack of Equipment	Procure Equipment	NPA	TBI
Inadequate infrastructure	Identify infrastructural needs and develop a plan to procure.		
	Upgrade police stations to be VEC's	SAPS	TBI
Referral Mechanisms	Formal referral mechanism as part of a protocol	NPA, DSD, DoH	TBI
Lack of alignment of data collection methods and priorities	Standardise and implement data collection and reporting templates that are strategically aligned	All Departments	TBI

Annexure 1

Mamelodi TCC Compliance Summary		
General Standards for Health Care services: general guiding principles	**Extent of Compliance**	**Comments**
Health and welfare of patients takes priority over medico legal services	c	The site is not working well and was not seeing clients consistently at the time of the visit. Except for one doctor (an anesthetist on call) the centre has no health personnel. After hours patients previously seen by casualty doctors -- currently patients are diverted to other NGO centre.
Health care providers are appropriately trained/skilled in management of sexual assault	c	Doctor in charge, the only HCP servicing the centre, in not trained in forensic health and depends on own initiative to learn about the management of sexual assault.
Services are responsive to the needs of children , elderly, mentally impaired, and other disabilities and special needs	c	The services, at the moment, are not genuinely responsive to anyone's needs
Services are available 24 hours a day	b	Based in casualty, services are accessible 24 hours
Sexual assault patients are prioritised irrespective of the nature of physical injuries	c	If served at all, sexual assault management clients would be served by casualty doctors who do not make TCC a priority
A quiet and private environment that ensures privacy and reduce anxiety, is provided for clients/patients/	b	Centre is made up of several rooms located in casualty. With the waiting space being mainly outside the office, privacy is insufficient when several clients are present at one time. There is a small waiting room with shower and space across hall for private consultation and counseling. Waiting room needs refurbishment.
Confidentiality is assured and maintained: locking files, telephone discussion, storage of information	a	Confidentiality is protected.
Patient's consent is sought including for examination, release of information for medico-legal and counseling services. Consent is sought at each step	b	Patient consent is sought but consent is not always in writing. Written consent form for HIV but not PEP or ECP.
Patients are treated with respect and non-judgmental attitude: participate in their care, and are well informed	a	A sense of compassion was expressed by all service providers seen -- volunteers, site coordinator and the doctor in

		charge
Forensic evidence is collected before treating injuries unless the need to treat injuries is urgent.	a	Examination is prioritised over treatment of minor injuries
Information about reporting procedures are provided to client	a	Site coordinator provides information. Patients are usually brought in by police and delivered home after the services. Police statements not taken onsite.
Patients are protected from secondary victimisation and further harm	b	Some reported problems with long waits, insensitive health providers (outside TCC) etc.
(a) Compliant	**4**	
(b) Partially compliant	**4**	
(c) Non-compliant	**4**	

General quality aspects for TCC reproductive health and HIV services (based on basic services for prevention of STIs, pregnancy and HIV)	**Extent of Compliance**	**Comments**
Information is given to clients about procedures and health matters: services in the centre, health risks after sexual assault, rights regarding reporting to police, STI treatment and alcohol; common side effects, be advised to use a condom, side effects, appropriate local support, treatment regimen, complains mechanisms	b	The site coordinator and lay counselors at the centre make effort to provide key information. Site coordinator/counselors play role in counseling patients on health related issues (PEP, psych impact, etc.) due to lack of nursing personnel assigned to site. Information is however not validated/corrected by health practitioners, or relevant literature.
Psychological support and counseling: trauma containment, Iong -term counseling for sexual assault psychological impact of sexual assault, and referrals	b	Trauma counseling is limited to the minimum that the counselors can provide, without skills in trauma management. Site coordinator also plays a role in comforting/supporting clients during office hours.
Pregnancy test: indicated for female children and women of child bearing age not adequately covered by contraceptives, Urine tests and results available on same day.	b	Pregnancy test is done to all women of reproductive age, by a volunteer
Emergency contraception: indicated to be taken within 5 days, Regimen include COC and POC, upping a dose in patients on liver enzyme inducing drugs, option of a levornogestrel stat does of 2 pills is also allowed for. Use of IUD is discouraged, anti emetic is recommended	b	Emergency contraception is only made available to clients presenting with 72hours
STI prophylaxis is administered to all clients	a	all clients receive STI prophylaxis

STI Treatment: leave out STI cultures and follow syndromic management treatment, Std treatment (doxycycline 100mg b.d- 7 days; ciprofloxicin 500mg po stat, metronidazole 2g po stat and for preg women: ceftriaxone 125ml stat, erythromycin 500mg for 7 days, metronidazole	b	Doctor prescribes the treatment, and its collected from the Pharmacy. There is however some inconsistency of the treatment given. The extent of variation is difficult because it was not possible to see more practitioners
Hepatitis B Screening: Blood should be taken for the screening of Hepatitis B, Full vaccine of 3 doses should be given to patients1 month apart, ask to return a month later	c	Hepatitis B is not routinely screened and vaccine is not routinely administered
Tetanus prophylaxis: indicated where there is a break in the skin or mucosa contaminated by external debris	c	No tetanus shots are not given
HIV counseling: pre test counseling, post test, balance between emotions and information, detailed post test counseling and referral for HIV management in case of HIV positive.	b	The VCT counselors do their best with minimal training/ mentoring and less supervision. The level and quality of counseling can benefit from some improvements.
HIV test: Rapid, or blood be sent to laboratory; immediately or after 3 days, and results may be presented immediately or after 3 days, PCR for children under 15 months (or antibody tests if PCR is not available), patients presenting after 72 hours be advised to return for repeat tests;	b	Rapid test is done by counselors to all clients before they can be examined. Clients not agreeing to be tested do not receive ART/PEP
Treatment administration: PEP/ARV therapy is offered to all presenting within 72 hours, 3 day starter pack to those not testing or not ready for results; the rest of the treatment given when the HIV status of the patient had been established, a month's treatment supply with an appointment card be given for those who cannot return for one week assessment discontinue PEP in sero-conversion.	b	Treatment is given to all testing HIV negative and presenting within 72 hours. No starter packs offered. PEP supplied in weekly supplies (42 100mg AZT pills per week!). Patients must return to site for monitoring and additional PEP.
The recommended regimen: AZT- 200mg 8hourly for 28 days 300mg 12 hourly, and 3TC - 150mg 12 hourly, and for children the dose is set in accordance with age, weight and height, and recommends caution and challenges in administration on PEP in pregnancy. In high exposure - a third drug lopinavir/ritonavir 400/100mg 12hourly	b	Treatment regimen and dosage given is AZT- 200mg 8hourly for 28 days (for which they give pills of 100 mg each) and 3TC -150mg 12 hourly. Ther children the dose is set in accordance with age, weight and height. There is no 3rd drug available
Treatment in pregnancy and in children: In pregnancy of less than 12 weeks clients must be informed about risks and be allowed to make a choice, in children treatment is calculated according to age, weight and height for AZT and 3TC on 12hourly basis	b	The counselors advise against the use of PEP in pregnancy. Syrups available for children. Drs. calculate dose.

Institute measures to facilitate compliance: advice return to health facility in case of side effects, provide anti - emetic, home visits, follow-up phone call, referral to NGOs, support groups	c	There are no systems of measure and foster compliance. Even though clients return on weekly basis, they are often not seen by a health practitioner, and treatment adherence is not addressed in a comprehensive way. No written handouts provided; no follow up calls or links with NGOs or community organizations to provide patients with support.
Follow-ups: HCP expected to ensure follow-ups at 3days, 6 weeks and 3 months. HIV tests also recommended at 6 weeks, 3 months and 6 months.	b	Follow-ups tests are encouraged and done at 6 weeks, 3 months and 6 months. The extent to which they happen is limited.
Referrals: written referrals should be provided if requested. Referrals to legal aid, soc services, reproductive health, rape crisis centres, shelters, etc	c	Site coordinator will arrange shelter and HIV+ patients referred to hospital ART unit. There are no written referrals made to other centres, and there are no systems in place to ensure appropriate referral.
Support to patients testing HIV positive: current emotional state and plans, and referral for further management.	a	Patients testing HIV positive are referred to the hospital ART site
Skills expected of health service providers: HIV pre and post test counseling, Screen for STI and HIV, Treat physical injuries Preventing unwanted pregnancy Prevent and treat STIs Administer HIV PEP Refer to appropriate resources, and provide psychosocial support (mainly show of empathy)	b	Skills in the areas of sexual assault management and HIV counseling are weak among health practitioners. Some of the trained professionals have had to take other posts within the hospital, leaving the centre without adequate personnel.
(a) Compliant	**2**	
(b) Partially compliant	**12**	
(c) Non-compliant	**4**	
Key & Summary Table		
(a) Compliant	6	20%
(b) Partially compliant	16	53%
(c) Non-compliant	8	
	30	73%

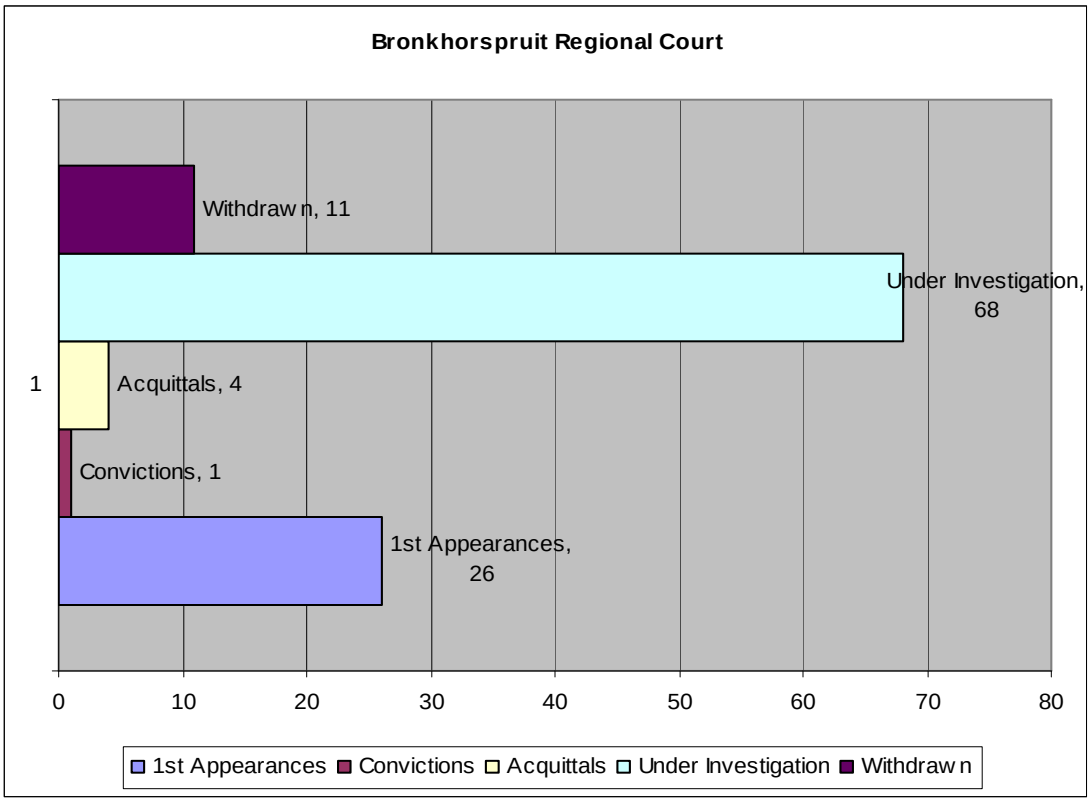

Figure 22

Bronkhorstspruit Regional Court

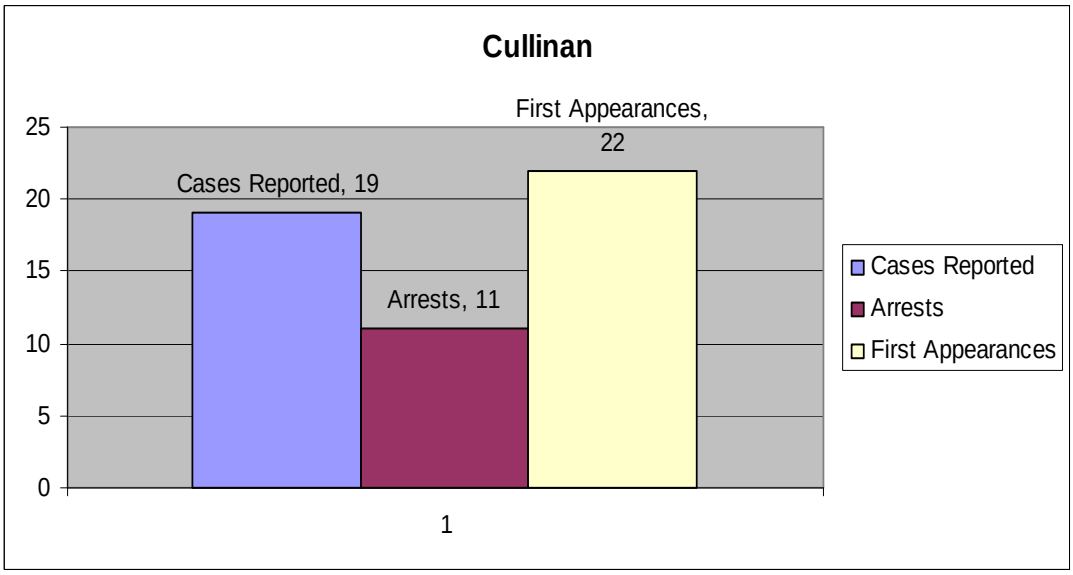

Figure 23

Cullinan Courts

Special thanks and gratitude to the audit team and all persons who assisted in the collection of data, set aside some time for interviews in person of telephonically. Special thanks to the Gauteng Departments of Health and Social Developments as well as the SAPS for availing persons to assist in the audits, data collection.