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Impact Evaluation of the “Increasing Services for Survivors of Sexual Assault in South Africa” Program

BASELINE REPORT

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ACRONYMS

APD	Association of Persons with Disabilities
CAPI	Computer Assisted Personal Interviewing
DoSD	Department of Social Development
FAMSA	Families South Africa
FPD	Foundation for Professional Development
GoSA	Government of South Africa
ICC	Intra-class Correlation Coefficients
IE	Impact Evaluation
IRI	Impact Research International
ISSSASA	Increasing Services for Survivors of Sexual Assault in South Africa
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
MDES	Minimum Detectable Effect Sizes
MSCRT	Multi-site Cluster Randomized Trial
NGO	Non-governmental Organization
NPA	National Prosecuting Authority
PEP	Post-exposure Prophylaxis
RCT	Randomized Control Trial
SAECK	Sexual Assault Evidence Collection Kits
SAPS	South African Police Service
SGBV	Sexual and Gender Based Violence
SI	Social Impact
SOCA	Sexual Offenses and Community Affairs
TCC	Thuthuzela Care Center
TVP	The Venus Project
VAO	Victim Assistant Officer
WHO	World Health Organization

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EXECUTIVE SUMMARY

INTRODUCTION

This report presents findings from the baseline data collection for USAID/South Africa’s (USAID/SA) Increasing Services for Survivors of Sexual Assault in South Africa (ISSSASA) Program. The objective of this program is to improve service provision and community awareness of services for survivors of sexual assault in South Africa, which struggles with one of the highest rates of gender-based violence in the world (Genderlinks, 2011). The Government of South Africa’s (GoSA) fight against sexual and gender based violence (SGBV) is spearheaded by the Sexual Offenses and Community Affairs (SOCA) unit of the National Prosecuting Authority (NPA) within South Africa’s Department of Justice and Constitutional Development (DOJ/CD). USAID has worked with the NPA/SOCA since 1999 to establish the Thuthuzela Care Center (TCC) model.¹ TCCs provide a comprehensive portfolio of services to survivors of SGBV, including emergency medical care, psychosocial counseling, post-exposure prophylaxis (PEP), HIV testing and counseling, and assistance with case reporting and court preparation in an integrated and victim-friendly manner. The TCC model seeks to streamline the care process for SGBV survivors by establishing effective linkages between various service providers and government stakeholders, and to improve legal services by reducing time-to-court and increasing the conviction rate.

This impact evaluation (IE) is a rigorous study of the effectiveness of two distinct intervention approaches to increase the rates of SGBV survivor reporting, follow-through with services, and public awareness and understanding of SGBV and resources available to survivors. The first of these interventions is a demand-side intervention implemented by Soul City Institute (Soul City) and Sonke Gender Justice (Sonke) and entails multi-media community dialogues held separately with women and men to provide information about SGBV and TCCs. The second is a supply-side intervention implemented by the Foundation for Professional Development (FPD) and includes multi-disciplinary trainings for service providers in the TCC referral and care networks.

This IE will serve to provide evidence about the effectiveness of supply-side versus demand-side outreach activities for improving service awareness in South Africa, and in similar contexts. The outcomes of this IE are expected to be highly informative for both the academic and development communities, and for stakeholders working to address SGBV in South Africa. The findings of this IE may also have implications for funding decisions bearing on accountability and other development objectives.

EVALUATION QUESTIONS AND DESIGN

This IE utilizes a Randomized Control Trial (RCT) design to assess the marginal effectiveness of each of the two interventions. This experimental evaluation design enables estimation of the average effect of each of the two interventions on the outcomes of interest by comparing communities that received either of the interventions to those that did not. Unfortunately, due to sample size and resource constraints, it was not possible to test the combined effect of both interventions administered simultaneously.

The IE was designed to address the following evaluation questions:

Do the interventions:

1. Increase utilization of TCCs?

¹ Thuthuzela is a Xhosa word meaning “to comfort.”

2. Increase public knowledge about SGBV and TCCs?
3. Reduce stigma associated with SGBV?

At the start of this IE, there were 51 TCCs operating in South Africa.² Three police precincts around each of the 51 TCCs were selected to participate in the IE, and randomized to one of the three study groups—control, demand-side treatment 1, or supply-side treatment 2.³ The resulting distribution of the communities selected for the evaluation was as follows: 50 communities received the demand-side community dialogues outreach program, 50 received the supply-side service provider training, and the remaining 50 received neither and serve as control group.

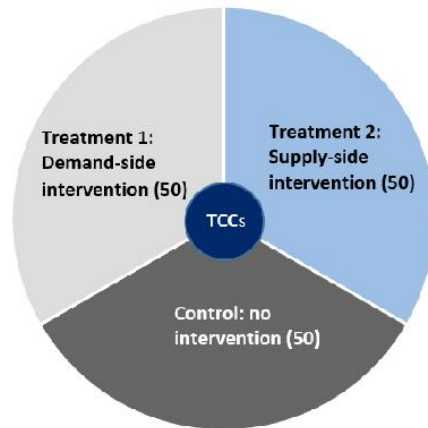


Figure 1: Treatment and control groups

This IE relies on administrative and government secondary data, and quantitative and qualitative data collected by the IE team, with each data source contributing to measurement of the evaluation outcomes. At the precinct level, the evaluation team has worked in collaboration with the NPA and the TCCs to collect precinct specific administrative data on use of TCC services. As suggested by Table 1, by comparing these TCC records across the treatment and control precincts, the evaluation team will be able to test which if any of the two interventions increases use of TCC services (Hypothesis 1). These quantitative data will be complemented by qualitative data collected through interviews. A total of 94 interviews were conducted across all 51 TCC catchment areas. Interviewees included senior staff from 51 TCCs,⁴ representatives of 40 local non-governmental organizations (NGOs)—many of which were characterized as Victim Empowerment Programs (VEPs), and three independent counsellors (non-NPA employed) who assist with survivor case management.

² Since the start of this IE, three more TCCs have been constructed, which are not included in the evaluation.

³ Because two TCCs reported working with fewer than three police precincts (one TCC works with one precinct and another works with two), the number of police precincts per treatment arm was reduced to 50.

⁴ One TCC interview was excluded from analysis due to discrepancies between the researcher’s original notes and the final transcription notes. See section 2.3.5 of this report for more detailed discussion.

Table 1: Quantitative data sources by hypothesis and outcome indicator

	Hypothesis	Outcome Indicator	Data Source
Precinct-level	H1: Increase in reporting of SGBV and utilization of TCC services	SGBV reporting	Police & TCC records, Supplemental Intake Form
		Utilization of TCC services	TCC records, Supplemental Intake Form
		Follow-through with TCC services	TCC records, Supplemental Intake Form
Individual-level	H2: Increase in knowledge of SGBV and TCCs	Community knowledge of SGBV	Women's survey
		Service providers' knowledge of SGBV	Service provider survey
		Community knowledge of TCCs	Women's survey
		Service providers' knowledge of TCCs	Service provider survey
	H3: Improvement in attitudes toward SGBV	Community perceptions of SGBV	Women's survey
		Service providers' perceptions of SGBV	Service provider survey

A survey of 1,500 women in treatment 1 and control areas at baseline and endline in all nine provinces in South Africa where TCCs operate will allow the evaluation team to test if community outreach campaigns increase community knowledge of and attitudes towards SGBV (Hypotheses 2 and 3). In addition, by comparing an endline survey with a baseline survey of service providers participating in trainings as part of treatment 2, the evaluation team will also test whether service providers' knowledge, attitudes, and self-reported behavior change as a result of the trainings (Hypotheses 2 and 3). Of the total 1,908 training participants, 1,789 (94%) participated in the evaluation at baseline.⁵ While the response rate among training participants was high, not all participants completed the survey in its entirety, so there are some missing data on most survey questions.

FINDINGS

TCC capacity

Qualitative data on TCC capacity collected via in-depth, targeted interviews yields important findings about the challenges confronting TCCs.

Variation in accessibility: Twenty-three TCCs were open Monday through Friday while 20 were open seven days a week. Twenty-one TCCs reported operating 24 hours a day with support from non-TCC staff, typically NGO staff. Operating hours for TCCs that were not open around the clock ranged from 7:00 AM to 7:00 PM, with the majority open between standard business hours (8:30 AM and 4:30 PM). Most TCCs that did not operate on a 24 hour schedule referred survivors to external partners for services after regular business hours. After-hours services were available at 34 TCCs, 33 of which received after-hours support from external partners.

Under-resourced: Even with NGO employees supplementing TCC staff, many TCCs reported being chronically understaffed. In thirty TCCs, at least one staff position was not filled at the time of the interview, and ten other TCCs had one or more unfilled staff positions in the months preceding the interview. Many TCCs were quite difficult to locate, even for experienced research staff. Despite having coordinates for each TCC, the research team was unable to find 31 of 50 sites without asking for directions.

⁵ Excludes participants from Margate precinct in KwaZulu-Natal province. This precinct was dropped from the evaluation due to delays in implementation.

Concerns over capacity: Few TCC Site Coordinators expressed high confidence in their TCC's capacity and ability to meet survivors' needs successfully. Respondents were asked to rate their TCC's overall capacity on a four-level scale ranging from "completely adequate" to "not at all adequate." Only one respondent rated their TCC as fully adequate. TCC respondents described their TCCs as having limited resources, supplies, staffing, and facilities as barriers to serving survivors.

Barriers to utilization: Because of the way TCC utilization data was captured, TCC utilization across TCCs and across precincts was still not available at the time of this report and will be included in the endline analysis. Interview respondents cited numerous factors that pose barriers to utilization of TCCs. Two of the main challenges were locating the TCC and access to transportation. Respondents observed that survivors are not aware of TCC services and have misperceptions of the type of services provided.

Important collaboration with NGOs: TCCs typically partner with NGOs that support their work with survivors, as well as extend and integrate services throughout the community. Nearly all NGO representatives reported favorable, productive working relationships with TCCs and understanding of TCC resource constraints.

Women's knowledge and attitudes

The women's survey administered to 1,500 women across the supply-side treatment 1 (community dialogues) and control police precincts produces important baseline information about respondents' knowledge of TCCs and attitudes towards SGBV.

Balanced groups: The treatment and control groups tested positively for statistical equivalence; balance statistics confirmed that the selection and random assignment of communities was successful in creating reasonably comparable treatment and control groups on demographic characteristics and key outcome variables. The typical woman in the sample is 32 years old, identifies as black, has attained a secondary education, and reports a household income of 1,001 to 5,000 Rand (\$73 to \$365 USD) per month.

Minimal knowledge of TCCs: Baseline data confirm anecdotal evidence that many South African women do not know about TCCs. Specifically, 82% of women's survey respondents reported not having heard of a TCC. Responses to this key survey question varied substantially by province, with only 2% of respondents in Gauteng responding affirmatively, compared with 38% in Eastern Cape Province. This relationship is statistically significant ($p < .01$). Knowledge of TCCs is also significantly associated with age ($p < .01$) and income ($p < .05$), with older and wealthier respondents being more likely to know of the TCCs.

SGBV is under-prioritized: In order to compare how women perceive sexual assault relative to other crime problems, respondents were asked to assess the severity of the problems presented by several common crimes. Respondents were more inclined to report house-breaking or mugging as problems than sexual assault or domestic violence. In contrast, South African Police Service (SAPS) crime statistics demonstrate that there were fewer instances of common robbery in South Africa in 2013: 53,439, compared with 66,197 instances of sexual assault. This finding suggests that sexual assault may actually be more prevalent than perceived by communities. Despite 54% of respondents ranking sexual assault as "not a problem" or "a minor problem," 25% of respondents report personally knowing women or girls who have been raped or sexually assaulted in the last year, and 37% report personally knowing a woman or girl who has been raped or sexually assaulted in her lifetime.

Progressive attitudes with some concerning exceptions: The responses to the survey module assessing gender attitudes show progressive gender attitudes among respondents at

baseline. Very few respondents indicated that there are some situations when violence toward women would be warranted or tolerated. Moreover, responses generally suggested low levels of victim-blaming in rape cases; however, there were a few concerning exceptions. Approximately one quarter of respondents indicated sexual violence is not rape if the victim does not fight back, and that one should consider a victim's sexual reputation in a rape case. Notably, 42% of respondents disagreed that a woman has the right to refuse sex with her husband if she so chooses.

Service providers' training, perceptions, and knowledge

All participants in the service providers' training (supply-side treatment 2) were requested to consent to and complete a brief survey about their knowledge of TCCs and SGBV perceptions, and recent practices with survivors of SGBV.

Service providers: As envisioned in the training curriculum, trainees came from a variety of professions, with social workers, NGO workers, and police attending the trainings at higher rates than other professions. Of those attending the training, 36% reported having previously attended a training on sexual assault (n=1,528). Two thirds of respondents in the sample who disclosed their sex (n=1,537) were female.

Mixed knowledge about TCCs before the training: Nearly 80% of respondents reported knowledge of TCC services, and 81% knew that there are services available to victims of sexual assault in their community. Despite reporting knowledge of TCC services, just over half of respondents correctly identified that TCCs provide medical assistance. Only 37% of respondents correctly indicated that TCCs provide legal assistance to survivors.

Room for improvement in referrals: While most respondents reported having informed survivors about their rights or receiving a report of SGBV, less than half reported personally taking someone to a TCC, and 59% reported helping a victim establish a safety plan.

Evidence of victim-blaming: In responses to questions on attitudes towards SGBV, service providers expressed moderate levels of victim-blaming. Nearly half of respondents indicated that the extent of a woman's resistance should be the major factor in determining if a rape has occurred, and some believed that women provoke rape by their appearance or behavior.

CONCLUSION

Qualitative and quantitative data collected at TCCs reveal that TCCs vary in capacity and in resource availability, with differences in days and hours of operation, appearance and quality of facilities, services provided, staffing, record keeping practices, and resources. Through coordination with NGOs and other stakeholders, TCCs are able to fill service gaps that they could not address on their own, and improve the quality of care provided survivors. TCC capacity and utilization data will be used as control variables in the final impact evaluation analysis and may help explain possible differential treatment effects across TCCs.

Baseline women's survey data (treatment 1 and control groups) confirm anecdotal evidence that many South Africans are not aware of the TCCs. While the women's survey data reveal generally progressive attitudes toward gender roles and the sexual assault scenarios, there are some areas of concern regarding the right of a woman to deny her husband sex and to condemn rape in all scenarios. The evaluation will test if there is a change in SGBV knowledge and attitudes as a result of the intervention, particularly in areas where concerning attitudes were expressed at baseline.

Baseline service provider survey data (treatment 2) reveal that many professionals participating in the Integrated Management training intervention had limited exposure to TCCs prior to the training, and harbored some misperceptions about TCCs and the services available, although most believe that TCCs

would be helpful in providing support to victims. Moreover, participants exhibited some victim-blaming attitudes. The evaluation will follow up with the same respondents at endline and will test for differences in knowledge and attitudes after the professionals completed the training.

I. INTRODUCTION

This report presents findings from baseline data collection for USAID/South Africa's (USAID/SA) ISSSASA Program, under the Democracy, Rights, and Governance – Learning, Evaluation, and Research (DRG-LER) contract. The ISSSASA project is a five-year, ten million-dollar project that is managed by USAID/SA's Democracy, Human Rights, and Governance Office. The objective of this program is to improve service provision and community awareness of services for survivors of sexual assault. The project is scheduled to run from 2013 to 2018 with the objectives of improving and expanding TCC services as well as raising public awareness of TCCs, TCC services for survivors of sexual assault, SGBV in general.

I.1 EVALUATION PURPOSE

Jointly commissioned by USAID/SA and the Learning Team at USAID's Center for Excellence in Democracy, Human Rights, and Governance, this IE rigorously evaluates the effectiveness of two distinct intervention approaches to improving SGBV survivor reporting, increasing follow-through with services, and increasing public awareness and understanding of SGBV and resources available to survivors. Results from this study will help inform USAID and implementing partners on effective approaches to addressing challenges in TCC and SGBV awareness, reporting, and service follow-through, and will also provide general information on the function and role of the TCCs in providing services to survivors of sexual assault in South Africa.

This IE will serve to provide evidence about the effectiveness of two different approaches—supply-side versus demand-side outreach activities—to improve TCC service awareness in South Africa, and in similar contexts. The outcomes of this IE are expected to be highly informative for both academic and development communities, and for stakeholders working to mitigate SGBV in South Africa. The findings of this IE may also have implications for funding decisions bearing on accountability and other development objectives.

I.2 PROJECT BACKGROUND

Sexual and gender based violence is a pervasive global health and development problem with substantial physical, social, and economic consequences. SGBV is committed by either intimate partners or strangers, and while both men and women experience and perpetrate SGBV, it is most commonly perpetrated by men against women. In all of its forms, SGBV is a human rights violation rooted in gender inequality, patriarchal social norms, and rigid gender roles that equate masculinity with violence. SGBV is linked to numerous health problems, including physical injuries, psychological trauma, unwanted pregnancy, adverse pregnancy outcomes, sexually transmitted infections (including HIV), issues with contraception and abortion, and increased mortality.

South Africa has one of the highest rates of SGBV in the world (Genderlinks, 2011). In 2013/2014, 62,649 sexual offenses were reported to the police (SAPS, 2014), a 5.6% decrease from the previous year. However, best estimates indicate that at most only one in nine rapes are reported to authorities (Jewkes and Abrahams, 2002), so the true number is likely significantly higher. One of four adult South African women report having experienced sexual and/or physical intimate partner violence in their lifetimes (Shai and Sikweyiya, 2015). Over half of all female homicides in South Africa are committed by an intimate partner—six times higher than the global average—and women of color and women ages 14 to 44 are especially vulnerable to mortality from intimate partner violence (Abrahams et al., 2009).

A 2011 study found that 42% of men disclosed having perpetrated intimate partner violence and almost 28% of South African men had raped a woman, whether an intimate partner, acquaintance, or stranger

(Jewkes et al., 2011). Over half of those men committed rape on multiple occasions, and 75% perpetrated their first rape before age 20. In addition to perpetrating sexual violence, young people are particularly likely to be victimized; 60% of survivors presenting at TCCs are under 18, and 40% of the survivors are under the age of 12 (South African government, 2013).

Although the scope of SGBV in South Africa has been increasingly documented, the subject remains understudied because many survivors do not report or discuss their experiences. Stigma, shame, and fear, as well as financial and emotional dependency on perpetrators, often deter survivors from reporting SGBV or seeking help. Further, current social structures tend to embed permissive patriarchal norms, condone sexual assault, and even stigmatize survivors and those who utilize SGBV services.

The GoSA fight against SGBV is spearheaded by the SOCA unit of the NPA within South Africa's Department of Justice and Constitutional Development. USAID has worked with the NPA/SOCA since 1999 to establish the TCC model. TCCs provide a comprehensive portfolio of services to survivors of sexual violence, including emergency medical care, psychosocial counseling, PEP, HIV testing and counseling, and assistance with case reporting and court preparation in an integrated and victim-friendly manner. The TCC model seeks to streamline the process for SGBV survivors by establishing effective linkages between various service providers and government stakeholders, and to improve legal services by reducing time-to-court and increasing the conviction rate.

Improperly or inadequately trained responders and service providers can further victimize SGBV survivors, who, in particular, require sensitivity and attention to privacy, confidentiality, and security. TCCs work to avoid possible secondary victimization, which can take the form of survivors being blamed or disbelieved, having to give their statements multiple times, or being forced to exhibit injuries or recount experiences in open areas of police stations. Even for SGBV survivors who report their experiences and receive services and medical care, successful prosecution of perpetrators is rare. In 2012/2013, only 7% of reported sexual offense cases resulted in conviction (Gibbs et al., 2014). The NPA is currently supporting research to better understand the challenges to successful prosecution of perpetrators and the best ways to overcome them. One key challenge is the collection, analysis, and presentation of medico-legal evidence, which includes genital and non-genital injuries and DNA evidence. Evidence of injuries are currently recorded on J88 forms at TCCs, which are completed by doctors or forensic nurses, and DNA evidence is collected through Sexual Assault Evidence Collection Kits (SAECK). Physical evidence has been shown to be a strong factor in successful sexual violence prosecutions (Ibid.), but its use has been inhibited by improper collection and handling of evidence and by victims not always coming forward right away.

While improving the quality of care is essential, it is imperative that victims actually access and utilize SGBV services. SGBV continues to carry significant stigma and many potential victims remain unaware of TCCs and their services. A formative research effort by the NGO Soul City identified significant barriers to the access and use of TCC services (Soul City Institute, 2013). The study conducted interviews with fifteen focus groups of eight to 12 participants each, spanning rural, semi-urban, and urban areas of five provinces to assess the general public's knowledge of sexual assault, TCCs and TCC services. Three of the main barriers identified by the study included: (1) shame and stigma associated with sexual assault; (2) lack of knowledge about the TCCs and TCC services; and (3) poor institutional support for the TCC referral system, i.e., the police and school teachers. This IE focuses on evaluating the effectiveness of interventions to alleviate the second and the third barriers to TCC utilization. This focus area was selected in consultation with the stakeholders and the USAID/SA Mission staff, taking into account the IE design and implementation constraints.

This IE evaluates two specific approaches to increasing public awareness about and increased use of TCCs, representing a subset of the USAID-funded ISSSASA program:

Demand-side intervention, multi-media community dialogues: This demand-side intervention provides information (e.g., flyers, posters) about TCCs and TCC services to the local communities, through a

community dialogue format, hosted by two CSOs—Sonke Gender Justice and Soul City. The dialogues seek to educate community members about sexual assault and other SGBV issues, and dispel common misperceptions of TCC services. Soul City hosts dialogues for women and girls, while Sonke Gender Justice hosts dialogues for men and boys.

Supply-side intervention, multi-disciplinary training programs: This supply-side intervention provides training for the professional service providers in TCC referral and care networks. Within each community, approximately thirty multi-disciplinary professionals, including police officers, teachers, social workers, health professionals, NGO representatives, and TCC staff attend a training conducted by FPD. Participants are trained on the legal framework and support standards for provision of services to survivors of SGBV, child protection, and court/litigation preparation. Roving teams provide follow-up with the trainees at their home institutions. The results chain for each of the two interventions is presented in Figure 2 below.

USAID and the implementing partners expect that the supply-side community dialogues and demand-side service providers training will have a direct effect on increasing awareness of TCCs and the associated services, therefore potentially increasing reporting of SGBV and utilization of TCC services, and improving the rate of follow-through with support services and criminal cases.

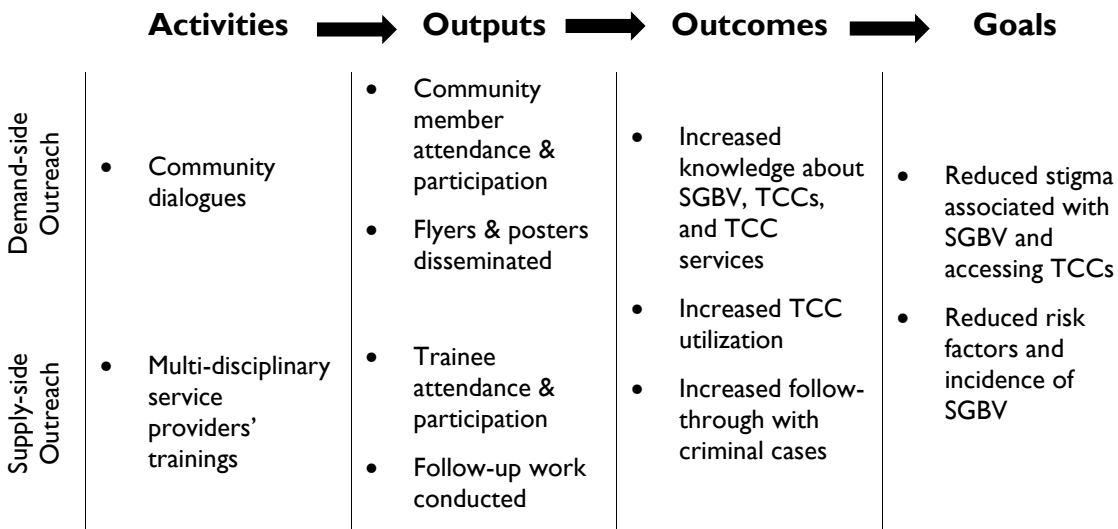


Figure 2: Results chain

2. EVALUATION DESIGN

This IE utilizes an RCT design to assess the effectiveness of each of these two interventions. This experimental evaluation design enables estimation of the average effect of each of the two interventions on the outcomes of interest by allowing effective comparison of communities that received either intervention to those that did not. As such, the RCT design permits causal identification by reducing selection bias and other endogeneity problems and by controlling for confounding variables (Angrist and Pischke 2010; Banerjee and Duflo 2008; Duflo, Glennerster, and Kremer 2006), permitting inference about the effectiveness of the supply-side versus the demand-side approach.

2.1 EVALUATION QUESTIONS AND HYPOTHESES

This impact evaluation was designed to address the following evaluation questions:

Do the interventions:

1. Increase utilization of TCCs?
2. Increase public knowledge about GBV and TCCs?
3. Reduce stigma associated with SGBV?

The resulting hypotheses⁶ are:

H1: Interventions will have a positive effect on the reporting of SGBV and on take-up of TCC services.

H2: Interventions will have a positive effect on the community and professionals' knowledge of SGBV, TCC presence and TCC services.

H3: Interventions will reduce community and professionals' attitude toward SGBV.

To test these hypotheses for each of the interventions, 150 police precincts around 51 TCCs were randomly selected into one of three groups: (1) a demand-side treatment group, consisting of communities in which multi-media community dialogues were conducted, (2) a supply-side treatment group, from which multi-disciplinary service providers were recruited to participate in a training program, and (3) a control group that did not receive any SGBV related intervention as part of the ISSSASA Program.⁷ A schematic diagram of this design is shown in Figure 3.

⁶ Discussions with the implementing partners and USAID revealed concerns over the ability of the intervention to measurably impact stigma associated with SGBV or follow-through with criminal cases. Accordingly, the evaluation team considers hypotheses 1 and 2 as primary, and hypothesis 3 as secondary.

⁷ Because two TCCs reported working with fewer than three police precincts (one TCC works with one precinct and another works with two), the number of police precincts per treatment arm was reduced to 50.

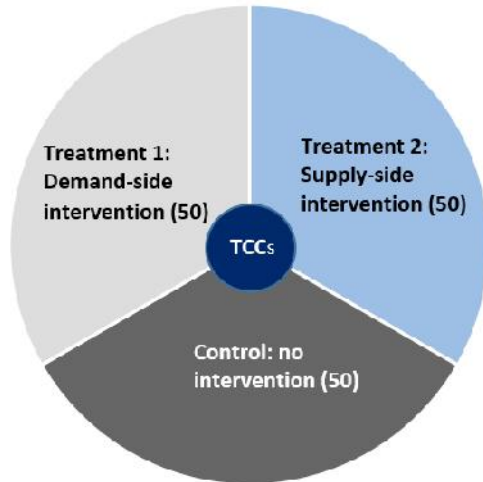


Figure 3: Treatment and control groups

This IE utilizes two layers of measurement: the police precinct level and the individual level. At the precinct level, the evaluation team has worked in collaboration with the NPA and the TCCs to collect precinct specific administrative data on use of TCC services. By comparing these TCC records across the treatment and control precincts (shown in Table 2), the evaluation team will be able to test which if any of the two interventions increases use of TCC services (Hypothesis 1). These quantitative data are complemented by qualitative data collected through interviews with TCC staff and supporting NGOs.

Table 2: Quantitative data sources by hypothesis and outcome indicator

	Hypothesis	Outcome Indicator	Data Source
Precinct-level	H1: Increase in reporting of GBV and utilization of TCC services	SGBV reporting	Police & TCC records, Supplemental Intake Form
		Utilization of TCC services	TCC records, Supplemental Intake Form
		Follow-through with TCC services	TCC records, Supplemental Intake Form
Individual-level	H2: Increase in knowledge of GBV and TCCs	Community knowledge of SGBV	Women's survey
		Service providers' knowledge of SGBV	Service provider survey
		Community knowledge of TCCs	Women's survey
		Service providers' knowledge of TCCs	Service provider survey
	H3: Improvement in attitudes toward SGBV	Community perceptions of SGBV	Women's survey
		Service providers' perceptions of SGBV	Service provider survey

A survey of women in treatment 1 and control areas at baseline and endline in all nine provinces in South Africa where TCCs operate will allow the evaluation team to test if community outreach campaigns increase community knowledge of and attitudes towards SGBV (Hypotheses 2 and 3). In addition, by comparing an endline survey with a baseline survey of service providers participating in trainings as part of treatment 2, the evaluation team will also test whether service providers' knowledge, attitudes, and self-reported behavior change as a result of the trainings (Hypotheses 2 and 3).

2.2 SAMPLING, RANDOMIZATION, AND POWER CALCULATIONS

This evaluation was designed as a multi-site cluster randomized trial (MSCRT). The sampling approach is bound by the total number of sites (TCCs) and the total number of geographic clusters (police precincts

served by each TCC).

2.2.1 Precinct level

At the start of this IE, there were 51 TCCs operating in South Africa;⁸ with each TCC serving from one to 18 police precincts, with the majority of TCCs serving three to six police precincts. The treatment and control groups were balanced to minimize bias during the sampling and randomization process. Three police precincts around each of the 51 TCCs were selected to participate in the IE.⁹ A sophisticated balanced assignment technique developed by Dr. Maximilian Kasy was applied to select three precincts within each TCC catchment area to assign each precinct to one of three groups: control (no treatment), demand-side treatment 1, or supply-side treatment 2.¹⁰

The balancing technique to select precincts optimally minimizes the expected squared error of estimators of treatment effects, based on a set of precinct covariates that balance on several characteristics. These included variables from census data and police crime statistics for each of the precincts likely correlated with sexual assault prevalence,¹¹ specifically: population size, sexual assault rate, homicide rate, and percentage of the population that is rural. The regression specification was:

$$Y_{ic} = \delta_t + \delta_c + X_{ic} \cdot \beta + \epsilon_{ic}$$

Where:

- i indexes precincts
- c indexes clinics
- t denotes treatment assigned
- δ_t is a treatment fixed effect, corresponding to the assigned treatment t
- δ_c is a clinic fixed effect
- X_{ic} is a set of precinct specific covariates, including population, sexual assault rate, homicide rate, and percent rural
- ϵ_{ic} is a regression residual

A total of 100,000 sets of possible treatment assignments (combinations of 0, 1, and 2), from all possible combinations, were drawn, blocking at the TCC (Kasy 2014). Using the regression specification above, the treatment assignment with the lowest value for the objective function was selected (Kasy 2014). The resulting distribution of the communities selected for the evaluation was as follows: 50 precincts selected for the demand-side community dialogues (treatment 1), 50 for the supply-side service providers' training (treatment 2), and the remaining 50 to serve as control group that received neither of the interventions. This design will allow the IE team to assess the marginal effectiveness of each of these approaches for the precinct-level outcomes. Initial power calculations conducted at the design phase (see Annex 1) indicate that the study would have the power to detect moderately large average program effects (0.65 to 0.53 standard deviation units); there is a risk that the study could find moderate but statistically insignificant impacts because the sample size is modest. The following assumptions formed the basis of the power calculations:

⁸ Since the start of this IE, three more TCCs have been constructed, which are not included in the evaluation.

⁹ Two TCCs reported working with fewer than three police precincts (one TCC worked with two precincts and another TCC with one precinct), reducing the number of police precincts per treatment arm to 50.

¹⁰ As previously noted, two TCCs work with fewer than three precincts, so triplicates (T1, T2, control) were not possible for each of the 51 TCCs.

¹¹ The randomization technique employed was developed by Dr. Maximilian Kasy at Harvard University's Department of Economics, and is based on the following working paper: Maximilian Kasy. Why experimenters should not randomize and what they should do instead, *working paper*, 2013.

Table 2: Assumptions for power calculations, precinct-level outcomes

Target power: 80%
$\alpha = 5\%$
Cluster Level Reliability (CLR) = .70 (Publishable standard)
B = .1, .2, .3 (*To be adjusted when data is received)
$\sigma^2 = 0$ (fixed effects)
K = 2
J = 50
δ = standardized Minimum Detectable Effect Sizes (MDES), to be estimated

2.2.2 Individual level

The individual-level design was originally designed as a two-armed RCT in which the marginal effectiveness of each of the two program approaches on the proposed hypotheses could be tested. However, further discussions with the implementer of the service provider training intervention, FPD, revealed that identification of a comparable control group of service providers would not be feasible. Accordingly, the individual-level evaluation design was modified such that only the demand-side intervention (treatment 1) would be evaluated with a control group, and the supply-side intervention (treatment 2) would be evaluated with a simple pre-post design without a control group for individual-level outcomes.

For the demand-side community dialogue intervention, 15 women were randomly selected to participate in a women's survey, from each randomly selected household in treatment 1 and control precincts. No comprehensive list of households in each precinct was available, so the data collection team worked with the police station in each precinct to map the precinct boundaries, and sample households within those boundaries using the *random walk* technique. Annex IV presents the random walk protocol. After household selection within each sampled precinct, an individual female respondent within the household was selected for participation in the survey using a simple lottery.

The evaluation team stratified the sample of households by two characteristics to improve the representativeness of the sample. First, households were stratified by percentage of the precinct population categorized as urban, rural, or tribal, according to SAPS 2013 data. Households were sampled such that the appropriate numbers of urban, rural, and tribal for that precinct were selected.¹² Second, households were stratified geographically according to any available sub-precinct boundaries to ensure adequate geographic coverage of the precinct. In all cases, precincts were comprised of several sectors, and in many cases the sectors were further delineated into subsectors. The 15 households were selected to be distributed equally amongst the sectors and subsectors, subject to consideration of any parameters with regard to the portion of rural, urban, or tribal households to be sampled.

Another consideration at this stage of sampling was that some sectors or subsectors did not meet the eligibility criteria for the intervention. The intervention is geared toward women who would be likely to visit TCCs. The implementing partners suggested that TCCs are primarily used by women who do not have private insurance, as a woman with private health insurance would receive private medical care. As such, the wealthier geographic sectors or subsectors in which the vast majority of residents would have access to private health insurance were excluded from the evaluation, since it would not be reasonable

¹² For example, if 20% of the precinct population is categorized as urban and 80% as rural, three urban households and 12 rural households would be selected.

to expect that women in these households would attend a community dialogue or visit a TCC.

Unlike the precinct-level design, the power calculations indicate that the individual-level design will have the power to detect relatively small average program effects. Table 3 shows the assumptions for the individual-level design, including the Intra-class Correlation Coefficients (ICC) at the blocking level (TCC) and the cluster level (precinct), which were calculated from the baseline data. Based on these calculated ICCs, the individual-level design will have the power to detect an effect of .23 standard deviations in knowledge of TCCs or other sexual assault centers, for example. These ICCs and MDES values are in the range of what was expected at the design phase.

Table 3: Assumptions for power calculations, individual-level design

Target power: 80%
$\alpha = 5\%$
$\sigma^2 = 0$ (fixed effects)
$K = 2$
$J = 50$
$\eta = 15$ women

Outcome	ICC _{TCC level}	ICC _{precinct level}	MDES
Knowledge of the TCC	.111	.132	.24
Knowledge of the TCC or other sexual assault center	.086	.108	.22
Knowledge of resources for victims in community	.072	.093	.22
Exposed to sexual assault awareness	.057	.071	.21
Exposed to sexual assault resources	.079	.084	.21
Personally know girls or women who are victims of sexual assault	.030	.021	.17

2.3 DATA SOURCES AND DATA COLLECTION

This IE relies on administrative and governmental secondary data, and primary quantitative and qualitative data collected by the IE team, with each data source facilitating measurement of the evaluation outcomes. We discuss each data source in turn:

2.3.1 Police records

Crime statistics for each of the sampled precincts are being collected from the SAPS. To date, this data has been used for balancing during the precinct sampling process. Additionally, this data will be analyzed in the final evaluation report, and potentially used as a control variable in regression analyses.

2.3.2 TCC records and supplemental intake form

In the initial evaluation design, the evaluation team proposed relying on TCC records of SGBV reporting and TCC utilization as the sole data sources on these outcomes. Through discussions with the NPA and the TCCs, SI learned that individual case records were not available at the vast majority of TCCs. Since data on these two outcomes are crucial for testing hypothesis I, the evaluation team developed an alternative method of capturing this data: a supplemental TCC intake form. This form was designed to capture basic data to track levels of SGBV reporting and TCC utilization before and after the intervention.

The form is divided into two parts. Part 1 is to be filled out by TCC staff for every survivor when she/he first presents at the TCC. Part 1 contains information about the incident, the survivor, and planned services. Part 2 of the supplemental intake form asks about how and why the survivor decided to come to the TCC and is only to be filled out for survivors returning for follow-up visits at the TCC. The form was reviewed by the NPA and approved for distribution to TCCs to supplement existing record-keeping. The supplemental TCC intake form is presented in Annex II.

There exists a significant risk to the IE if the supplemental intake forms are not consistently utilized by TCCs for the full duration of the evaluation data collection period: from the initial baseline visit when the forms are distributed to at TCC, to three months after the intervention, approximately a five-month period. In the absence of reliable data from these forms, it will not be possible to obtain a measure of whether or not the interventions have increased SGBV reporting or utilization of TCCs. To mitigate this risk, the evaluation team developed a robust system for following up with TCCs repeatedly over the data collection period to inquire about their use of the forms, remind the TCC to complete them, and answer any questions.

2.3.3 Women's survey

A women's survey was administered at households in the demand-side treatment 1 and control group communities surrounding TCCs to capture community knowledge of TCCs and SGBV and attitudes toward SGBV. Respondents were limited to women due to sample size and budget considerations. To allow a sufficient sample of both women and men, the sample size would have had to be doubled. Since the vast majority of SGBV survivors are women, the evaluation team and USAID jointly decided to conduct household surveys with women. The women's survey was administered to a randomly selected adult woman in each of the 15 randomly selected households in treatment 1 and control households using Computer Assisted Personal Interviewing (CAPI). Since the evaluation is nationwide, the survey was translated to all 12 official languages in South Africa, and administered by regionally-based teams of fieldworkers, fluent in the languages of each area. The women's survey instrument is presented in Annex II.

There were some challenges in data collection, as the field team experienced barriers to entry in four police precincts near Cape Town due to high violence, crime, and drug use, coupled with racial and ethnic tensions in those areas. In order to conduct data collection in this area, the evaluation team partnered with a highly localized data collection firm with experience working in these areas to survey households in those precincts. Paper-based data collection was used in these areas due to the security challenges.

2.3.4 Service provider survey

The service provider survey measures knowledge of TCCs and knowledge and attitudes toward SGBV among professionals in the continuum of care for survivors of SGBV, in particular police, teachers, health care workers, social workers, NGO workers, and TCC staff. Respondents to the service provider survey were attendees of the FPD training (supply-side treatment 2). As mentioned previously, no control or comparison group was possible for the service provider professionals, as it would not be possible to replicate the recruitment mechanism used by FPD for training participants with a group of non-participants. The service provider survey is shown in Annex II. The evaluation was able to achieve a 94% response rate for trained professionals at baseline; however, each respondent did not complete all questions resulting in missing data, which ranges from 2% to 10% for most questions (see Annex IV).

2.3.5 Qualitative TCC and NGO data

This IE utilized qualitative data collected from TCC staff and local NGOs serving survivors of SGBV to supplement the quantitative measures. At almost all of the 51 TCCs, an interview was conducted with the Site Coordinator and one NGO serving the same population as the TCC, for a total sample size of 94 qualitative interviews. Interview questions focused on awareness and utilization of TCCs, and TCC

capacity to serve survivors. This data was used to triangulate responses from the women's survey, TCC records, and supplemental TCC intake forms, and to explore alternative explanations for limited TCC use and TCC constraints. The qualitative data will be used to construct a TCC Capacity Indicator, which will be used as a control variable in the final regression analysis. The interview protocols for the TCC and NGO staff interviews are presented in Annex II.

While the majority of TCC Site Coordinators and NGO staff were receptive to the interviews, several TCC Site Coordinators refused participation in evaluation activities at some point during the study. First, the NPA representative affiliated with the USAID project relinquished her role midway through baseline data collection, resulting in some confusion around the study team's permission to access TCCs. The subsequent point of contact for the evaluation worked to promote the project, but with varying degrees of success. Some TCCs expressed continued pressure from the NPA not to participate in evaluation activities, despite NPA assurance that this was not taking place.

In addition, some TCC staff were reluctant to participate in the research despite NPA endorsements. It is likely that due to political tensions and bureaucracy at the NPA respondents did not feel they could not speak freely, despite assurances that the recording and notes would be kept confidential.

Finally, one TCC was used for pilot purposes to test the TCC visit protocol and interview guide. This interview has been excluded from the analysis because we did not receive consent from that TCC to release the resulting interview notes in their original form.¹³

2.3.6 Training, piloting, and data collection

Baseline data collection took place on a rolling basis over an 11-month period from August 2014 to June 2015, in tandem with the implementing partners' implementation schedule across all nine provinces in South Africa. Prior to the start of baseline data collection, fieldworkers from SI's data collection partner, Impact Research International (IRI), were trained for one week on the details of survey administration of the survey instruments and qualitative interview protocols for the TCC and NGO interviews. The training included definition of the roles and responsibilities for fieldworkers in various positions, sampling and all other relevant field protocols, research ethics, data quality assurance measures, and utilization of electronic devices used for CAPI. After the training was completed, both the women's survey and the service provider survey were pilot tested in communities not sampled for the evaluation. The qualitative TCC and NGO interview protocols were not formally piloted as there was not an appropriate set of respondents not participating in the study who could serve in the pre-test. However, SI accompanied an IRI fieldworker to the first TCC and NGO visit to assess the adequacy of the protocols and associated procedures, and to make any necessary adjustments. SI evaluation team members provided oversight for the training, pilot testing, and the initial days of field work. Additionally, SI provided ongoing remote data quality monitoring for the duration of the baseline period, which included a review of sampling procedure for each precinct, survey data, and survey metadata on a rolling basis, and a review of interview transcripts and random audits of interview audio files.

¹³ Specifically, this TCC requested that they be allowed to review and verify the transcribed notes taken after the interview before they be introduced into the larger dataset; the resulting edited transcript appeared markedly different than the researcher's original notes, thus the evaluation team did not feel comfortable including these in the dataset.

3. FINDINGS

3.1 TCCS

Qualitative research was utilized to provide context for quantitative data and delve more deeply into the operation of TCCs and perceptions of TCC staff. Qualitative data on TCC capacity and utilization were collected via in-depth, targeted interviews. Initially, interviews were only planned with TCC staff, but at the beginning of data collection, the evaluation team learned that many TCCs outsource their after-hours or specialized services to external entities, including NGOs, the Department of Health (DoH), and the Department of Social Development (DoSD). As such, interviews were conducted with TCC Site Coordinators, TCC Victim Assistant Officers, and TCC case managers, as well as NGO management staff, nurses, clinicians, and social workers. Formal consent was obtained from all respondents prior to interviews. First, respondents were presented an informational pamphlet about the study and a formal NPA research endorsement letter. They were then asked to review the informed consent document that specified that the interview was being recorded and sign it if they agreed. In the event that respondents were unavailable during on-the-ground site visits, interviews were conducted by phone, following electronic delivery of the study purpose and receipt of signed documentation of consent.

A total of 94 interviews were conducted across all 51 TCC catchment areas. Interviewees included senior staff from 51 TCCs,¹⁴ representatives of 40 local NGOs—many of which were characterized as Victim Empowerment Programs (VEPs), and three independent counsellors (non-NPA employed) who assist with survivor case management. Figure 4 and Figure 5 show the locations of interviews with TCC staff, NGO staff, and counsellors.



Figure 4: TCC interview sites

¹⁴ One TCC interview was excluded from analysis due to data quality concerns. See section 2.3.5 of this report for more detailed discussion.

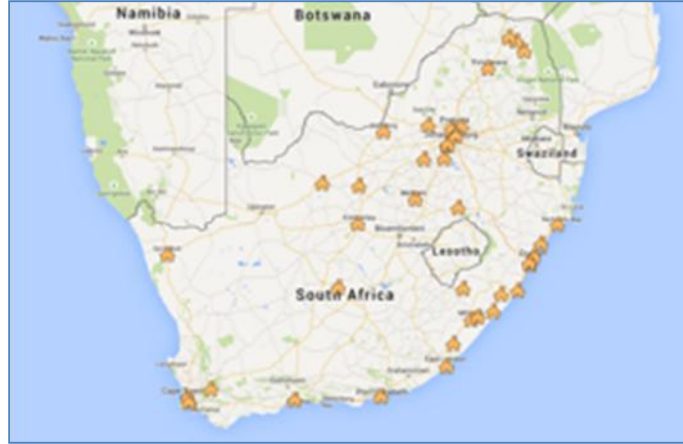


Figure 5: NGO/Counsellor interview sites

Each digitally recorded interview was transcribed and both voice and text data were uploaded to a shared and encrypted server. To ensure consistent interpretation of the qualitative data, the data was reviewed by a team of researchers who were responsible for quality control, particularly with regard to transcribed interview data, which were checked for accuracy. For interviews conducted in languages other than English, an indigenous speaker translated the content, and a second team member fluent in that language performed an accuracy check. English transcriptions were used for data analysis. Coding and analysis of the transcript data was completed using Dedoose, an online, cross-platform application for mixed methods research. All coding of transcripts were undertaken by the same two individual to mitigate concerns around inter-rater reliability.

Factors considered in the assessment of TCC capacity include geographic distribution across the country, location, days and hours of operation, appearance and quality of facilities, services provided, staffing, record keeping practices, and available resources.

3.1.1 Days and hours of operation

Twenty-three TCCs were open Monday through Friday while 20 were open seven days a week. Twenty-one TCCs reported operating 24 hours a day, with support from non-TCC staff, typically the NGOs. Operating hours for TCCs that were not open around the clock ranged from 7:00 AM to 7:00 PM, with the majority open between standard business hours (8:30 AM and 4:30 PM). Most TCCs that did not operate on a 24-hour schedule referred survivors to external partners for services after regular business hours.

3.1.2 After-hours services

After-hours services were available at 34 TCCs, 33 of which received after-hours support from external partners. This number includes TCCs that are open 24 hours as well as those that have regular business hours but also provide after-hours services. Most TCCs that have after-hours services on-site were operated by NGO counsellors and staff (often from LifeLine and ChildLine) and many have medical staff on-call after hours. TCCs that do not have formal after-hours services often directed survivors to the casualty department of the nearest hospital and to return to the TCC during normal operating hours for counselling and other services not provided by the hospital. TCCs without on-site after-hours services were less equipped to provide comprehensive care, as a TCC Site Coordinator described: “We [are] only operating office hours. Most of our cases were report[ed] during after-hours ... which means victims who report to the health facility after-hours have to come back the following day to get the remaining services. So our biggest challenge here is that most of our victims do not come back.”

When asked how after-hours intake and service differ from regular business hours operations, one TCC

Site Coordinator explained, “the process is supposed to be the same, it’s just that what was supposed to be done by the site coordinator and the VAO [victim assistant officer] won’t be done the same. In this one we rely mostly on [local NGO] staff people. ... We expect them to take the victim through all the channels or all the processes and to ensure that the victim gets the services as expected.” The same Site Coordinator explained that the NGO, TVP, also provides staff support—trauma counsellors, victim advocates and general staff members—who perform housekeeping and cooking duties. Other TCCs reported similar arrangements, with NGOs providing staff support, both during regular business hours and after hours.¹⁵

3.1.3 Staffing

Even with NGO employees supplementing TCC staff, many TCCs reported being chronically understaffed. In 31 TCCs, at least one staff position was not filled at the time of the interview, and ten other TCCs had one or more unfilled staff positions in the months preceding the interview. The length of these vacancies ranged from four to 41 months. Many respondents were not able to estimate vacancy lengths because there is a high rate of staff turnover and transfers between TCC sites. Staffing shortages were reported across all positions: case managers, forensic nurses, physicians, counsellors, victim assistant officers, case managers, police liaisons, social workers, and support staff. Some positions were vacant because former staff members had resigned, but others reported not having the budget for full-time positions in those areas.

“To tell you the truth, our staff is not enough. ... I work with six counsellors where three counsellors work in a day. ... They don’t get enough off days. It’s strenuous for them. Sometimes I have to go to workshops and sometimes the invite said I have to come with one or two counsellors, so it becomes a problem really because of the shortage of staff. We need people who can help us.”

-TCC Site Coordinator

Another concern with the staffing structure raised by interview respondents was the gender of the TCC staff working with survivors. While 36 site coordinators were women, only 16 Victim Assistant Officers were women. No respondents were able to report if TCC staff members had completed gender sensitivity training. Because many TCC staff are male while the majority of survivors are female, survivors must work with a male TCC service provider, regardless of their comfort with this arrangement. Qualitative reports also suggested that space constraints may contribute to secondary victimization if a female survivor must not only recount her story to a male TCC employee, but do so in close quarters. A Site Coordinator explained, “The psychologist once said that we were not doing justice to our victims. When they do the counselling in such a small office, and sometimes we deal with people who were obviously raped, traumatized, and the psychologist is a man so a lady being confined in that small space with another man.”

3.1.4 Location and appearance

Many TCCs were quite difficult to locate, even for experienced research staff. Despite having coordinates for each TCC, the research team was unable to find 31 of 50 sites without asking for directions. In two cases, employees at the reception desk of the hospital within which the TCC was located were unable to provide directions to the TCC. Only 34 TCCs have a sign on the building/facility in which it is located.

3.1.5 Self-assessed capacity

Few TCC Site Coordinators expressed high confidence in the TCC’s capacity and ability to meet survivors’ needs successfully. Respondents were asked to rate their TCC’s overall capacity on a four-level scale ranging from “completely adequate” to “not at all adequate.” As shown in Figure 6, only one respondent rated their TCC as fully adequate, while 23 rated their TCC as mostly adequate, 19 as somewhat adequate, and four as not at all adequate. One respondent who said their TCC’s capacity was mostly adequate also

¹⁵ The services NGOs provide, as well as more detail about the relationship between TCCs and NGOs is discussed in more detail in the “Role of NGOs as Service Providers” section of this report.

stated that the facility was not victim friendly. Respondents' assessment of their TCC's ability to meet survivors' needs was measured on the same adequacy scale as the overall facility indicator. No respondents indicated their TCC's ability to meet survivor needs was fully adequate, 23 said their TCC's ability was mostly adequate, 22 ranked their TCC's ability as somewhat adequate, and four respondents said their TCC's ability was not at all adequate.

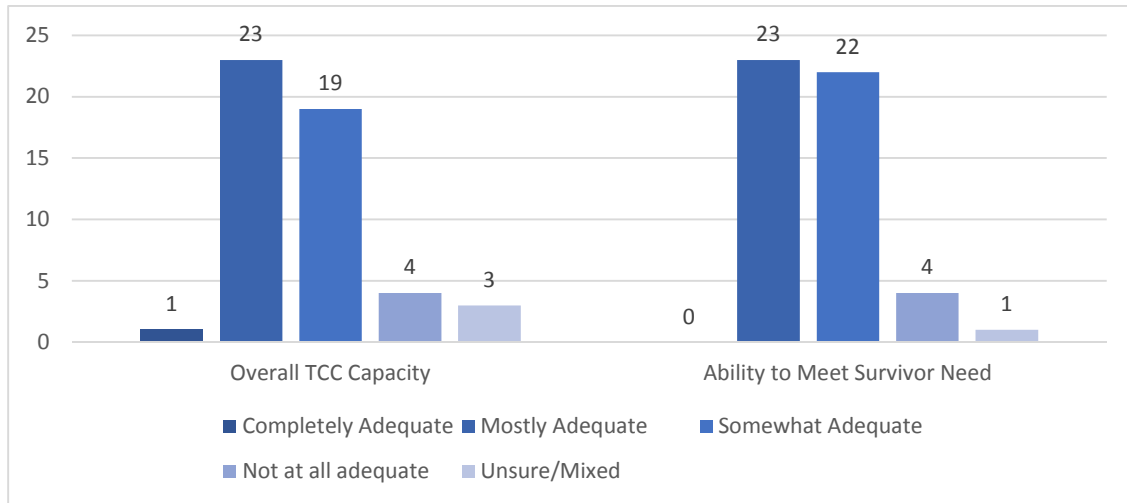


Figure 6: Self-assessed TCC capacity and ability to meet survivors' needs

3.1.6 Space and supplies

The inability of some TCCs to meet survivor needs effectively can be linked to the state of the facilities. Insufficient office space was repeatedly cited as a significant problem. Only four TCCs rated their space as fully adequate, and 20 TCCs rated their space as mostly adequate, 14 as somewhat adequate, and 12 as not at all adequate. Inadequate space can be especially problematic when police bring suspected perpetrators to the TCC for forensic examination and evidence collection. A Site Coordinator explained that sometimes survivors and suspected perpetrators will have to wait in the reception area at the same time:

“We have only one examination room and we still get perpetrators that come in for DNA, so we don’t have a suspect room whereby the suspect can be examined. So it happens that the suspect will also use the same room as the examination room that is also used by survivors, and because of that you will find that sometimes the suspect will be coming for DNA while there is a victim coming for rape.”

Another Site Coordinator echoed this concern:

“I feel that our clients don’t feel comfortable sitting in our waiting room because they were using the same door [as suspected perpetrators]. We have only one entrance. So imagine you were raped and you see the police coming in... and you as the victim were trying to digest what happened to you and seeing that up and down happening in the waiting room.”

As a result of space limitations, administrative offices were sometimes used for multiple purposes, including as examination or consultation rooms.

The condition and upkeep of facilities was also a source of concern. The research staff independently ranked the appearance of each TCC on a four-level scale ranging from “very nice” to “poor.” Twelve TCCs were assessed as very nice, 15 somewhat nice, 12 in some disrepair, and eight in poor condition. A Site Coordinator of a TCC located within a hospital reported that the hospital rarely extends its cleaning

or maintenance services to the TCC, even specifically omitting the grass in front of the TCC when it mows. The Site Coordinator stated that “visitors of the hospital will throw cans of alcohol in front of the TCC because they were seeing that it is dirty.” The Site Coordinator repeatedly reported the issue to the NPA and the DoH, but they did not take steps to address the matter. TCC staff reported cleaning the office themselves and paying for maintenance and mowing services with their own money because TCCs do not have the budget for these services.

In addition to space limitations and poor quality facilities, 84% of TCCs were deemed to have inadequate connectivity. Many TCC staff mentioned difficulties with phone service and Internet connectivity. Some TCCs were not equipped with landline phone service, so staff had to rely on personal cell phones to make calls. TCCs that have landlines have limited budgets for phone service. One respondent explained:

“We were allocated R100 a month for calls, which is not enough to communicate with survivors to remind them of their next appointment ... and to call standby staff. ... We end up using our own money for work-related calls which is not paid back to us.”

Staff also reported having to go to nearby Internet cafés to use the Internet at their own expense.

3.1.7 Medical supplies, clothing, and food

Most TCCs reported having adequate medical supplies, which were supplied by either DoH or the hospitals. Two TCCs did not have colposcopes, specialized medical cameras used to photograph genital injuries invisible to the unaided eye. Nearly all TCCs had sufficient supplies of comfort packs, which include personal hygiene items and underwear. Comfort packs were typically provided by DoH, NPA, and NGOs; however, most do not include clothing other than underwear. Many survivors come to TCCs with dirty or bloody clothing, which is collected as evidence if they choose to file a police report, yet most TCCs do not have a sufficient supply of clothing for survivors. NPA and DoH provide tracksuits to a few TCCs, but some staff members reported purchasing clothing themselves. Other sites rely on clothing donations, but one TCC Site Coordinator explained that TCCs were not allowed to solicit donations because they were government-operated. Individuals may make voluntary clothing donations to the TCCs, but donors must write letters explaining why they want to donate the clothes, as well as where and how they acquired them, even for second-hand clothing, which could present an impediment to would-be donors.

“The challenge now is clothing. You might find that a victim came and was beaten or had been stabbed. He/she is bleeding and the clothes they were wearing is bloody, so we don’t have clothing. Even though we have clothes, it is not enough. Even when you give the victim, you don’t give them decent clothes, you give them something shabby.”

-NGO Trauma Counsellor

Many survivors come to TCCs with dirty or bloody clothing, which is collected as evidence if they choose to file a police report, yet most TCCs do not have a sufficient supply of clothing for survivors. NPA and DoH provide tracksuits to a few TCCs, but some staff members reported purchasing clothing themselves. Other sites rely on clothing donations, but one TCC Site Coordinator explained that TCCs were not allowed to solicit donations because they were government-operated. Individuals may make voluntary clothing donations to the TCCs, but donors must write letters explaining why they want to donate the clothes, as well as where and how they acquired them, even for second-hand clothing, which could present an impediment to would-be donors.

The food supplies were also frequently inadequate. The NPA had previously supplied groceries to TCCs, but that practice has largely ceased. One TCC employee said that RTI International had previously provided their groceries, however that support has been discontinued:

“.. ever since we came into the NPA, we haven’t received anything, and those used to assist especially with these long waiting hours, then you know you can give them tea, and now it’s cold, give them tea, give them something to warm themselves up. ... So right now [local NGO] is buying groceries, but sometimes that is not enough. It gets finished before the time comes for them to buy, then we have to wait for them to buy because the NPA does not give groceries at all.”

Many TCCs that were able to offer food service utilize hospital kitchens to prepare food for their clients. However, that option is not readily available outside of regular business hours or to TCCs not located in hospitals. Several TCC staff members purchased food for survivors with their own money.

Survivors who come to a TCC from the police station, and those who had travelled great distances to reach a TCC, may not have eaten for extended periods of time, so providing food to survivors at TCCs

is considered a critical need. TCC awareness campaigns advise survivors not to eat before medical examinations, which can further extend the length of time that a survivor has not eaten. A TCC employee illustrated how long a survivor could go without food:

“Let’s say that the victim was raped today and could not find transport to come to the TCC and only comes the following day. Remember you told the victim not to eat until the medical examination is done. Look at that, they won’t get anything when it comes to food.”

The need for food can also be related to treatment, as survivors should take the PEP on a full stomach. PEP must be taken within 72 hours of a sexual assault in order to reduce the likelihood of HIV transmission, but can have negative side effects if taken on an empty stomach.

3.1.8 Transportation

Lack of transportation funding is another significant challenge for the TCCs, and it affects the survivors’ ability to make an initial visit and to receive continuity of care during follow-up visits. Most TCCs do not have a TCC-owned vehicle or funding to reimburse survivors for transportation costs. A TCC Site Coordinator explained:

“The stats on our follow-ups were very alarming because transport as a resource is a problem. To get people to come here for follow-ups, they have to travel, and sadly and unfortunately a lot of our clients were unemployed. They come from rural areas and they don’t have the means to come to town. Some of them even walk.”

Many survivors cannot afford to return to TCCs for follow-up care, and reimbursement for follow-up transportation costs is rare. Certain transportation costs are reimbursed, but usually only for survivors traveling to and from court to testify or attend legal proceedings. Survivors who do not come back for follow-up might not take the full course of PEP for the recommended duration of the treatment, as they are usually given a starter pack of PEP during their initial visit and required to return to receive the remainder of the PEP medication. Some respondents said that survivors are sometimes given the full course of PEP if they know they will be unable to return to the TCC, but this practice is not common. Lack of transportation also inhibits the TCCs’ ability to conduct outreach and awareness campaigns around the community.

“It’s very strange that a person would risk being infected with HIV, by just saying ‘I’m not going to use my last R10 and go there’. That’s poverty, you know, the point of poverty there were choices that people make—rather buy bread now and have everybody in the family eat than take a taxi to Mamelodi, to come and get medication.”

-TCC Site Coordinator

3.1.9 Survivor demographics

The age and sex of survivors utilizing TCC services varies significantly between TCCs, and even within individual TCCs over time. Many TCCs reported that children ages 0-12 are the largest group of the survivors they serve. Some TCCs estimated that youth under the age of 18 comprised as much as 80% of all survivors. The other most common survivor demographic was females over the age of 18. One TCC Site Coordinator explained the differences in vulnerability between child and adult survivors and how vulnerability changes seasonally throughout the year:

“I think in winter they were not vulnerable. They were indoors as it is cold. In summer they were outdoors, partying and that is where they were vulnerable. If the weekend is rainy and cold, we were happy because then it is quiet. We will say at least people were not raped. It is nice. With children, they were raped inside homes, so yes those were the types of cases we usually get, the serious cases that we get in winter. These were the types of cases were they break down your door and they come into your house.”

Adult males were reported to be the least frequent users of TCCs. One TCC said they would sometimes serve one or two adult males a month, but often none for months at a time. Many of the adult male survivors were prisoners brought in by the Department of Correctional Services. There is a significant

stigma associated with male victimization that likely contributes to the rarity of reporting. A TCC doctor explained that adult males

“don’t want to go and expose themselves, because they have a problem and then go to a police station, and you go there you see all sorts of sexual assaults, police officers mock them, and that is where it’s very demoralising, and that is why we find that males do not come for help, unless the family knows about it and they bring them. But to go to a police station now and say that I was abused, it’s very demoralising to the man, I think the police officers need to be more sensitive to this issue because it’s a problem in our society.”

Most respondents said that lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals reported to TCCs for care only in rare cases. However, several respondents noted that TCCs do not ask about a person’s sexual orientation during intake or at any point during the consultation, so unless a survivor self-identifies as LGBTI, there had been no recorded data on this demographic group. It is likely underreported due to stigma around LGBTI identities. One TCC Site Coordinator said that sexual violence against LGBTI people is “about correction. They [perpetrators] think they can correct people to be straight. This one case they burned inside, he ran away naked in the street. It was traumatic.”

3.1.10 Referrals to TCCs

Survivors are referred to TCCs by a variety of sources, including police, hospitals, clinics, schools, NGOs, social workers, and churches. Many TCCs cited schools (teachers, Department of Education social workers, and school social workers) as the primary referral source, and nearly all school referrals were for cases of child sexual abuse. A TCC Site Coordinator cautioned that teachers were not always knowledgeable about TCC referral procedures, and “sometimes you will find that they do not take it seriously. There is this thing with our people, if they don’t see an injury and if the child walks normally then the child can’t have been raped.” The Site Coordinator underscored the need for continued stakeholder engagement and education to address this misperception.

The police were another significant referral source, with one TCC estimating approximately 90% of its cases are brought by police referrals. TCCs work extensively with SAPS, because the police were usually involved at some point throughout the process, even if the survivor was not brought in or referred by them. Survivors who first report their experiences to the police were often subsequently brought to a TCC for examination. If survivors first present to the TCC, the police were usually called, but survivors were not required to make a police report before receiving care from the TCC. Most respondents reported positive working relationships with police stations in their area, but some expressed frustration with police officers that were not familiar with the referral procedures. One Victim Assistant Officer said some police stations “don’t know where the TCC is, they don’t come with the correct forms. Sometimes they bring victims in a van or the victim will sit in between two officers at the front. Sometimes they take longer to come, and at times they don’t have cars. Some don’t bring the correct crime kits.” Respondents’ observation of police treatment of survivors does not always meet TCC standards of support and compassion. Some respondents described problems with how survivors were transported to TCCs, particularly if they were forced to ride in the back of the police car or between two officers in the front. Many respondents reported that survivors endure long wait times at police stations without the opportunity to clean up or change clothes before being brought to the TCCs, which can be embarrassing and secondarily traumatic.

3.1.11 Barriers to accessing TCCs

There were numerous factors identified by interview respondents that pose barriers to the use of TCCs and their services. Two potential challenges included locating the TCC and access to transportation, which were discussed in the TCC Capacity section. Respondents also noted observing a lack of knowledge about TCCs more generally—many people were not aware that the TCC exists or have misperceptions of the type of services provided. One Victim Assistant Officer commented that hospitals refer people who have not experienced sexual violence to TCCs for general counseling or social work services, demonstrating a misunderstanding of the scope and purpose of TCCs. A TCC Site Coordinator explained, “even in the hospital itself, some of the nurses don’t know what is being done here, so we try our best to engage them and to do training.” This problem demonstrates a broader misunderstanding of the scope and purpose of TCCs, with many people believing TCCs provide shelter and services to individuals experiencing homelessness or to people in crisis situations. There is also a misperception that TCCs do not treat male rape survivors, only providing care to women and children, which is untrue. Others reported thinking that people who go to TCCs would be arrested for other crimes. Some people thought that TCCs provide assistance with applications for SASSA grants (social and disability grants) and offer general social work services. Others believe that going to a TCC guarantees a conviction in court, which was described as a source of frustration for survivors whose attackers were not convicted.

“They think we offer shelter for homeless people and all those things, even some of the police members don’t understand. Even the guys from the emergency medical services don’t understand, they will just get an old lady who is staying on the streets and then they bring them to the hospital and they say no, just take her to the TCC and when you interview them and you don’t find anything related to a sexual offence, you must say there is nothing we can do unfortunately.”

-TCC Site Coordinator

TCCs have attempted to combat the lack of information and misinformation with workshops, outreach campaigns, and radio broadcasts. A TCC Counsellor explained, “we do awareness campaigns in schools and everywhere, to teach people that if something like this happens to you, you don’t have to hide in the house, you must come to the TCC where you will get help and support. Last month we had an awareness campaign at two schools, and we also go to our local radio station to talk about the services the TCC provides.” These awareness campaigns were designed to increase knowledge of the existence of TCC facilities and the services they provide, as well as dispel stigma surrounding sexual violence and address the roots of broader sociocultural factors that contribute to SGBV.

Despite TCC outreach and awareness-raising campaigns, stigma and fear were two of the biggest barriers to TCC utilization noted by interview respondents. An NGO coordinator said, “some people still think that if you were raped you asked for it, because maybe you wore short clothes or you drank someone’s booze now you have to pay.” A TCC Site Coordinator also said, “People were still scared to report rape because of stigma in the society. People don’t want to be associated with being raped. People were scared of the perpetrators.” The fear of retaliation can be especially problematic for survivors who were victimized by perpetrators residing in their community. Many survivors also fear not being believed. A Site Coordinator reported:

“We found that a lot of our survivors, the perpetrators were related to them or they were their husbands, fathers, stepfathers on girls, so it is that fear of not being believed, it is the fear of the family, intimidation and those types of things. ... They don’t want to go to the police because they fear they will be laughed at or maybe they had a few drinks and now they feel guilty. We get those cases where they go to the police and they’ve had a few beers and the police tell them ‘no come back tomorrow, go sleep off that beer or whatever,’ and then they don’t feel like returning the next morning.”

Many respondents described a cultural norm that prescribes sexual violence be kept within the family and not reported to the authorities.

There were also widespread misperceptions that a survivor is required to file a police report or bring charges against a perpetrator in order to utilize TCCs. In reality, TCCs provide medical and counseling services to any survivor, regardless if s/he chooses to pursue criminal action. A Victim Assistant Officer explained the process TCCs follow in this circumstance:

“If a victim does not want to go to the police and they know about the TCC and they come straight to the TCC, we will assist the victim, but we will also inform the victim that they can lay a charge. If they then want to lay a charge, we will call the police or the detective to come out. But we will not refuse services, even if the victim indicates they only wants a medical examination and PEP, we will assist that victim, even when she changes her mind later we will assist that victim. We will not refuse a victim from services at the TCC.”

A TCC Site Coordinator added “we do take the evidence so that if they change their minds, and they want to open a case later, they can have the evidence. We keep the specimen for six months, then after that if they don’t come back we discard it.”

3.1.12 Coordination with NGOs as Service Providers

Given the limited hours of operations, financial constraints, and the numerous and diverse needs of survivors, TCCs depend heavily on NGOs. As such, TCCs have partnerships with many NGOs that extend and integrate services throughout the community. Representative organizations include Mosaic, an

“The TCC is providing a remarkable service to its victims; people regain their dignity and respect after they have been to the TCC, especially those that complete their follow-up sessions. Their mission statement says that they turn victims into survivors and that is exactly what they do, because people recover from completely from their ordeal.”

-NGO Social Worker

NGO that serves domestic violence survivors, OPTIONS, an NGO that works with crisis pregnancies and HIV, and the Association of Persons with Disabilities (APD), an NGO that works with people with intellectual disabilities, among many others. Key areas of NGO-provided assistance were after-hours support, psychosocial counselling, and outreach activities. Some NGOs provided temporary housing or shelter to survivors. LifeLine and ChildLine were two NGOs with which TCCs frequently partnered. A counsellor said LifeLine “helps the broken souls, abused children, and women. People that have been abused, we were dealing with abuse, marriages, divorces

and different types of counseling, trauma and debriefing.” ChildLine provides similar services, but for youth ages 17 and under. A counsellor said ChildLine counsels survivors “so that they were able to cope with the situation that they find themselves in. We also make sure that we empower them so that they were able to go on or to cope with the traumatic situation which they have been exposed to.” The same counsellor highlighted ChildLine’s education initiatives and outreach campaigns in schools and throughout the community to educate children about sexual violence. Families South Africa (FAMSA) is another NGO that provides trauma counselling to survivors of sexual violence and domestic violence, as well as marriage counseling.

Nearly all NGO representatives reported favorable, productive working relationships with TCCs. A LifeLine site manager explained that despite occasional interpersonal disputes, patient care is always prioritized:

“We work well together, you know that complications were here and there, but when it comes to the victim, we put aside our differences because the victim comes first. We work together. If we have our own vendetta, we will solve them later. But the good thing is that if there is something I don’t like that Thuthuzela is doing, I confront her [the Site Coordinator].”

Most respondents reported similar sentiments. A Lifeline Site Manager said that her TCC holds monthly implementation forums where all stakeholders can air any grievances and work collaboratively to find solutions.

NGO staff generally praised the work of TCCs and expressed understanding of their constraints. A lack of resources, such as telephones and transportation, has detrimental effects on patient care, but coordination with external stakeholders, like NGOs, can help alleviate these problems. A FAMSA counsellor described her experience with the consequences of limited resources:

“Victims can be here for ten hours without being assisted but because I sit with them [TCC staff] in their implementation meetings, I get a chance to see what challenges they were faced with, especially shortage in resources and sometimes in their uncoordinated responses from key stakeholders. With those challenges I can still say they were doing their best, and if they were to be supported by other key role players, there can be improvement.”

An NGO counsellor commended TCC employees for their hard work despite limitations:

“They perform well and beyond their mandates, they sacrifice their time to help the survivors. ... They work tirelessly to provide the best service and ensure that the clients were served with respect. They perform well under those circumstances. They don’t complain that they don’t have all the resources they need. They do their work, improvise where necessary, ask for help elsewhere to get the job done.”

Coordination with NGOs and other stakeholders fills service gaps that TCCs were not always able to address, and improves the overall quality of care given to survivors. A LifeLine social worker described how LifeLine and other organizations backstop the TCC’s efforts:

“Let’s say our patient needs a home. We at LifeLine will get a home but the problem would be transport, so we will help each other again—maybe SAPS will provide transport so that we meet the patients’ needs, because at the end they have to be holistic. They cannot as a TCC provide all the services, maybe medically, but socially if the patient does not have a place to stay, it’s not holistic. So we need to provide the patient holistically in every way and be able to provide everything they need.”

Even with TCC work being supplemented by NGO efforts, TCCs continue to face challenges in providing the most holistic care possible. One TCC Site Coordinator acknowledged the TCC’s shortcomings, and identified empowerment and vocational training as key areas for growth. Vocational training is especially important for women who were financially dependent on their abuser. The Site Coordinator said:

“We need to do empowerment so in this area we still lack. Maybe if we have like an NGO where once they were done with their counselling we give them business management skills and teach them how to start their own businesses, teach them anything that they can use to put food on the table, because that’s when we see them dropping cases and getting confused. To say at least this person even though he raped my child we never slept with an empty stomach, that’s when you get all of those issues and once you come with R5000, to say please withdraw the case you ask yourself twice, I am hungry, there is money, I am the one who went there to open the case I can still go there and withdraw the case and some even were coached to say that the person just disappeared so that the police cannot find them, so the case will be withdrawn then they take the money. Empowerment for me I think is the key.”

3.2 WOMEN’S KNOWLEDGE AND ATTITUDES

Women’s survey data collected at households within the selected communities near each TCC was used to measure female respondents’ knowledge of TCCs and SGBV, and attitudes toward SGBV prior to community outreach efforts by Soul City and Sonke. The women’s survey was administered to 1,500 women across treatment I (community dialogue) and control police precincts in all nine provinces in South Africa. A comparison between baseline and endline data will allow the evaluation team to test if communities that receive outreach efforts realize a positive change in knowledge and attitudes vis a vis control communities.

Table 4 presents the distribution of the respondents by province.

Table 4: Number of women’s survey respondents by province

Province	Freq.	Percent
Gauteng	210	14%
Limpopo	150	10%
North West	135	9%
Kwa-Zulu Natal	210	14%
Eastern Cape	240	16%
Western Cape	150	10%
Northern Cape	135	9%
Free State	120	8%
Mpumalanga	150	10%
Total	1,500	100%

3.2.1 Balance statistics

For purposes of the evaluation, the first priority is to ensure that the treatment I and control precinct samples are comparable. In an individualized randomized sample, individuals would be randomly selected into control and treatment group such that—provided a large enough sample size—any differences observed between the two groups would be a product of random chance. However, because randomization was done at the precinct level and because there were only a limited number of precincts, there was a risk that sampled treatment I and control groups would be systematically different from one another on key characteristics. The balance statistics of the final sample confirm that the selection and random assignment process was successful in creating reasonably comparable treatment and control groups.

Independent sample t-tests and chi-square analyses were conducted to test for statistical equivalence of the treatment and control groups (see

Table 5). The treatment and control groups were found to be statistically equivalent on all demographic variables, although there was a slightly great percentage of coloured respondents in the treatment group than the control ($p < .01$).¹⁶ Moreover, the treatment and control groups were found to be comparable with respect to key outcome variables as well, with a statistically significant difference in only one key variable: the number of respondents reporting they heard of a center that serves victims of sexual assault in their community ($p < .01$). These local characteristics will be controlled for in data analysis.

¹⁶ While not presented in the table, there were also some statistically significant differences in some of the smaller language groups.

Table 5: Balance statistics between treatment I and control samples

Variable	Treatment (%)	Control (%)	p-value
Age	32.4	31.9	0.22
Black	84.8	88.1	0.06
Coloured	12.4	8.5	0.01**
Zulu	21.2	20.9	0.90
Xhosa	20.7	21.6	0.66
Tswana	14.0	13.5	0.76
Afrikaans	10.8	9.1	0.26
Other language	32.8	34.7	0.45
Less than elementary education	2.4	2.0	0.60
Elementary education	24.9	21.2	0.09
Secondary education	54.5	56.9	0.35
Higher than secondary	17.7	19.7	0.32
Income less than or equal to R1,000	24.7	23.9	0.72
Income between R1,00-R5,000	55.1	55.3	0.92
Income higher than R5,001	19.9	20.7	0.70
Heard of TCC (yes)	17.2	18.5	0.50
Heard of sexual assault centre (yes)	2.1	5.2	0.003**
Hear of TCC or other sexual assault center (yes)	18.9	22.8	0.07
Knows of centre run by NGO (yes)	20.1	20.5	0.85
Awareness sexual assault (yes)	59.2	55.9	0.19
Awareness of sexual assault resources (yes)	77.8	74.3	0.12
Knows location of nearest TCC (yes)	67.6	69.4	0.73
Average no. of women known who have been to TCC	1.3	1.2	0.50
Average no. of women/girls known who have been sexually assaulted	2.9	3.0	0.71

*p<.05, ** p<.01***p<.001

The following section presents the findings from the women’s survey. The baseline results pool the data from control and treatment areas, while the final report will present the changes in outcomes for the control and treatment groups separately.

The sample of women surveyed for this IE cannot be considered representative of all women in South Africa, but rather as representative of women in evaluation precincts. Furthermore, the survey eligibility criteria stipulated that respondents were to be between the ages of 18 and 49 and reside in areas not identified as high-income areas (in which the majority of residents have private insurance). The demographic characteristics of the sample are shown in Figure 7. On average, women in the sample were 32 years old, identify as black, have attained a secondary education, and reported a household income of 1,001 to 5,000 Rand (\$73 to \$365 USD) per month.

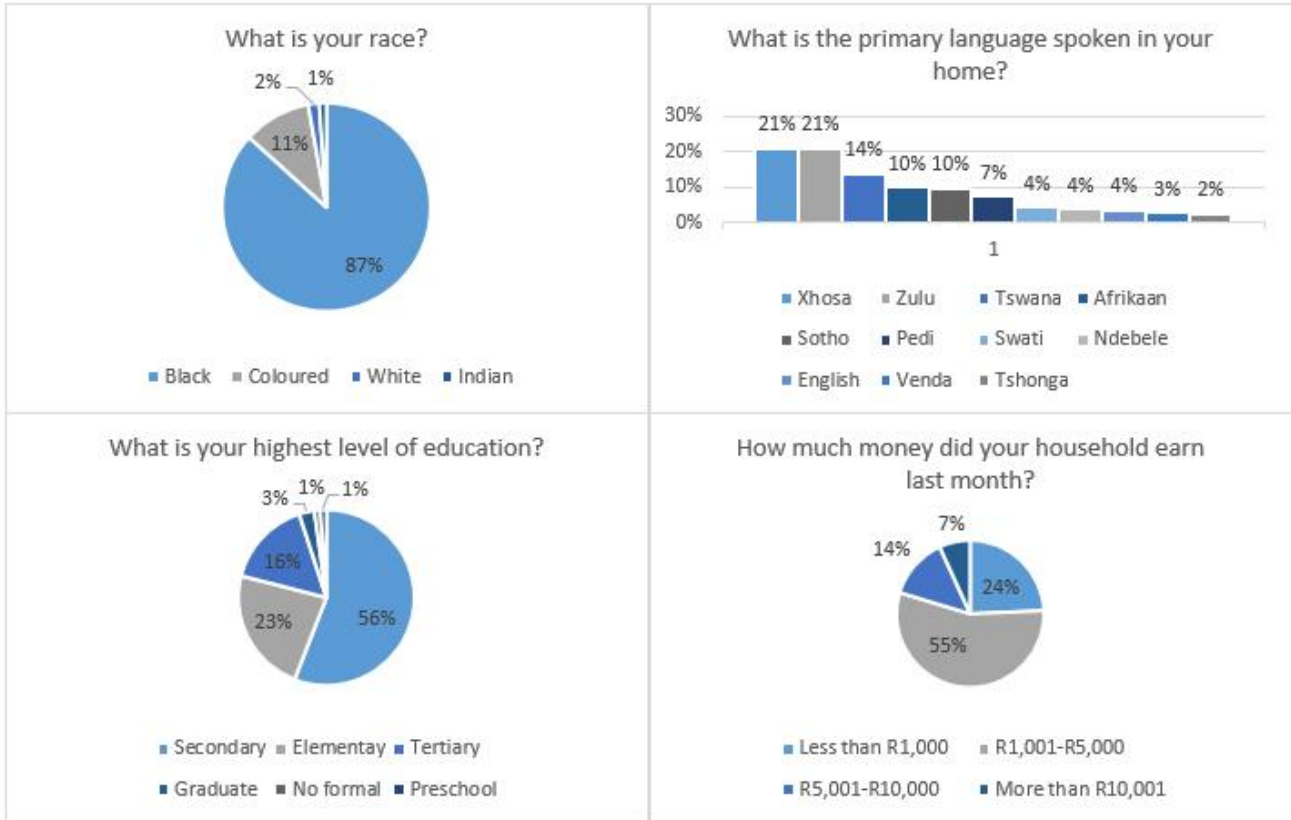


Figure 7: Demographic characteristics of women’s survey respondents

3.2.2 Knowledge of TCCs

A formative research study conducted by Soul City Institute in 2013 on knowledge, attitudes, and behaviors relating to sexual assault reporting and the use of TCCs found that the vast majority of South Africans are not aware of TCCs. The baseline women’s survey data mirrors the results of this study. When asked: “Have you heard of the Thuthuzela Care Centre,” 82% of respondents answered “no.” Responses to this key survey item varied substantially by province, with only 2% of respondents in Gauteng responding affirmatively, compared with 38% in Eastern Cape Province (see Figure 8). This relationship is statistically significant ($p < .01$). Knowledge of TCCs is also significantly associated with age ($p < .01$) and income ($p < .05$), with older and wealthier respondents being more likely to know of the TCCs.

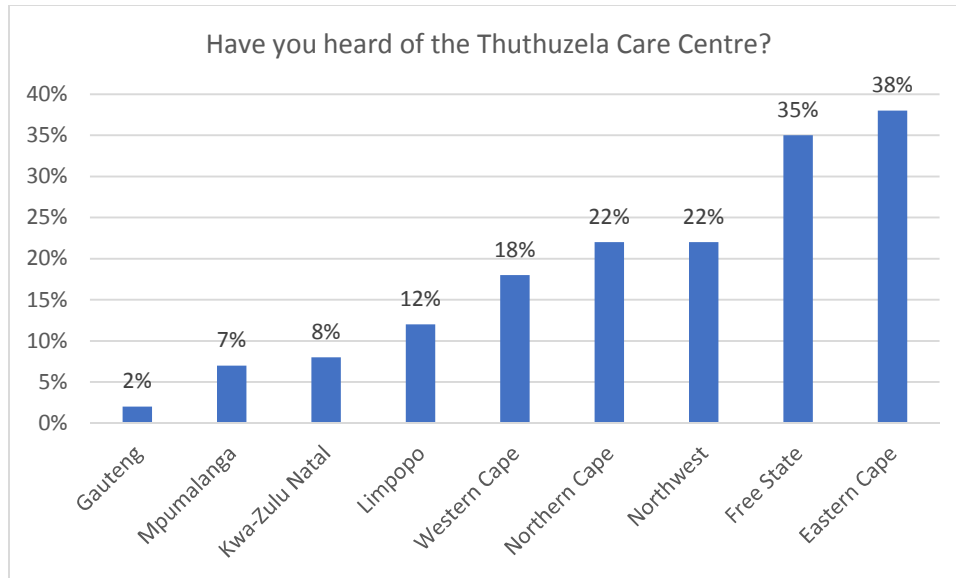


Figure 8: Knowledge of TCCs by province

Respondents who were unaware of the TCCs were read an explanation of what a TCC is and asked to assess whether they know of a sexual assault center, but do not recognize the name: “A *Thuthuzela Care Centre* is a crisis centre to help victims of sexual assault. Do you know of any places like this in your community?” Only 4% of those who answered “no” to the previous question reported knowing of a sexual assault center in their community, meaning that only 21 of respondents have either heard of the TCC or know of a place that serves victims of sexual assault (see Table 6).

Table 6: Respondent knowledge of TCCs & other support resources for victims of sexual assault

	Yes	No	Don't know
Have you heard of the Thuthuzela Care Centres? (n=1,500)	18%	82%	
Do you know of any places like this [TCC] in your community? (n=1,232)	4%	96%	
Are there services available in your community for victims of sexual assault? (n=1,500)	20%	74%	6%
Do you know if any care centers run by NGOs? (n=1,500)	20%	80%	

Respondents were also asked a series of related questions to gauge their knowledge about TCCs and other resources for victims of sexual assault. Responses to each of the questions are shown in Table 6, Figure 9, and Figure 10. These data suggest that the vast majority of South African women are not aware of the TCCs or where survivors of SGBV can receive assistance.

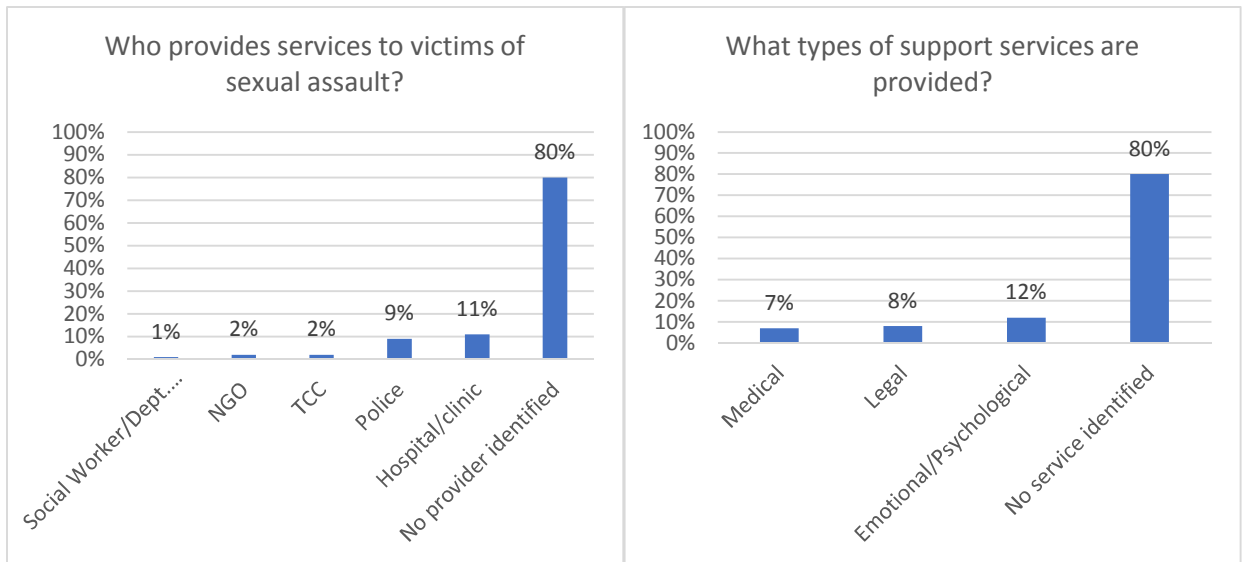


Figure 9: Knowledge of providers and services available to victims of sexual assault

Partially as a consequence of this lack of information, when women were asked where they would go first to report a sexual assault, less than 1% of all respondents said they would first report a sexual assault to a TCC and 57% cited the police as the first point of reporting (Figure 10). In fact, as discussed above, most of the victims brought to the TCCs are brought by the police.

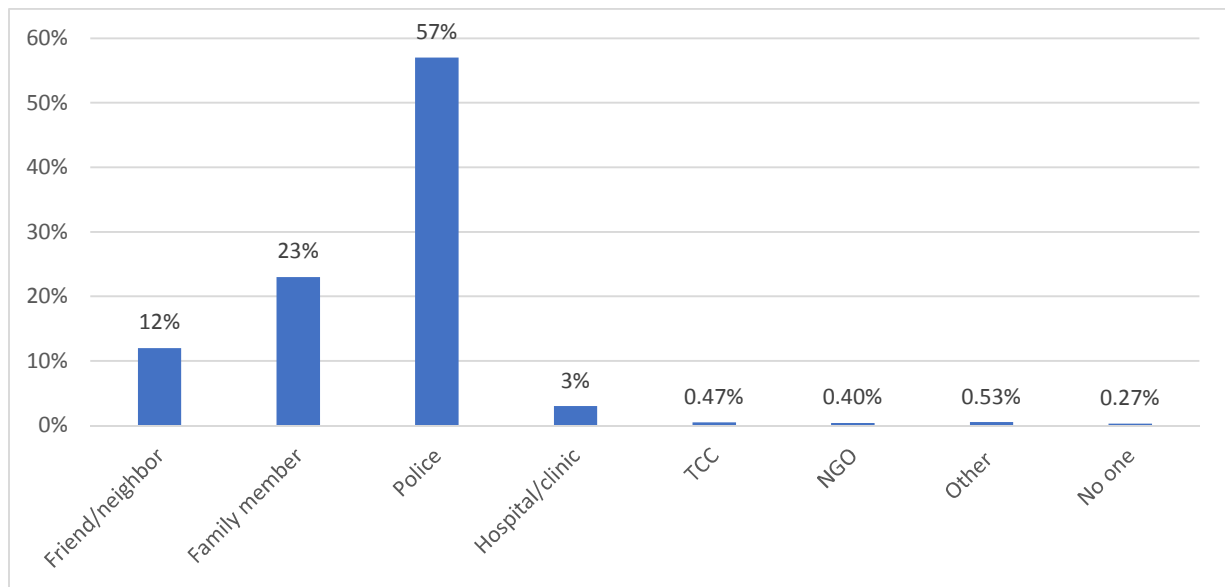


Figure 10: Where respondents would report a sexual assault

The 313 respondents (21%) who did report knowledge of TCCs or knowledge of a similar place were asked a series of additional questions about TCCs and TCC services. The majority of these respondents reported knowing of the services the TCC offers (79%) and the location of the nearest TCC (69%). Two follow-up questions were asked to assess possible response bias on these two items. The first asked respondents to name the location of the nearest TCC. Nearly half of respondents (42%) who reported knowing the location of the nearest TCC were not able to provide a specific location when asked,

indicating some possible response bias for this question. The second follow-up question enquired about types of services offered by the TCC. Nearly all respondents who indicated knowledge of the services offered by TCCs responded correctly that TCCs offer medical (97%) and psychological (99%) services, while fewer responded correctly about TCC provision of legal services (81%) (see Table 7).

Notably, the vast majority of respondents reported that TCCs do not offer transportation services. While transportation to the TCC is provided, transportation home from the TCC or back to the TCC for follow-up appointments is not. Moreover, transportation to the TCC is only offered from the police station, so respondents may perceive transportation as being offered by the police rather than the TCC.

Table 7: Knowledge of general TCC services

Of the following services, which are offered by TCCs? (n=313)	Correct response	% responding “yes”
Transportation	Yes	9
Medical assistance	Yes	97
Psychological and counseling service	Yes	99
Legal assistance	Yes	81

As shown in Table 8, the majority of respondents in the subsample of those knowledgeable about TCCs correctly answered additional questions about the TCC. However, it is clear that some important misperceptions remain about the TCCs; 80% of respondents incorrectly answered that clients visiting the TCC must report the name of her/his attacker, and 97% incorrectly believed that the TCC requires her/him to take legal action. These misperceptions are likely to dissuade victims from seeking services from the TCCs.

Table 8: Knowledge of terms of use of TCC and services

Percent of respondents responding “yes” to TCC questions (n=313)	Correct response	% responding correctly
Can a man receive help from the TCC?	Yes	83
Can a child receive help from the TCC?	Yes	88
Do clients have to pay for TCC services?	No	97
Are clients required to report the name of the attacker?	No	20
Is it possible to file a police report at the TCC?	Yes	78
Does TCC require you to take legal action?	No	87

As another measure of community awareness of TCCs, respondents in the subsample were asked their perception of community knowledge of TCCs. As shown in Figure 11, 55% of these respondents reported that a few women in their community know of the TCC.

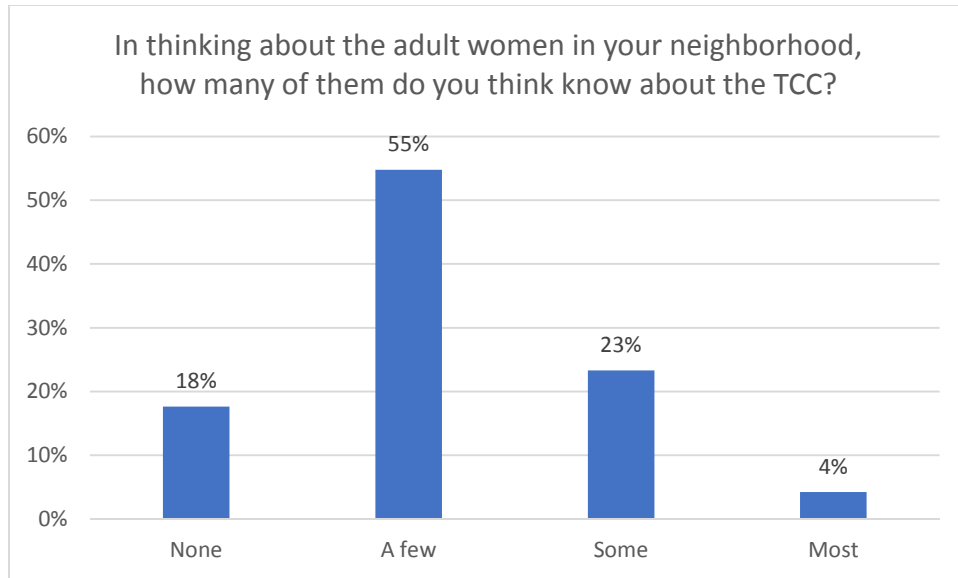


Figure 11: Respondent perception of community awareness of TCCs (n=313)

Since the treatment I intervention aims to increase awareness of the TCCs and knowledge of the services they provide, at endline the evaluation will test whether awareness and knowledge of TCC increase as a result of the intervention.

3.2.3 Perceptions of Sexual Assault and Sexual Assault Reporting

In order to increase utilization of the TCCs, it is important to understand the barriers to use, respondents were asked to categorize a series of possible barriers to visiting a TCC as either: not at all a barrier, a minor barrier, a barrier, or a major barrier. Nearly three quarters of respondents reported that (lack of) awareness of the TCCs as a major barrier to visiting TCCs, which was the most common barrier reported (see Figure 12). These results make clear the need for great outreach. The second most prominent barrier is fear of punishment by the perpetrator, followed by the offer of money not to report the sexual assault. Responses to these items provide additional evidence that programs to raise awareness about the TCCs could be highly beneficial.

Using the same structure as the previous question, respondents were asked to categorize a series of possible barriers to reporting a sexual assault case to the police. Respondents similarly reported fear of punishment by the perpetrator and fear the perpetrator would find out as the most significant of the barriers.

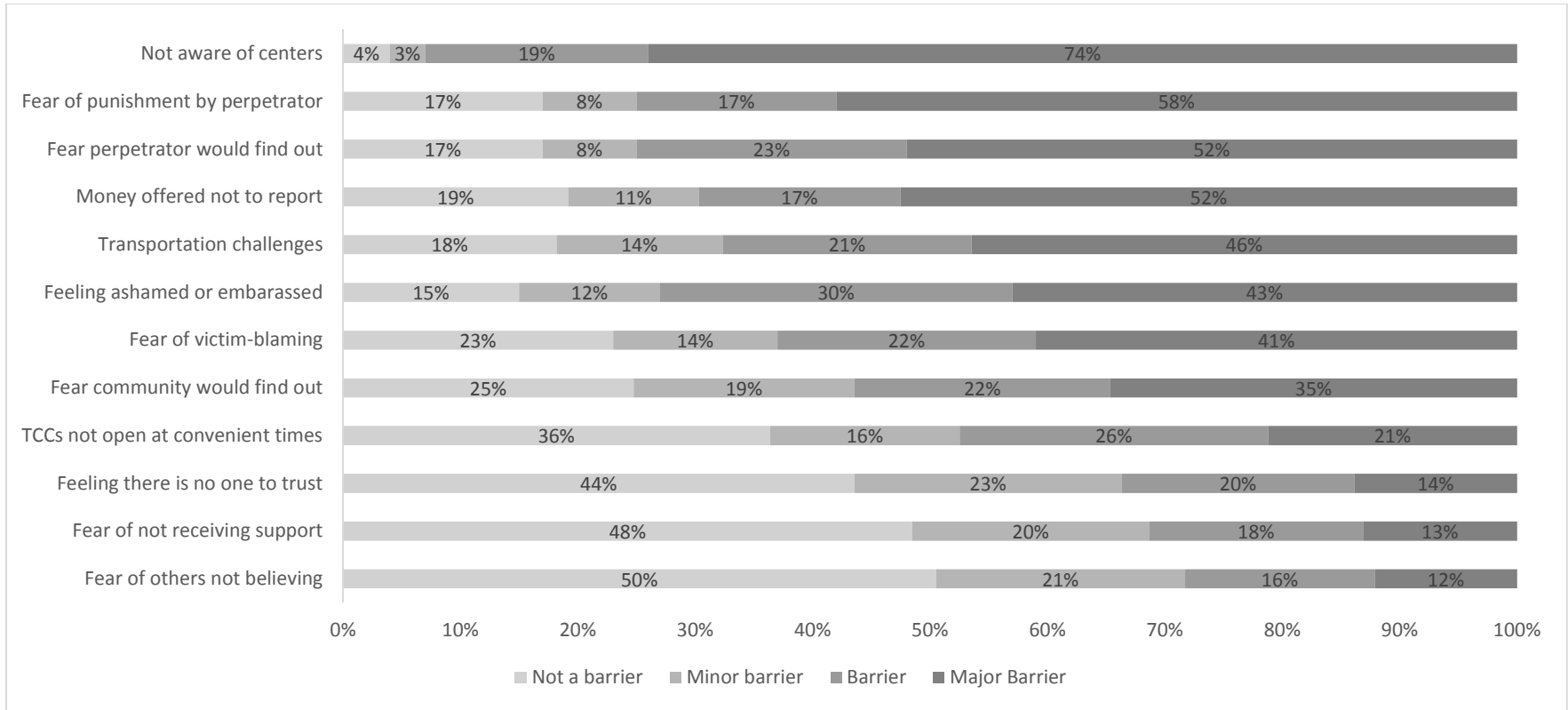


Figure 12: Respondent perceptions of barriers to visiting the TCC

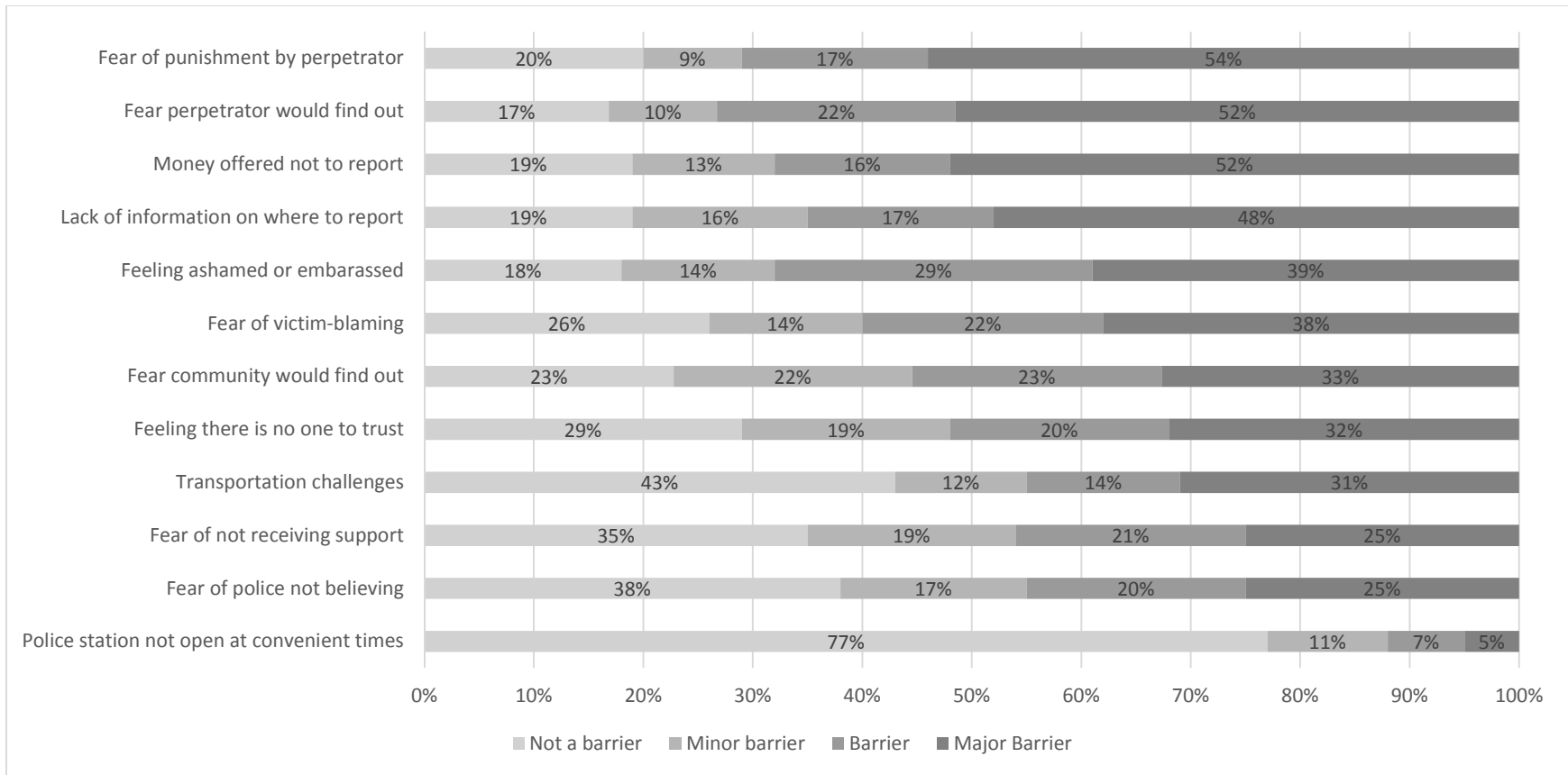


Figure 13: Respondent perceptions of barriers to reporting to the police

In order to compare how women perceive sexual assault relative to other crime problems, respondents were asked to rate several common crime problems on a four-point scale—*not a problem*, *a minor problem*, *a problem*, or *a major problem*. Respondents were more inclined to report house-breaking or mugging as problems than sexual assault or domestic violence. In contrast, according to SAPS crime statistics, there were 53,439 instances of common robbery in South Africa in 2013 compared with 66,197 instances of sexual assault. While both are likely to be underreported, this contrast suggests that sexual assault may be more prevalent than commonly perceived by communities. These findings suggest that there is a need for continued awareness raising of the extent and gravity of the problem of sexual assault. These results are not entirely uniform, however. As one could expect, respondents in precincts with higher rates of reported sexual assault were statistically significantly more likely ($p < .01$) to indicate sexual assault as “a problem” or a “major problem” than “not a problem” or “a minor problem.”

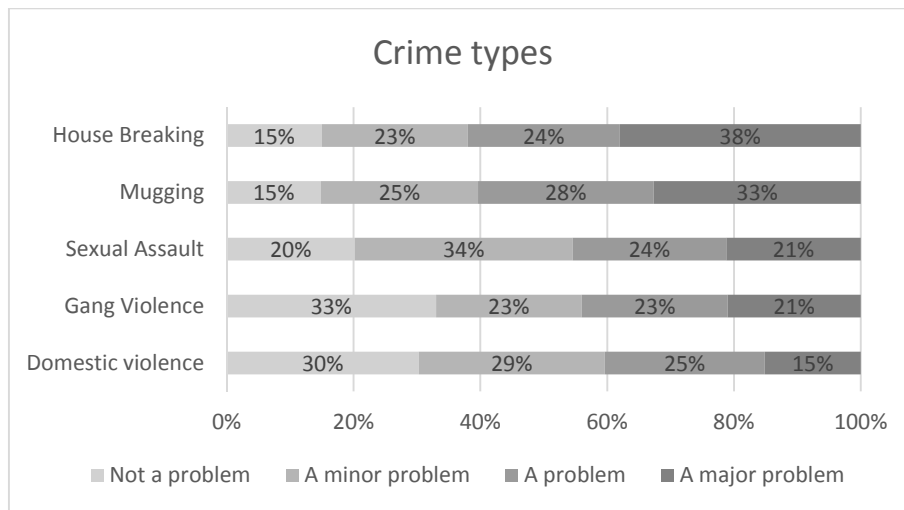


Figure 14: Respondent perceptions of crime problems

Despite 54% of respondents ranking sexual assault as “not a problem” or “a minor problem,” 25% of respondents report personally knowing women or girls who have been raped or sexually assaulted in the last year, and 37% report personally knowing a woman or girl who has been raped or sexually assaulted in her lifetime.

Table 9: Percentage of respondents who personally know victims of rape or sexual assault

Survivor gender/age and time period	% Yes
Women/girls (assaulted in the last year)	24.8
Women/girls (assaulted in their lifetime)	36.9
Men/boys (assaulted in the last year)	2.6

Respondents who reported knowing victims of sexual assault were asked how many victims they knew. On average, this sub-sample of respondents reported knowing 1.9 women or girls who had been assaulted in the last year, 2.3 women or girls who had been assaulted in their lifetime, and 0.7 men and 1.4 boys who had been assaulted in the last year. These data are presented in

Table 10.¹⁷

Table 10: Number of survivors of SGBV respondent personally knows

Survivor gender/age and time period	n	Mean	SD	Min.	Max.
Women/girls (assaulted in the last year)	368	1.9	1.3	0	19
Women/girls (assaulted in their lifetime)	541	2.3	1.9	1	27
Men (assaulted in the last year)	38	0.7	0.7	0	2
Boys (assaulted in the last year)	40	1.4	0.9	0	4

Respondents in the subsample of those 311 people knowledgeable about TCCs were asked how many women, men, girls, and boys they know personally who have visited a TCC. Results are presented in Table 11, and show that these respondents reported the highest rate of use of TCCs among girls under the age of 18, an unsurprising result since the sexual assault rate in South Africa is highest among this group. On average, women in this subsample personally knew one or two women and girls who had visited a TCC and some knew a man or boy who had visited a TCC.

Table 11: Average number of SGBV survivors respondent knows who have visited a TCC

How many...do you know personally? (n=311)	Mean	Min	Max
Women 18 and older	1.2	0	10
Men 18 and older	0.14	0	5
Girls under age 18	1.5	0	15
Boys under age 18	0.66	0	10

3.2.4 Attitudes toward gender

The women's survey also included several questions drawn from other international surveys designed to assess attitudes toward gender and gender roles. Specifically, items were drawn from the 2008 International Men and Gender Equality Women's Survey and the 2003 World Health Organization (WHO) Multi-country study of Women's Health and Life Events. Generally speaking, the results show progressive gender attitudes among respondents at baseline. Very few respondents indicated scenarios when violence toward woman would be warranted or tolerated. Moreover, responses indicated low levels of victim-blaming in rape cases. There were a few concerning exceptions, however. Approximately one quarter of respondents indicated sexual violence is not rape if the victim does not fight back, and that one should consider a victim's sexual reputation in a rape case. Notably, 42% of respondents disagreed that a woman has the right to refuse sex with her husband if she does not want to.

Table 12: Gender attitudes: percentage of respondents indicating agreement with gender statements

Gender Attitudes	Agree (%)
Rights for women mean that men lose out.	6
There are times when a woman deserves to be beaten.	4
A man should have the final word about decisions in his home.	18
A woman should tolerate violence in order to keep her family together.	8

¹⁷ Minimum value in table 12 is zero in some cases because some women answered "yes" to knowing a survivor of SGBV but then respond "0" to the number of survivors she knows.

A man and a woman should decide together what type of contraceptive to use.	47
If a man sexually assaults his wife, others outside of the family should intervene.	71
A man can hit a woman if...	
She does not complete her housework to his satisfaction.	1
She disobeys him.	3
She refuses to have sexual relations with him.	2
He suspects that she is unfaithful.	1
He finds out that she has been unfaithful.	7
A woman can refuse sex with her husband if...	
She doesn't want to.	58
He is drunk.	66
She is sick.	76
He mistreats her.	75
When a woman is raped, she usually did something careless to put herself in that situation.	6
In some rape cases, women actually want it to happen.	5
If a woman doesn't physically fight back, you can't really say it was rape.	23
In any rape case, one would have to question whether the victim sleeps around a lot or has a bad reputation.	28

Women were also asked to respond to a series of questions following two hypothetical scenarios of sexual assault. The purpose of these questions is to assess women's attitudes toward rape in two distinct scenarios:

Scenario 1: A woman has to work late each night. The bus she takes home lets her off .5km from her home. One night, when walking home, she is assaulted by a man. She is unable to fight him off and he rapes her.

Scenario 2: An attractive 20-year-old single woman wearing a mini-skirt goes out on a Friday night with friends. She stays for a few hours and has a few drinks. On her way home, she is assaulted by a man. She is unable to fight him off and he rapes her.

As shown in Figure 15, respondents were more likely to agree that the woman was partially to blame for being sexually assaulted in Scenario 2 than in Scenario 1. Moreover, respondents reported that women in their neighborhood would be less likely to file a police report and that the police would be less helpful for Scenario 2.

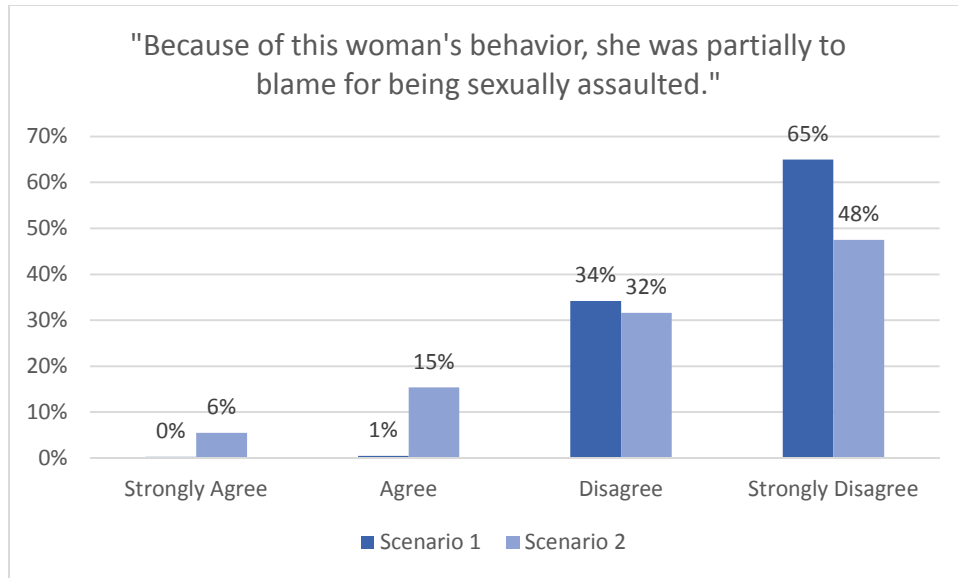


Figure 15: Prevalence of victim-blaming attitudes among respondents, by scenario

A SGBV attitudes index was constructed by combining responses from 21 survey items regarding attitudes toward gender roles and the sexual assault scenarios. The maximum possible score (84 points) indicates strong agreement with gender equality norms, whereas the lowest possible score (21 points) indicates strong disagreement with gender equality norms. Scores are generally quite high across all respondents with an average score of 68.2.

In summary, while the survey reveals generally positive attitudes toward gender roles and the sexual assault scenarios, there are some areas of concern regarding the right of a woman to deny her husband sex and to condemn rape in all scenarios. The evaluation will test if there is a change in the SGBV index as a result of the intervention and look for more targeted changes in these areas of concern.

3.3 SERVICE PROVIDERS' TRAINING, PERCEPTIONS, AND KNOWLEDGE

Paper surveys were administered to service provider professionals attending the FPD-led *Integrated Management of Sexual and Gender Based Violence* (Integrated Management) training. All training participants were requested to consent to and complete a brief survey about their knowledge of TCCs and SGBV, perceptions, and recent practices with survivors of SGBV. Table 13 shows the number of professionals attending the training in each province, as well as the number of those professionals agreeing to participate in the evaluation at baseline. Ninety-four percent of trainees consented to participate in the baseline survey; however, as noted above, respondents often skipped questions. As such, sample sizes vary somewhat from question to question, although for the majority of question, data is not missing for more than 10% of respondents.

Table 13: Number of service providers trained and participating in the evaluation

Province	# Trained	# Surveyed	% Trainees Surveyed
Gauteng	222	212	95%
Limpopo	253	233	92%
North West	226	214	95%
Kwa-Zulu Natal ¹⁸	276	245	89%
Eastern Cape	377	356	94%
Western Cape	143	139	97%
Northern Cape	118	104	88%
Free State	155	148	95%
Mpumalanga	138	138	100%
Total	1,908	1,789	94%

As envisioned in the training curriculum, trainees represented a variety of professions, with the majority of trainees being social workers, NGO workers, and police (see Figure 16). Of those attending the training, 36% reported having previously attended a training on sexual assault (n=1,528).

¹⁸ Excludes participants from Margate precinct in KwaZulu-Natal province. This precinct was dropped from the evaluation due to delays in implementation.

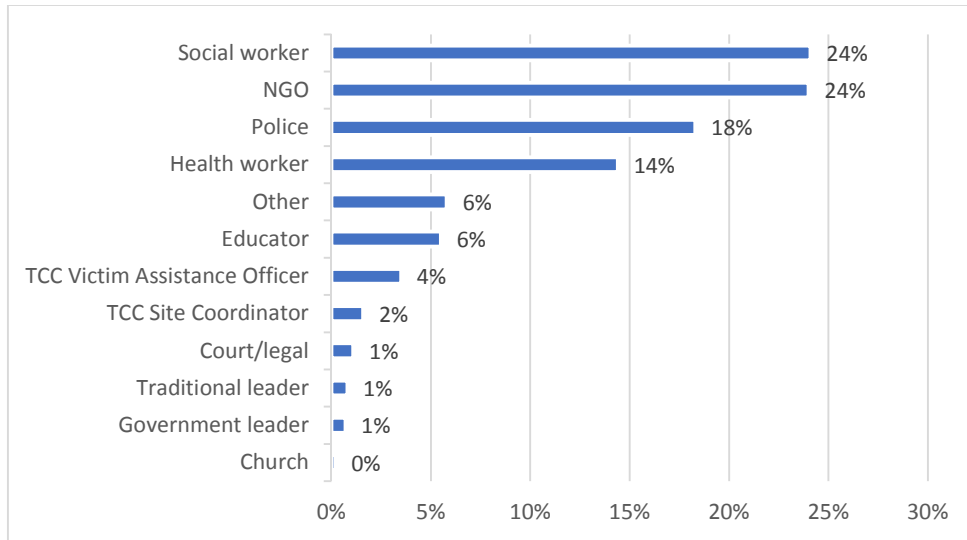


Figure 16: Respondent professions (n=1,559)

Two thirds of respondents in the sample who reported their sex (n=1,537) were female. Reported ages are presented in Figure 17. The majority of respondents were under 40 years old.

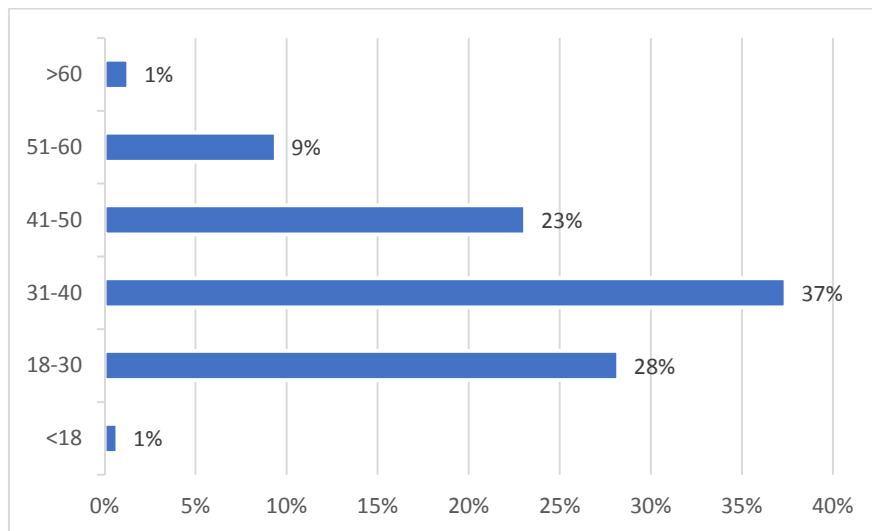


Figure 17: Respondent age (n=1,541)

3.3.1 Knowledge of TCCs

Respondents were asked a series of questions to test their knowledge of TCCs. Nearly 80% reported knowledge of TCC services, and 81% knew that there are services available to victims of sexual assault in their community. Although most reported knowledge of TCC services, prior to the training, respondents did not have a good understanding of what services are offered at TCCs (Table 14). Just over half of respondents correctly identified that TCCs provide medical assistance, while 74% correctly noted that TCCs provide psychological and counseling services. Notably, only 37% believed that TCCs provide legal assistance to survivors, despite litigation being an important facet of TCC services. Finally, as was the case with women’s survey respondents, few professionals reported knowing about TCCs’ provision of

transportation services, even though this service is provided.¹⁹

Table 14: Knowledge of TCC services (n=1,522)

Of the following services, which are offered by TCCs?	Correct response	% responding correctly
Transportation	Yes	24
Medical assistance	Yes	58
Psychological and counseling service	Yes	74
Legal assistance	Yes	37

Three quarters of respondents said they knew the location of the nearest TCC. When asked to specify the location of the TCC, not all trainees answering yes were able to specify an actual location (81% of this group reported a location²⁰), indicating some possible response bias on this question.

Respondents were asked to report how widely known TCCs are at their workplace. As shown in Figure 18, responses to this item varied substantially. There was high variability in TCC awareness between workplaces both across professions and within the same profession, although educators tended to reported lower levels of knowledge of the TCC in their workplace relative to other professions.

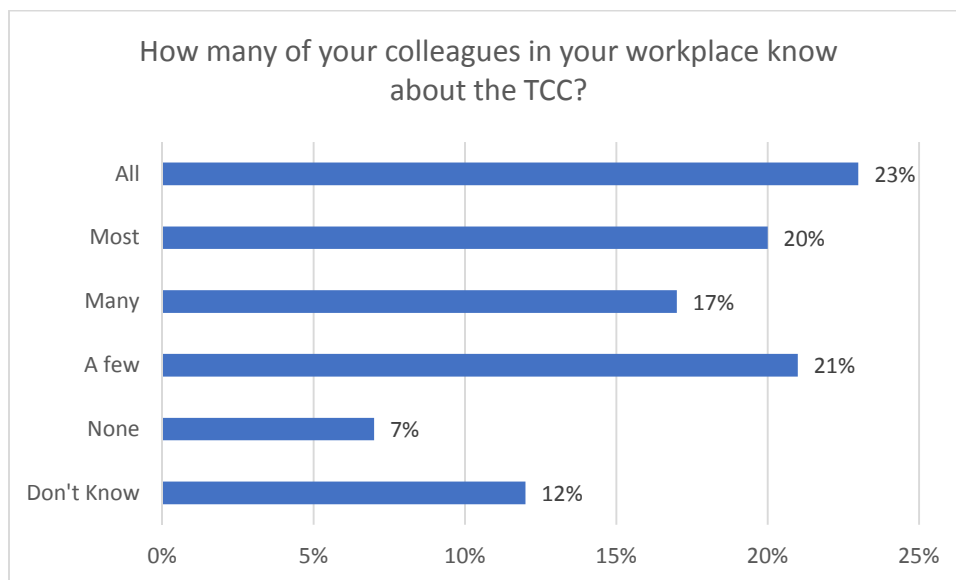


Figure 18: Respondent perception of awareness of TCCs (n=1,576)

As shown in Table 15, misperceptions about TCCs are common among service provider respondents. While most respondents correctly noted that men and children can receive help from the TCC and that clients do not have to pay for services received at the TCC, about half of respondents believed that TCCs require a survivor to report the name of the attacker and to pursue legal action. Moreover, 48% of respondents were not aware that a survivor could file a police report at the TCC. The endline analysis

¹⁹ While service providers were less likely to respond correctly to these items than respondents in the women’s survey, it should be noted that these questions were only asked the subsample of 313 respondents in the women’s survey that had heard of the TCC.

²⁰ These responses were not assessed for correctness because TCCs can go by different names in different communities.

will explore the extent to which these misperceptions have changed amongst professionals after the training.

Table 15: Respondents’ knowledge of TCC services (n=1,552)

Survey question	Correct response	% responding correctly
Can a man receive help from the TCC?	Yes	87%
Can a child receive help from the TCC?	Yes	89%
Do clients have to pay for TCC services?	No	91%
Are clients required to report the name of the attacker?	No	55%
Is it possible to file a police report at the TCC?	Yes	48%
Does TCC require you to take legal action?	No	51%

3.3.2 Recent services provided to SGBV survivors

The evaluation also seeks to measure whether or not treatment 2 training participants adopt behavior changes in how they interact with SGBV survivors after participating in the Integrated Management training. To measure this change, respondents are asked to report instances when they assisted SGBV survivors. Table 16 shows how often respondents reported providing each of these services at baseline. While many respondents report informing victims about their rights, or receiving a report of SGBV, fewer than half personally took someone to a TCC, while 59% reported helping a victim establish a safety plan.

Table 16: Respondent provision of support services to survivors of SGBV in the last 60 days

In the past 60 days, how often did you...	n	% reporting one or more times
Personally take someone to the TCC to get help.	1,469	41%
Help a victim of SGBV in a dangerous situation establish a safety plan.	1,481	59%
Assess the level of danger a victim of SGBV was facing.	1,460	61%
Document information about a case of SGBV.	1,453	63%
Identify a student or client that you suspected to be a victim of SGBV.	1,481	65%
Inform a victim of SGBV about other resources.	1,478	65%
Contact a service provider on behalf of a victim of SGBV.	1,489	66%
Coordinate with another service provider to assist a victim of SGBV.	1,440	68%
Have someone report SGBV to you.	1,500	72%
Inform a victim about her/his rights with respect to SGBV.	1,471	80%

Of those professionals who contacted a service provider on the behalf of a victim, 31% contacted a TCC, 32% reached out to a hospital, and 54% contacted the police.²¹ Of those professionals who reported coordinating with another service provider to assist a victim, 71% coordinated with a TCC, 65% with a hospital, and 52% with the police.²² Overall, these data suggest that many professionals in the continuum of care for survivors are already engaging with TCCs, hospitals, and the police to assist victims.

Service providers were also asked about their perceived level of difficulty talking with a victim about SGBV. Of the 1,520 trainees responding to this question, 42% stated this is “difficult” or “very difficult.” These results will be compared with endline results to determine whether the training has improved the

²¹ Percentages exceed 100% because the question used a “select all that apply” format.

²² Percentages exceed 100% because the question used a “select all that apply” format.

service providers' comfort level in talking with survivors about SGBV.

3.3.3 Attitudes toward SGBV

The Integrated Management training also seeks to influence trainee attitudes toward survivors of SGBV. At baseline, many professionals revealed moderate levels of victim-blaming. Notably, nearly half indicated that the extent of a woman's resistance should be the major factor in determining if a rape has occurred. This is alarming since this is a misplaced belief for multiple reasons, such as because many rape victims are unable to resist or feel it would be futile to do so. A third of respondents believed that women provoke rape by their appearance or behavior.

Table 17: Proportion of service providers in agreement with SGBV statements

SGBV Statement	n	Agree (%)
The extent of the woman's resistance should be the major factor in determining if a rape has occurred.	1,640	47
A raped woman is usually an innocent victim.	1,736	69
Women often claim rape to protect their reputations.	1,710	29
Women who have had prior sexual relationships should not complain about rape.	1,695	10
Women do not provoke rape by their appearance or behavior.	1,687	65
Women who are raped while accepting rides from strangers get what they deserve.	1,708	7
Many women invent rape stories if they learn they are pregnant.	1,682	20
Many women claim rape if they have consented to sexual relations but have changed their minds afterwards.	1,684	37
Accusations of rape by bar ladies, strippers, and prostitutes should be viewed with suspicion.	1,675	25

Professionals were also asked to respond to a series of questions following a hypothetical scenario of sexual assault. The purpose of this section was to assess women's attitudes toward rape in a potential real-world scenario.

Scenario: An attractive 20-year-old single woman wearing a mini-skirt goes out on a Friday night with friends. She stays for a few hours and has a few drinks. On her way home, she is assaulted by a man. She is unable to fight him off and he rapes her.

Although responses indicated some victim blaming, 86% of the respondents either disagreed (30%) or strongly disagreed (56%) that a woman in this scenario is to blame for the sexual assault (n=1,706). Respondents (n=1,684) also reported that women would always or often report such a situation to the police (41%), and that fear of being blamed would be the main reason a woman would not file a police report in the situation.

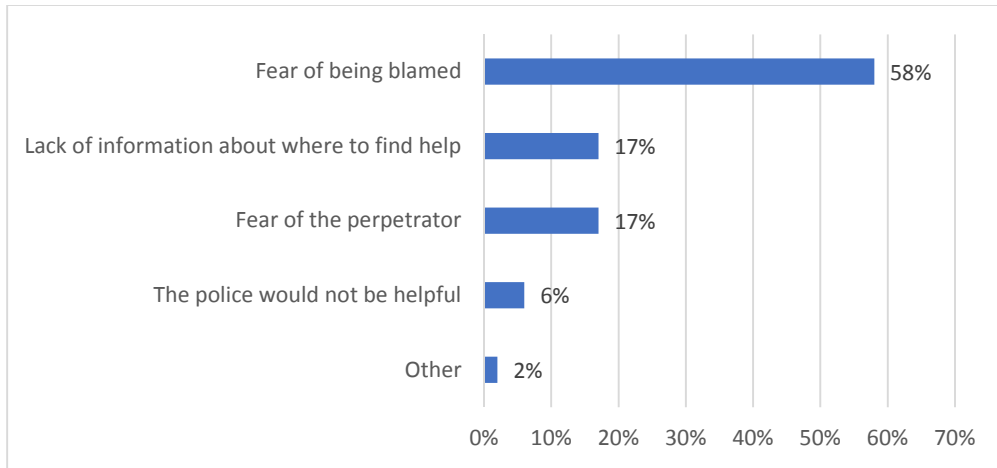


Figure 19: Reasons a survivor in this scenario would not report to the police (n=1,687)

When asked if the police would be or helpful in this situation (n=1,737), 95% of respondents reported the police would be either “very helpful” or “helpful,” suggesting there is a general perception of trust in the police amongst respondents. As is shown in Figure 20, respondents believe that women in this scenario are as likely to go to a TCC, as to report the incident to police. The reasons for not reporting to a TCC differ, however, with 58% reporting a lack of information about where to find help rather than fear of being blamed as the main reason that a woman would not go to a TCC (see Figure 21).

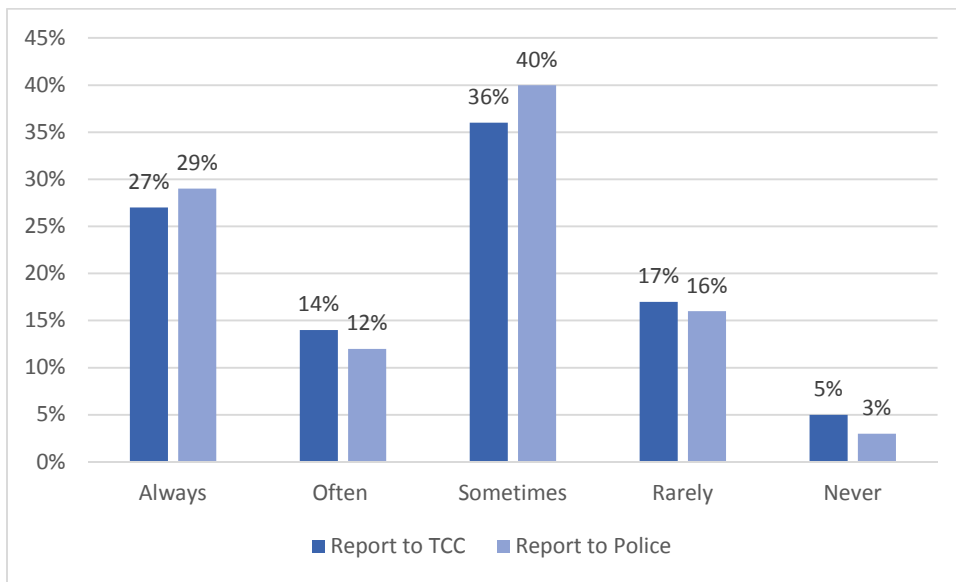


Figure 20: Perceived likelihood that a woman in the scenario would report to a TCC and to the police

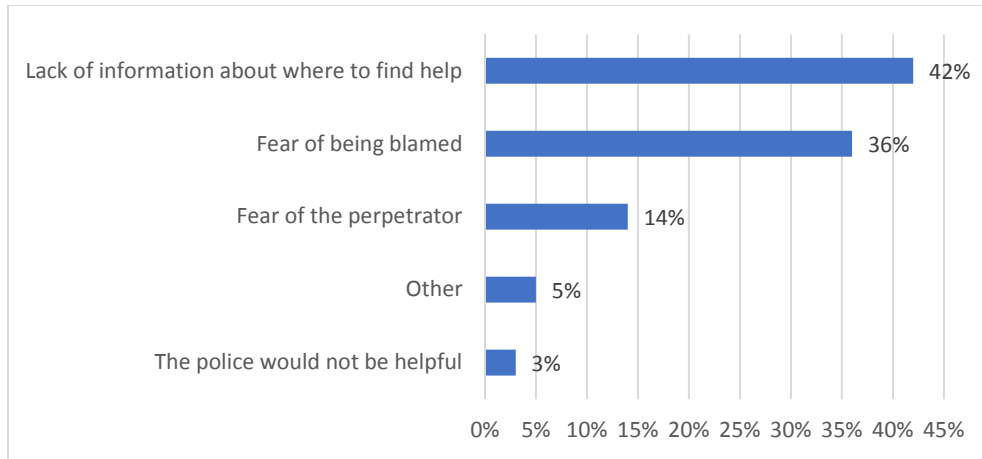


Figure 21: Reasons victims in this scenario would not report to the TCC (n=1,628)

Table 18 shows that nearly all respondents believed a TCC would be “very helpful” or “helpful” in this scenario for medical, legal, and psychological/emotional support.

Table 18: Respondent perception of helpfulness of TCCs

	Very helpful	Helpful	Not very helpful	Not at all helpful
Medical	74%	23%	12%	1%
Legal	61%	34%	3%	2%
Psychological/emotional	77%	22%	1%	1%

In summary, the baseline professionals survey data reveal that many professionals participating in the intervention had limited exposure to TCCs prior to the training, and harbored some misperceptions about the TCC and TCC services, though they report that TCCs would be helpful in providing support to victims. Moreover, participants exhibited some victim-blaming attitudes. The evaluation will follow up with the same respondents at endline and will test for differences in knowledge and attitudes after the group has completed the Integrated Management training.

4. CONCLUSION

Qualitative and quantitative data collected at TCCs reveal that TCCs vary in capacity in resources, including in their days and hours of operation, appearance and quality of facilities, services provided, staffing, record-keeping practices, and available resources. While some TCC staff described their TCC as being mostly adequate in their overall capacity and meeting the needs of survivors, no TCC staff reported being fully able to meet the need of survivors and staff at only one TCC reported that its overall capacity is completely adequate. TCC interview respondents described their TCCs as having limited resources, supplies, staffing, and facilities as barriers to serving survivors. Through coordination with NGOs and other stakeholders, interview respondents perceived that TCCs are able to fill service gaps that they could not address on their own, and felt that this collaboration improved the quality of care provided to survivors. TCC capacity and utilization data will be used as control variables in the final impact evaluation analysis and may help explain possible differential treatments affects across TCCs.

Baseline data confirm anecdotal evidence that many South Africans are not aware of the TCCs. While the women's survey data reveal generally progressive attitudes toward gender roles and the sexual assault scenarios, there are some areas of concern regarding the right of a woman to deny her husband sex and to condemn rape in all scenarios. The evaluation will test if there is a change in the SGBV index as a result of the demand-side intervention (treatment 1) and look for more targeted changes in these areas of concern.

Baseline service provider survey data reveal that many professionals participating in the Integrated Management training intervention had limited exposure to TCCs prior to the training, and harbored some misperceptions about the TCC and TCC services, although most believe that TCCs would be helpful in providing support to victims. Moreover, participants exhibited some victim-blaming attitudes. The evaluation will follow up with the same respondents at endline and will test for differences in knowledge and attitudes after the professionals completed the supply-side training (treatment 2).

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK

Impact Evaluation Strategy for South Africa GBV Project

Eric Mvukiyehi
November 15, 2012

Background

Over the past 5 years, USAID South Africa has worked with the South African Government and other development partners to set up dozens of Thuthuzela Care Centers (TCCs), one-stop facilities designed to provide clinical services and psychological counseling to victims of rape and other sexual assaults. Currently, there are 52 TCCs around the country, at least one in each of the 9 provinces. The mission is now launching a new 5-year project titled “*Increasing Services for Survivors of Sexual Assault in South Africa*,” which will be implemented by the Foundation for Professional Development (FPD) along with Soul City and Soke as sub-implementers.

This new project seeks to move beyond service provision to also focus on broader **issues of Gender-Based Violence (GBV) prevention** through a wide range of public awareness-raising and capacity-strengthening activities. Specific objectives of the project are: (i) to increase public awareness of the services provided at all 52 TCCs; and (ii) to expand and improve the services provided at TCCs and in the TCC catchment areas. If met, these objectives should contribute to increase in utilization TCC clinical service by the survivors of rape and other sexual assaults and more generally to a change in attitudes and behaviors about rape as well as to a decrease in risks and incidence of GBV in TCC-catchment areas.

An impact evaluation study is being explored to ascertain the effectiveness of this project. This memo outlines the broader contours of design options for such a study.

Evaluation objectives

Based on the aforementioned project objectives and on conversations with the stakeholders, the following evaluation objectives are achievable:

- To ascertain the effects of project activities on survivors’ propensity to seek out and utilize TCC services
- To ascertain the effects of project activities on survivors’ psychological and social wellbeing
- To ascertain the effects on GBV-related attitudes and behaviors on the part of community members, healthcare professionals and law enforcement authorities
- To ascertain the effects of project activities on incidence of GBV in communities

Activities to be evaluated

This research study will focus on the efficacy of different project activities on key outcomes of interested. Thus far, it seems that the main outcomes have to do with (i) increasing survivors’ propensity to seek out TCC services and staying through the counseling and legal processes; and (ii) changing attitudes and behaviors on the part of members of the broader community, including survivors’ families and

professionals involved in the referral systems. Presumably, project implementers have identified the list of key factors that contribute to the problems that underlie underutilization of TCC services and prevalence of GBV such that the proposed activities are designed to address these root causes. From what I can gather in the project documents and the conversations with implementing partners, the following barriers or risk factors have been singled out:

- Lack of information about availability (and benefits) of TCC services
- Social structures that embed permissive gender social norms (e.g., patriarchy) and condone rape and other sexual assaults or stigmatize the victims
- Weak protection environments and lack of trust in institutions and services that are supposed provide assistance to survivors (e.g., police, TCC and hospital staff, law enforcement services, etc.)

Thus, it seems to me that the array of project activities designed to address these risk factors fit in two broad categories: (i) **public awareness-raising activities** aiming to provide information about TCC services and to educate the public about GBV issues; and (ii) **capacity-strengthening activities** aiming to enhance service delivery and/or to create a safe and trusting environment for the survivors. Arguably, some activities such as “open days” may have a dual purpose.

Target populations of interest

This project targets at least three primary populations of interest:

- Survivors of rape and other sexual assaults
- Survivors’ families and fellow community members (in TCC catchment areas)²³
- Professionals who are part of the referral systems (e.g., TCC and hospital staff; police; prosecutors; local NGOs; etc.)

Key outcome areas of interest

Outcomes of interest are indicators of change, which can tell you whether project activities have been effective or not and are typically operationalized from project and evaluation objectives. These indicators have to be measurable empirically, either through surveys or some other ways. One way to organize these outcomes is to thinking about the main project activities that will be carried out and the population of interest these activities will be targeting and ask yourself the following question: “*what changes should I expect to see on this population of interest if project activities are effective?*” From this perspective, it seems that there are three primary indicators of change and a number of secondary ones.

Primary outcome #1: Survivors’ propensity to seek out and utilize TCC services

- Knowledge about TCC services and benefits
- Seek out treatment
- Satisfaction with TCC services
- Staying on through a counseling plan

²³ This category encompasses many different subgroups, including, potential victims of rape and other sexual assaults (e.g., girls women at risk of GBV); potential perpetrators of GBV crimes; victims’ families; ordinary community members; community leaders; among others.

- Trust in referral systems
- Willingness to report GBV crimes
- Likelihood to stay through the legal processes or to withdrawal case
- Psychological and social well being (e.g., less-strained relations with family community members; positive outlook; paranoia; sense of self-worth; etc.)
- Civic engagement

Primary outcome #2: Change attitudes and behaviors about GBV issues on the part of referral systems professionals as well as the survivor’s family and community

- Knowledge about GBV issues
- Attitudes about GBV issues
- Empathy and support toward survivors
- Behavioral intent regarding GBV
- Attitudes toward women and gender rights

Primary outcome #3: Decrease in risk of exposure to (and in incidence of) of GBV

- Prevalence of GBV-risk factors
- Prevalence of GBV

Research questions

The research questions will gauge the extent to which specific project activities (or combination thereof) influence the outcomes of interest on a given target population. The following are suggested generic questions, which can be refined based on the theories of change that underlie specific activities.

1. Do **awareness-raising activities** increase the likelihood that survivors will seek out TCC services and go through the entire counseling and legal process?
2. Do **capacity strengthening activities** improve survivors’ psychological and social wellbeing?
3. Do **awareness-raising activities** lead to changes in attitudes and behaviors about GBV?
4. Do **awareness-raising activities** lower the risk of exposure to (and incidence of) GBV?
5. Do **capacity strengthening activities** increase the likelihood that survivors will seek out TCC services and stay through counseling and legal processes?
6. Do **capacity strengthening activities improve** survivors’ psychological and social wellbeing?
7. Do **capacity strengthening activities** lead to changes in attitudes and behaviors about GBV?
8. Do **capacity strengthening activities** lower the risk of exposure to (and incidence of) GBV?

Hypotheses

Hypotheses are conjunctures between specific project activities and the key outcomes of interest, based on the program’s theory of change. That is, these are *provisional* answers to your research questions, pending confirmation from empirical evidence. To construct sound hypotheses, you need to ask yourself the following questions: “Which project activities are likely to produce the desired change on a particular

population of interest? Will such change occur under any circumstances or will change depend on other factors?"

[NOTE TO IMPLEMENTING PARTNERS: IT WOULD BE HELPFUL IF YOU COULD COME UP WITH A LIST OF THE MAIN ACTIVITIES YOU PLAN TO CARRY OUT, THE POPULATION WILL BE TARGETED AND THE KIND OF CHANGE YOU EXPECT TO SEE ON THIS POPULATION AND WHY AT THE END OF THE INTERVENTION.]

Based on our conversations, I propose the following hypotheses, but these will have to be refined or modified depending on your precise understanding of the theories of change on which your interventions rest. Please do keep in mind that we have different populations and outcomes of interest and so project activities may not have the same effects on these. Thus, in refining these hypotheses, we will be paying attention to such potential differences.

Hypotheses about survivors' attitudes and behaviors

This population of interest is targeted by both public awareness raising (whether through radio programs or community dialogue) and capacity-strengthening activities, though at different stages of the process. Thus, it could be argued that public awareness-raising activities may increase the likelihood that an individual survivor seeks out TCC services, but we wouldn't expect that public awareness alone will influence the likelihood that this individual stays on course of counseling program and through the legal process. The latter outcomes will probably depend on whether this individual trusts the systems and feels safe enough, which in turn depends on professionals getting training to create a safe environment for survivors. Thus, the following hypotheses can be formulated:

H1. Awareness-raising activities (e.g., community dialogues; radio programs) will increase survivors' knowledge about TCC services and increase survivors' likelihood to seek out TCC services

H2. Capacity-strengthening activities (e.g., multidisciplinary training) will increase the likelihood that survivors will stay through the process (counseling and legal)

H3. Capacity-strengthening activities (e.g., multidisciplinary training) will improve survivors' psychological and social well-being

H4. Capacity-strengthening activities (e.g., multidisciplinary training) will improve survivors' psychological and social well-being only if survivors have also been exposed to GBV awareness-raising activities

Hypotheses about attitudes and behaviors of referral systems professionals

This population interest encompasses a variety of groups including TCC and hospital staff; law enforcement authorities (e.g., police; prosecutors); members of local NGOs, among others. Arguably, this population is primarily targeted through capacity-strengthening activities, even though public awareness activities can also have some influence indirectly. Thus, the following hypotheses are suggested:

H5. Capacity-strengthening activities (e.g., multidisciplinary training) will change the way referral systems professionals provide assistance to survivors

H6. Capacity-strengthening activities (e.g., multidisciplinary training) will change GBV attitudes and behaviors on the part of referral systems professionals

H7. Capacity-strengthening activities (e.g., multidisciplinary training) will change GBV attitudes and behaviors on

the part of referral systems professionals only if these professionals have also been exposed to GBV awareness-raising activities

Hypotheses about attitudes and behaviors of survivors' families and of fellow community members

This population of interest is probably targeted primary through public awareness activities (e.g., community dialogues; radio programs; open days) and we wouldn't expect capacity strengthening activities to influence its attitudes and behaviors directly. However, there could be some indirect influence. For example, if policy or prosecutors who receive training change the way they handle GBV cases then would-be perpetrators will take this into account before they engage in crime. Thus, I propose the following hypotheses:

H8. *Awareness-raising activities (e.g., community dialogues; radio programs) will change GBV attitudes and behaviors of community members*

H9. *Awareness-raising activities (e.g., community dialogues; radio programs) will decrease the risk of exposure to (and incidence of) GBV in communities*

H10. *Capacity-strengthening activities (e.g., multidisciplinary training) will decrease the risk of exposure to (and incidence of) GBV in communities*

H11. *Capacity-strengthening activities (e.g., multidisciplinary training) will decrease the risk of exposure to (and incidence of) GBV in communities only if community members have also been exposed to awareness-raising activities*

H12. *The effects of either awareness-raising activities or capacity-strengthening activities on community members' attitudes and behaviors about GBV will depend on socioeconomic conditions that prevail in each community*

Identification of effects of project activities

Programmatic and logistical constraints make it difficult to carry out program activities across all TCC areas simultaneously. Therefore, we propose to randomize targeted areas in two groups, whereby the first group will receive some types of project activities (either awareness-raising or capacity-building or both) as soon as the project launches, the other group will receive project activities in the second wave.

A phase-in strategy would be followed to identify the effects of project activities on key outcomes for each of the three populations of interest. First, the project period will be divided in two waves, whereby in the first part of project life different intervention options are tried out in different communities and in the latter part of project life the best performing intervention(s) get(s) rollout in all targeted communities. As activities in the first wave are phased out and before activities in the second wave are phased in, we will gather follow-up data on both groups to ascertain the effects of project activities. These results can inform which activities are the most effective and perhaps focus on those going forward. I provide details below. How to divide the two waves is subject to discussion. One suggestion would be as follows:

- Wave#1: First 12-20 months of project life
- Follow-on data collection: 2-4 months after wave one is completed
- Wave #2: Remaining projects life (i.e. the last 36 months)

[NOTE TO IMPLEMENTING PARTNERS: NOTHING IS SET HERE. OTHER SCENARIOS ARE

FEASIBLE. KEY IS TO SELECT A PERIOD FOR WAVE ONE THAT YOU THINK WILL BE SUFFICIENT FOR PROJECT ACTIVITIES TO HAVE MEANINGFUL EFFECTS.]

This strategy will enable to ascertain project effects in two ways.

Ascertaining the efficacy of any type of project activities

The first approach would be to compare outcomes of interest between communities that receive some type of project activities and those that haven't yet. As suggested above, target communities or individuals will be divided in two groups, a larger subset of communities or individuals that receive different types of project activities in wave#1 and a smaller subset of where project activities are delayed until wave#2. [NOTE: WE ARE NOT TALKING ABOUT CLINICAL SERVICES HERE. THAT ASPECT OF THE PROJECT IS UNTACHED.] The idea is that at the end of the first wave (and before rollout of the second wave), we will gather from both groups and ascertain program effectiveness by comparing the outcomes of interest between the two groups—that the groups that did and did not receive any program activities in the first wave.

Ascertaining the efficacy different types of project activities

The second approach will allow us to ascertain not only whether a program works or not, but also what specific program activities have the greater effects on the key outcomes of interest. Thus, within the first wave, target communities or individual beneficiaries will receive different types of project activities: some will receive awareness-raising activities only, other will receive capacity-strengthening activities only and others will receive some combination of both. Thus, a key aspect of the evaluation here is to investigate which of the different intervention options has the greatest impact on key outcomes of interest for the different target populations.

Sampling plan

Sampling here is tricky. The difficulty is that the structure of the community are not very well defined, partly as a result of TCCs' emplacement in populated areas that are most at risk of GBV. Another difficulty is that this study is targeting two different populations of interest (i.e. victims of rape and other sexual assaults and community member) whose distribution may not completely overlap. With these problems in mind, I suggest a design that presumes that we are interested in learning about all 3 populations of interest (i.e., survivors; referral systems professionals and survivors' families and communities).

Use 'community' as the primary unit of treatment for survivors and fellow community members

One option would be to use "community" as a unit of treatment, meaning that project activities will be assigned to different communities and assume that all individuals within a particular community have been exposed to such activities. The difficulty here, though, is that the study will require a lot more communities that we may have initially wanted to work in. This is because the study requires a minimum number of units required to be able to detect the effects of project activities, if they do exist.

Based on power calculations, we determine that a minimum number of 208 communities will be required to adequately detect meaningful effects of project activities of any types, if they exist, and to be able to

distinguish the relative efficacy of 4 different kinds of project activities.²⁴ One way to go about drawing this sample is to select 4 communities in TCC’s catchment areas that are equally eligible to receive project activities. ¾ of these communities (i.e. 156) will receive different types of project activities (e.g., awareness-raising, capacity-building or both) in the first wave of project rollout, while the remaining quarter will receive activities in the second wave. **The main thing here is that that community goes through the program first and what types of activities they receive will be decided through lottery (public or private).**

In terms of data collection, we would not need to interview every single individual in these communities. Rather, we can select a sample as small as 30 individuals (10 survivors; 10 professionals and 10 fellow community members) and as big as 60 individuals, depending the level of detailed subgroup analysis we want to investigate. Table I below provides an illustration of one possible design option.

Table I. Impact Evaluation Design

There are a number of difficulties to keep in mind, however. One big unknown is the structure of

Communities in Wave #1 (Y1 & 2)	Wave #2 (Y2-5)
Intervention type #1 Community dialogue (26 communities)	
Intervention type #2 Community radio (26 communities)	Implement
Intervention type #3 Multi-disciplinary training (26 communities)	Most successful
Intervention type #4 Multi-disciplinary training plus (26 communities)	Intervention
Intervention type #5 Combination of public awareness- Raising and capacity-strengthening (26 communities)	In all 208 communities
Intervention type #6 Pure control in wave#1 (26 communities)	

communities in different catchment areas. We know that TCCs that are in rural provinces are likely to be surrounded by more organic, structured and distinguishable villages, but the same is probably not true of TCCs located in urban areas where there is likely to be undifferentiated townships and informal settlements. For the purpose of the study, we will need to define what we consider “community” in TCC catchment areas, which should be eligible for project activities and ensure that we have enough of these in each area to make this design option work.

Another concern is that the distribution of some of population of interests, especially survivors and referral systems professionals, may be uneven in different TCC catchment areas. For example, it is plausible that some communities may not have any members from these categories, while others may have an over-representation. In addition, in some cases, survivors who use services at a particular TCC

²⁴ A review of prior studies of sexual assault education programs suggests an average effect size of .30 to .35, meaning that typically those attending a sexual education program tend to have about a third of a standard deviation better than those who do not (Anderson and Whiston 2005). However, many of these studies have been carried out in the US context and we allow for the possibility that GBV programming in developing countries may have much smaller effect sizes.

may be coming from distant communities, rather than from TCC catchment areas. Thus, possible lack of adequate overlaps between the three populations of interest is going to be challenge for both targeting project activities to the relevant populations of interest and for conducting sampling for the baseline and follow-up data collection. One alternative strategy to keep in mind is that these two categories may be sampled at the individual, rather than community level. But in that case we would need to think carefully about the mechanisms through which individuals are expected to get exposure to the different project activities.

ANNEX II: DATA COLLECTION INSTRUMENTS

Service Provider Survey

Baseline Professional Survey Questionnaire

Thank you for agreeing to participate in the survey. We very much appreciate your help. Please take the time to answer the following questions as accurately as you can. There are no right or wrong answers. We just want to learn the opinion of trainees on the following issues. All answers will be confidential and will not be identified with your name.

Section 0: Introduction

A1. In what Police Precinct do you work?

A2. What is the name of the TCC in your area?

A3. What is your Profession?

- | | |
|--|--|
| <input type="checkbox"/> Health Worker | <input type="checkbox"/> NGO Worker |
| <input type="checkbox"/> TCC Site Coordinator | <input type="checkbox"/> Educator |
| <input type="checkbox"/> Victim Assistance Officer | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Police officer | <input type="checkbox"/> Other |

A3a. If you marked other, please specify:

Section A: Thuthuzela Care Centres

A4. Do you know what services the Thuthuzela Care Centres offer?

- Yes
 No

A5. Are there services available in your community for victims of sexual assault?

- Yes Don't Know
 No

A6. Of the following services, which are offered by Thuthuzela Care Centres? **(PLEASE SELECT ALL THAT APPLY)**

- | | |
|---|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Psychological and counseling assistance |
| <input type="checkbox"/> Medical assistance | <input type="checkbox"/> Legal assistance |
| | <input type="checkbox"/> Don't Know |

A7. Do you know the location of the nearest Thuthuzela Care Centre (a help Centre for victims of sexual violence)?

- Yes Don't Know
 No

A7a. If you answered yes to the previous question please state the location

A8. How many of your colleagues in your workplace (e.g., school, police station, office) know about the Thuthuzela Care Centre?	
<input type="checkbox"/> None	<input type="checkbox"/> Most
<input type="checkbox"/> A few	<input type="checkbox"/> All
<input type="checkbox"/> Many	<input type="checkbox"/> Don't Know
A9. Who can go to the Thuthuzela Care Centre for help? (PLEASE SELECT ALL THAT APPLY)	
<input type="checkbox"/> Women	<input type="checkbox"/> Boys
<input type="checkbox"/> Men	<input type="checkbox"/> Lesbian, gay, bisexual, and transgender
<input type="checkbox"/> Girls	<input type="checkbox"/> Don't Know
A10. Can a person under age 18 receive help from a Thuthuzela Care Centre?	
<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<input type="checkbox"/> No	
A11. Can a man receive help from the Thuthuzela Care Centre if he has experienced sexual violence?	
<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<input type="checkbox"/> No	
A12. How often do those who go to the Thuthuzela Care Centre have to pay for the services?	
<input type="checkbox"/> Always	<input type="checkbox"/> Rarely
<input type="checkbox"/> Often	<input type="checkbox"/> Never
<input type="checkbox"/> Sometimes	<input type="checkbox"/> Don't Know

A13. If a person goes to a Thuthuzela Care Centre for help, is she/he required to report the name of the person who attacked her/him? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know
A14. Is it possible to file a police report at the Thuthuzela Care Centre without having to go to the police station? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know
A15. If a person goes to the Thuthuzela Care Centre for help, is she/he required to prosecute or take legal action against the person who attacked her/him? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know
A16. How many of your colleagues at your workplace know about the Thuthuzela Care Centre services? <input type="checkbox"/> None <input type="checkbox"/> A few <input type="checkbox"/> Many	<input type="checkbox"/> Most <input type="checkbox"/> All <input type="checkbox"/> Don't Know
A17. How many of your colleagues at your workplace regularly refer victims to the Thuthuzela Care Centre? <input type="checkbox"/> None <input type="checkbox"/> A few <input type="checkbox"/> Many	<input type="checkbox"/> Most <input type="checkbox"/> All <input type="checkbox"/> Don't Know

Section B: Recent Practices

<i>Staff can respond to victims of violence in many ways. In the past 60 days, how often did you do each of the following on average?</i>	
B1. Had someone report sexual or gender based violence to you. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B2. Identified a student or client that you suspected to be a victim of sexual or gender based violence. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B3. Documented information about a case of sexual or gender based violence. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B4. Informed a victim about her/his rights with respect to sexual or gender based violence. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B5. Informed a victim of sexual or gender based violence about resources available at the Thuthuzela Care Centre. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B6. Personally taken someone to the Thuthuzela Care Centre to get help. <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times <input type="checkbox"/> 3-5 Times
B7. Informed a victim of sexual or gender based violence about other services (please specify): <input type="checkbox"/> Never <input type="checkbox"/> Once	<input type="checkbox"/> 2-4 Times → <input type="checkbox"/> 3-5 Times →

<p>B7a. If you informed a victim about other services please specify what service.</p> <p>_____</p>	
<p>B8. Assessed the level of danger a victim of sexual or gender based violence was facing.</p>	
<input type="checkbox"/> Never	<input type="checkbox"/> 2-4 Times
<input type="checkbox"/> Once	<input type="checkbox"/> 3-5 Times
<p>B9. Helped a victim of sexual or gender based violence in a dangerous situation establish a safety plan.</p>	
<input type="checkbox"/> Never	<input type="checkbox"/> 2-4 Times
<input type="checkbox"/> Once	<input type="checkbox"/> 3-5 Times
<p>B10. Contacted a service provider on behalf of a victim of sexual or gender based violence.</p>	
<input type="checkbox"/> Never	<input type="checkbox"/> 2-4 Times
<input type="checkbox"/> Once	<input type="checkbox"/> 3-5 Times

<p>B11. If you have contacted a service provider on behalf of victim, which type(s) of service provider did you contact? (PLEASE SELECT ALL THAT APPLY)</p> <p><input type="checkbox"/> TCC <input type="checkbox"/> Police <input type="checkbox"/> Hospital <input type="checkbox"/> Other</p>	
<p>B11a. If you selected other, please specify _____</p>	
<p>B12. Coordinated with another service provider to assist a victim of sexual or gender based violence</p> <p><input type="checkbox"/> Never <input type="checkbox"/> 2-4 Times <input type="checkbox"/> Once <input type="checkbox"/> 3-5 Times</p>	
<p>B13. If you have coordinated with another service provider, which type(s) of service provider did you coordinate with? (PLEASE SELECT ALL THAT APPLY)</p> <p><input type="checkbox"/> TCC <input type="checkbox"/> Police <input type="checkbox"/> Hospital <input type="checkbox"/> Other</p>	
<p>B13a. If you selected other, please specify _____</p>	
<p>B14. How difficult or easy is it for you to talk with a victim about sexual or gender based violence?</p> <p><input type="checkbox"/> Very difficult <input type="checkbox"/> Easy <input type="checkbox"/> Difficult <input type="checkbox"/> Very easy <input type="checkbox"/> Neither difficult nor easy</p>	

Section C: Sexual Assault and the Legal System

Now please consider a few questions about laws in South Africa.

<p>C1. Are there any laws in South Africa that address sexual and gender based violence?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No</p>	
<p>C2. What percentage of sexual or gender based violence cases do you think are actually reported to the police?</p> <p><input type="checkbox"/> 0-25% <input type="checkbox"/> 76-100% <input type="checkbox"/> 26-50% <input type="checkbox"/> Don't Know <input type="checkbox"/> 51-75%</p>	
<p>C3. What percentage of sexual or gender based violence cases that are reported do you think are false (the person reporting was not actually assaulted)?</p> <p><input type="checkbox"/> 0-25% <input type="checkbox"/> 76-100% <input type="checkbox"/> 26-50% <input type="checkbox"/> Don't Know <input type="checkbox"/> 51-75%</p>	
<p>C4. What percentage of sexual or gender based violence victims do you think go to the TCC for treatment or support?</p> <p><input type="checkbox"/> 0-25% <input type="checkbox"/> 76-100% <input type="checkbox"/> 26-50% <input type="checkbox"/> Don't Know <input type="checkbox"/> 51-75%</p>	
<p>C5. Have you ever received training related to sexual or gender based violence?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> No</p>	

Section D: Perceptions

This section will ask you about your views regarding various issues in society. We are interested in your views regarding these statements. Please feel free to answer any way you like – there are no right or wrong answers.

<i>For each statement, please state whether you strongly agree, agree, disagree or strongly disagree with each statement.</i>	
D1. The extent of the woman's resistance should be the major factor in determining if a rape has occurred.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D2. A raped woman is usually an innocent victim.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D3. Women often claim rape to protect their reputations.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D4. Women who have had prior sexual relationships should not complain about rape.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D5. Women do not provoke rape by their appearance or behaviour.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D6. Women who are raped while accepting rides from strangers get what they deserve.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D7. Many women invent rape stories if they learn they are pregnant.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D8. Many women claim rape if they have consented to sexual relations but have changed their minds afterwards.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
D9. Accusations of rape by bar ladies, strippers, and prostitutes should be viewed with suspicion.	
<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	

Section E: Case Scenario

An attractive 20 year old single woman wearing a mini-skirt goes out on a Friday night with friends. She stays for a few hours and has a few drinks. On her way home, she is assaulted by a man. She is unable to fight him off and he rapes her.

E1. Would you agree or disagree with the following statement: "Because of this woman's behaviour, she was to blame for being sexually assaulted."

<input type="checkbox"/> Strongly agree	<input type="checkbox"/> Strongly disagree
<input type="checkbox"/> Agree	<input type="checkbox"/> Don't know
<input type="checkbox"/> Disagree	
E2. For women in this neighbourhood who experience such situations, would they file a police report?	
<input type="checkbox"/> Always	<input type="checkbox"/> Rarely
<input type="checkbox"/> Often	<input type="checkbox"/> Never
<input type="checkbox"/> Sometimes	
E3. Would it be helpful for this woman to report this situation to the police?	
<input type="checkbox"/> Very helpful	<input type="checkbox"/> Not very helpful
<input type="checkbox"/> Helpful	<input type="checkbox"/> Not at all helpful
E4. Among the following reasons, what would be the main reason that most women would not file a police report in this case?	
<input type="checkbox"/> Fear of being blamed	<input type="checkbox"/> Lack of information about where to find help
<input type="checkbox"/> The police staff would not be helpful	<input type="checkbox"/> Other
<input type="checkbox"/> Fear of the perpetrator	
E4a: If other, please specify	

E5. Considering women in this neighbourhood who experience such situations: would they go to the Thuthuzela Care Centre?	
<input type="checkbox"/> Always	<input type="checkbox"/> Rarely
<input type="checkbox"/> Often	<input type="checkbox"/> Never
<input type="checkbox"/> Sometimes	
E6. Among the following reasons, what would be the main reason that a woman would not go to a Care Centre in this case?	
<input type="checkbox"/> Fear of being blamed	<input type="checkbox"/> Lack of information about where to find help
<input type="checkbox"/> The Centre staff would not be helpful	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Fear of the perpetrator	
E7. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?:	
Medical	
<input type="checkbox"/> Very helpful	<input type="checkbox"/> Not very helpful
<input type="checkbox"/> Helpful	<input type="checkbox"/> Not at all
E8. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?: Legal	
<input type="checkbox"/> Very helpful	<input type="checkbox"/> Not very helpful
<input type="checkbox"/> Helpful	<input type="checkbox"/> Not at all
E9. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?:	
Psychological/emotional	
<input type="checkbox"/> Very helpful	<input type="checkbox"/> Not very helpful
<input type="checkbox"/> Helpful	<input type="checkbox"/> Not at all
E10. Thinking about what would happen in such cases: assume 10 such police reports were filed this year, how many of these reports would ultimately result in prosecution? [Your best guess is fine.]	

Section F: Background

Now I am going to ask a few final questions about you.

F1. What is your gender?
<input type="checkbox"/> Female

- Male
- Other

F2. What is your age?

- Younger than 18
- 18-30 years old
- 31-40 years old
- 41-50 years old
- 51-60 years old
- over 60 years old

F3. Have you attended a previous training on sexual assault?

- Yes
- No

F3a: If you answered yes to the previous question, please specify to date of the most recent training on sexual assault that you attended.

(Month)

(Year)

Section G: Contact Information

We plan to contact you again 3 months after this training to follow-up. Please indicate the best phone number to reach you, and an alternate phone number. If you have an email address, please list that as well.

G1. Phone number (primary):

G2. Phone number (alternative):

G3. Email:

Women's Survey

Instructions: Thank you for agreeing to participate in this study. We really appreciate your assistance. This survey will take approximately 30 minutes to complete. Please take the time to answer the following questions as accurately as you can. There are no right or wrong answers, we just want to find out what people in this community know about sexual violence and related issues. All answers will be confidential and will not be identified with your name. You are under no obligation to complete the survey, and are welcome to leave out any of the questions that you do not want to answer.

A.0) Below are a list of crime problems. For each, please state whether it is: not a problem, a minor problem, or a major problem in your community.

1. Domestic violence	0=not a problem, 1= a minor problem, 2=a problem, 3=a major problem
2. Gang violence	0=not a problem, 1= a minor problem, 2=a problem, 3=a major problem
3. Sexual assault	0=not a problem, 1= a minor problem, 2=a problem, 3=a major problem
4. Mugging	0=not a problem, 1= a minor problem, 2=a problem, 3=a major problem
5. House breaking	0=not a problem, 1= a minor problem, 2=a problem, 3=a major problem

A.1) Knowledge

Question	Response
<i>Read: Sometimes women and men-or even girls or boys- are sexually assaulted without their consent. This could include rape, any unwanted sexual contact, or being forced or threatened into any unwanted sexual acts. I am now going to ask you some questions about your knowledge of help that is available for people who have been victims of such sexual assaults in this community.</i>	
6. Are there services available in your community for victims of sexual assault? [If no/dk/rf, skip to Q10]	1=Yes 2=No 3=Don't know 4=rf
7. If yes, who provides these services? [Do not prompt, enumerator codes all categories that respondent mention if a victim mentions the applicable NGO name in that region but does not specifically call it an NGO, still code this as "NGO"s]	a) Hospital/clinic (TCC/NGO not mentioned) b) NGO Help desk c) Police d) TCC(even if within a hospital/clinic) e) NGO (even if within a hospital/clinic) f) Other: _____
8. If yes, please tell me what types of support services are provided? You can provide more than one answer. [Do not prompt, enumerator codes all categories that respondent mentions]	g) Medical h) Legal

	i) Psychological/emotional j) Spiritual/religious Other: _____ _____
9. If you were a victim of a sexual assault, who would you first report to in order to get help? [Do not prompt, code only one]	a) a close friend or neighbour b) a family member c) police d) hospital or clinic (TCC/NGO not mentioned) e) TCC (even if located within hospital/clinic) f) NGO (even if located within hospital/clinic, if applicable) g) Other h) No one
10. In the past three months, have you heard or seen any advertisements, announcements, or spots promoting awareness of sexual assault?	1=Yes 2=No 3=Don't know 4=rf
11. In the past three months, have you heard or seen any advertisements, announcements, or spots promoting awareness of resources available to victims of sexual assault?	1=Yes 2=No 3=Don't know 4=rf
12. If yes, what were the main messages do your remember? <i>[Do not prompt, enumerator codes all categories that respondent mentions]</i>	1=Awareness of sexual violence and sexual assault as a problem 2=Where to seek help 3=Rights of victims 4=Messages to deter perpetrators

	<p>5=Other: _____</p> <p>6=dk 7=rf</p>
<p>13. Have you heard of the Thuthuzela Care Centres? [If yes, skip to 16]</p>	<p>1=Yes 2=No 3=Don't know 4=rf</p>
<p><i>Read: A Thuthuzela Care Centre is a crisis centre, to help victims of sexual assault.</i></p> <p>14. Do you know of any places like this in your community? [If no, Skip to 30]</p>	<p>1=Yes 2=No 3=Don't know 4=rf</p>
<p><i>Read: As you may know, a Thuthuzela Care Centre is a crisis centre, to help victims of sexual assault.</i></p> <p>15. Do you know what services the Thuthuzela Care Centres offer?</p>	<p>1=Yes 2=No 3=Don't know 4=rf</p>
<p>16. Do you know the location of the nearest Thuthuzela Care Centre?</p>	<p>1=Yes 2=No 3=Don't know 4=rf</p> <p>Location:</p>
<p>17. Of the following services, which are offered by the Thuthuzela care Centres?</p> <p>a) Transportation b) Medical assistance c) Psychological and counseling assistance d) Legal assistance</p>	<p>a) 1=Yes 2=No 3=dn b) 1=Yes 2=No 3=dn c) 1=Yes 2=No 3=dn d) 1=Yes 2=No 3=dn</p>
<p>18. Can a man receive help from the Thuthuzela Care Centre if he has experienced sexual assault?</p>	<p>1=Yes 2=No 3=don't know 4=rf</p>
<p>19. Can a person under age 18 receive help from the Thuthuzela Care Centre, even without parental consent?</p>	<p>1=Yes 2=No 3=don't know 4=rf</p>
<p>20. Do those who go to the Thuthuzela Care Centre have to pay for the services?</p>	<p>1=Always 2=Often 3=Sometimes 4=Rarely 5=Never</p>
<p>21. If a person goes to the Thuthuzela Care Centre for help, is she/he required to report the name of the person who attacked her/him?</p>	<p>1=yes 2=no 3=dk 4=rf</p>
<p>22. Is it possible to file a police report at the Thuthuzela Care Centre without having to go to the police station?</p>	<p>1=Yes 2=No 3=Dk 4=rf</p>

23. If a person goes to the Thuthuzela Care Centre for help, is she/he required to prosecute or take legal action against the person who attacked her/him?	1=Yes 2=No 3=Dk 4=rf
24. In thinking of the adult women in your neighbourhood, how many of them do you think know about the Thuthuzela Care Centre?	0=None 1=A few 2=Some 3=Most 4=All 5=Dk 6=rf
25. How many women (18 and older) do you know personally that have visited a Thuthuzela Care Centre (or were taken there) to get help?	
26. How many men (18 and older) do you know personally that have visited a Thuthuzela Care Centre (or were taken there) to get help?	
27. How many girls (under age 18) do you know personally that have visited a Thuthuzela Care Centre (or were taken there) to get help?	
28. How many boys (under age 18) do you know personally that have visited a Thuthuzela Care Centre (or were taken there) to get help?	
29. Do you know of any care centers run by a non-governmental organization (NGO) in this community?	1=yes 2=no 3=dk 4=rf

A.2 There could be many reasons why a victim of sexual assault may not visit a Thuthuzela Care Center. We are interested in learning what some of these reasons are for people living in your community.

For each of the following statements, please indicate how much you think each of the following is a barrier to visiting the Thuthuzela Care Centre, on a scale of 0-3 with “0” meaning *not at all a barrier*, “1” a *minor barrier*, “2” a *barrier*, and “3” meaning a *major barrier*.

Responses: 0=Not a barrier, 1=A minor barrier, 2=A barrier, 3=A major barrier

30. Victims are not aware of the centers.	
31. Transportation challenges in going to the Thuthuzela Care Centre.	
32. The Thuthuzela Care Centre is not open during convenient times.	
33. Feeling ashamed or embarrassed.	
34. Feeling there is no one to trust at the Thuthuzela Care Centre.	
35. Fear that the perpetrator would find out.	
36. Fear that others in the community would find out.	
37. Fear that people will blame the victim.	
38. Fear that the victim will not receive the support she/he needs from the Thuthuzela Care Centre.	
39. Fear that people at the Thuthuzela Care Centre will not believe the victim.	
40. Fear that the perpetrator will punish the victim.	
41. The offer of money not to report the sexual assault.	

42. What other reasons might prevent someone in your community from seeking assistance at the Thuthuzela Care Centre:

Now, please indicate how much you think each of the following is a barrier to reporting sexual offenses as crimes to the police, on a scale of 0-3 with “0” meaning *not at all a barrier*, “1” a *minor barrier*, “2” a *barrier*, and “3” meaning a *major barrier*.

Responses: 0=Not a barrier, 1=A minor barrier, 2=A barrier, 3=A major barrier

43. Transportation challenges to the police station.	
44. The police station is not open during convenient times.	
45. Feeling ashamed or embarrassed.	
46. Feeling the police cannot be trusted.	
47. Fear that the perpetrator would find out.	
48. Fear that others in the community would find out.	
49. Fear that people will blame the victim.	
50. Fear that the victim will not receive the support she/he needs from the police.	
51. Fear that the police will not believe the victim.	
52. Fear that the perpetrator will punish the victim.	
53. Lack of information about where and to whom the incident should be reported.	
54. The offer of money not to report sexual violence.	
55. What other reasons might prevent someone in your community from reporting a crime to the police: _____	

B) In this community and elsewhere, people have different ideas about various issues in society, family, and relations between men and women. For the following list of statements, please state whether you strongly agree, agree, disagree or strongly disagree.

Responses: 1=Strongly agree, 2=Agree, 3=Disagree, 4=Strongly disagree, 0=Don't know

Statements	Response
56. Rights for women mean that men lose out.	1=SA 2=A 3=D 4=SD 0=DK
57. There are times when a woman deserves to be beaten.	1=SA 2=A 3=D 4=SD 0=DK
58. A man should have the final word about decisions in his home.	1=SA 2=A 3=D 4=SD 0=DK
59. A woman should tolerate violence in order to keep her family together.	1=SA 2=A 3=D 4=SD 0=DK
60. A man and a woman should decide together what type of contraceptive to use.	1=SA 2=A 3=D 4=SD 0=DK
61. If a man sexually assaults his wife, others outside of the family should intervene.	1=SA 2=A 3=D 4=SD 0=DK
62. Would you agree or disagree that a man has the right to hit his wife in the following situations: a) She does not complete her housework to his satisfaction b) She disobeys him	a) 1=SA 2=A 3=D 4=SD 0=DK

<ul style="list-style-type: none"> c) She refuses to have sexual relations with him d) He suspects that she is unfaithful e) He finds out that she has been unfaithful 	<ul style="list-style-type: none"> b) 1=SA 2=A 3=D 4=SD 0=DK c) 1=SA 2=A 3=D 4=SD 0=DK d) 1=SA 2=A 3=D 4=SD 0=DK e) 1=SA 2=A 3=D 4=SD 0=DK
<p>63. Would you agree or disagree that a married woman can refuse to have sex with her husband in the following situations:</p> <ul style="list-style-type: none"> a) She doesn't want to b) He is drunk c) She is sick d) He mistreats her 	<ul style="list-style-type: none"> a) 1=SA 2=A 3=D 4=SD 0=DK b) 1=SA 2=A 3=D 4=SD 0=DK c) 1=SA 2=A 3=D 4=SD 0=DK d) 1=SA 2=A 3=D 4=SD 0=DK
<p>64. When a woman is raped, she usually did something careless to put herself in that situation</p>	<p>1=SA 2=A 3=D 4=SD 0=DK</p>
<p>65. In some rape cases, women actually want it to happen</p>	<p>1=SA 2=A 3=D 4=SD 0=DK</p>
<p>66. If a woman doesn't physically fight back, you can't really say it was rape</p>	<p>1=SA 2=A 3=D 4=SD 0=DK</p>
<p>67. In any rape case, one would have to question whether the victim sleeps around a lot or has a bad reputation.</p>	<p>1=SA 2=A 3=D 4=SD 0=DK</p>

Sources: *International Men and Gender Equality Survey, Women's Survey (2008)*, section 2: attitudes about relations between men and women; *WHO multi-country study on women's health and life events, version 10 (2003)*; section 6: attitudes towards gender roles.

C) This section will ask you about your views regarding various issues related to experiences with sexual assault in your community. We are interested in your views regarding these statements. Please feel free to respond any way you like -- there are no right or wrong answers.

Statements	Response
68. Do you personally know any girls or women who have been raped or sexually assaulted in the last year?	1=Yes 2=No 3=Dk 4=Rf
69. If yes, how many?	_____
70. Do you know of any girls or women that have been raped or sexually assaulted in their lifetime?	1=Yes 2=No 3=Dk 4=Rf
71. If yes, how many?	_____

72. How often do women who are victims of sexual assault go to the police for assistance?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never
73. Do you personally know any men or boys who have been raped or sexually assaulted in the last year?	1=Yes 2=No 3=Dk 4=Rf
74. If yes, how many?	____ men (18+) ____ boys (<18)
75. How often do men who experience sexual violence go to the police for assistance?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never
76. How often do women who experience sexual violence seek medical treatment in a hospital, clinic, Thuthuzela Care Centere, or NGO crisis center?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never
77. How often do men who experience sexual violence seek medical treatment in a hospital, clinic, Thuthuzela Care Centere, or NGO crisis center?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never
78. How often do learners (younger than 18) who experience sexual violence go to school teachers for assistance?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never

D) Case Scenarios

Scenario I: A woman has to work late each night. The bus she takes home lets her off .5 km from her home. One night when walking home she is assaulted by a man. She is unable to fight him off and he rapes her.

79. To what extent would you agree or disagree with the following statement: "Because of this woman's behaviour, she was partially to blame for being sexually assaulted."	1=Strongly agree 2=Agree 3=Disagree 4=Strongly disagree 0=Don't know
80. For women in this neighborhood who experience such situations, how likely is it that they would file a police report?	1=Very likely 2=Likely 3=Not very likely 4=Not at all likely
81. Would the police be helpful in this situation?	1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful

<p>82. Among the following reasons, what would be the main reason that most women would not file a police report in this case? Please rank these 4 in order of importance.</p> <ul style="list-style-type: none"> a. Fear of being blamed b. The police staff would not be helpful c. Fear of the perpetrator d. Lack of information about where to find help 	<p>_____</p>
<p>83. Among the following reasons, what would be the second most important reason that most women would not file a police report in this case? Please rank these 4 in order of importance.</p> <ul style="list-style-type: none"> e. Fear of being blamed f. The police staff would not be helpful g. Fear of the perpetrator <p>84. Lack of information about where to find help</p>	
<p>85. For women in this neighborhood who experience such situations, how likely are they to go to the Thuthuzela Care Centre?</p>	<p>1=Very likely 2=Likely 3=Not very likely 4=Not at all likely</p>
<p>86. What would be the main reason that a woman would not go to the Thuthuzela Care Centre in this case? <i>[Do not prompt]</i></p> <ul style="list-style-type: none"> a. Fear of being blamed b. The Centre staff would not be helpful c. Fear of the perpetrator d. Not aware of the TCC e. Dk 	<p>_____</p>
<p>87. Would the Thuthuzela Care Centre be helpful in this situation in any of the following ways?</p> <ul style="list-style-type: none"> a. Medical b. Legal c. Psychological/emotional 	<p>a. 1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful b. 1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful c. 1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful</p>
<p>88. If you were in this situation, which of the following would you go to for help?</p> <ul style="list-style-type: none"> a. Police: b. Hospital: c. Thuthuzela Care Centre: d. NGO crisis centre: e. Family member: f. Friend: g. Other: 	<p>1=Definitely 2=Maybe 3=No 4=dk 5=rf</p>

Scenario 2: An attractive 20 year old single woman wearing a mini-skirt goes out on a Friday night with friends. She stays for a few hours and has a few drinks. On her way home, she is assaulted by a man. She is unable to fight him off and he rapes her.

<p>89. To what extent would you agree or disagree with the following statement: "Because of this woman's behaviour, she was to blame for being sexually assaulted."</p>	<p>1=Strongly agree 2=Agree 3=Disagree 4=Strongly disagree 0=Don't know</p>
<p>90. For women in this neighbourhood who experience such situations, how likely is it that they would file a police report? =</p>	<p>1=Very likely 2=Likely 3=Not very likely 4=Not at all likely</p>
<p>91. Would the police be helpful in this situation?</p>	<p>1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful</p>
<p>a. Among the following reasons, what would be the main reason that most women would not file a police report in this case? Fear of being blamed b. The police staff would not be helpful c. Fear of the perpetrator d. Lack of information about where to find help e. None of the above: specify _____</p>	<p>_____</p>
<p>92. Among the following reasons, what would be the second most important reason that most women would not file a police report in this case? Fear of being blamed The police staff would not be helpful Fear of the perpetrator Lack of information about where to find help None of the above: specify _____</p>	
<p>93. For women in this neighbourhood who experience such situations, how likely are they to go to the Thuthuzela Care Centre? <i>[Prompt]</i></p>	<p>1=Very likely 2=Likely 3=Not very likely 4=Not at all likely</p>
<p>94. What would be the main reason that a woman would not go to a Thuthuzela Care Centre in this case? <i>[Do not prompt]</i> a. Fear of being blamed b. The Centre staff would not be helpful c. Fear of the perpetrator d. Lack of information about where to find help e. dk</p>	<p>_____</p>
<p>95. Would the Thuthuzela Care Centre be helpful in this situation in any of the following ways?</p>	<p>a. 1. Very helpful, 2. Helpful,</p>

<ul style="list-style-type: none"> a. Medical b. Legal c. Psychological/emotional 	<ul style="list-style-type: none"> 3. Not very helpful, 4. Not at all helpful b. 1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful c. 1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful
<p>96. If you were in this situation, which of the following would you go to for help?</p> <ul style="list-style-type: none"> h. Police: i. Hospital: j. Thuthuzela Care Centre: k. NGO crisis centre: l. Family member: m. Friend: <p>97. Other:</p>	<ul style="list-style-type: none"> 1=Definitely 2=Maybe 3=No 4=dk 5=rf

G) Now I am going to ask a few questions about you.

<p>98. What is your age?</p>	
<p>99. What is your race?</p>	<ul style="list-style-type: none"> 1=Black 2=White 3=Coloured 4=Indian 5=Asian 6=other: <hr/>
<p>100. What is the primary language spoken at your home? (Do not, prompt]</p>	<ul style="list-style-type: none"> 1. Afrikaans 2. English 3. Ndebele 4. Pedi 5. Sotho 6. Swati 7. Tshonga 8. Tswana 9. Venda 10. Xhosa 11. Zulu 12. Other: <hr/>
<p>101. What is the highest level of education you have completed? (Do not, prompt]</p>	<ul style="list-style-type: none"> 1=No formal schooling 2=Preschool 3=Primary school 4=Secondary School 5=Tertiary/FET

	6=Graduate or higher
102. How much money did your household earn last month? (R per year)	1=Less than 1,000 2=1,000-5,000 3=5,001- 10,000 4=More than 10,000

Supplemental TCC Intake Form

**IMPACT EVALUATION INTAKE FORM
PART I (MANDATORY FOR 1ST VISIT)**

*TO BE COMPLETED BY TCC SITE MANAGER FOR ALL SURVIVORS PRESENTING TO TCC STARTING IN AUGUST 2014

1. TCC Name:

2. Date survivor presented to TCC: _____ / _____ / _____ Time
(00:00h): _____ : _____
(DD) (MM) (YYYY) (hh) (mm)

Question	Response
3. Is this the survivor's first visit to this TCC?	Yes___ No___ Unknown___ Refused response ___
4. If no, when was the survivor's first visit to this TCC?	_____ / _____ / _____ N/A (1 st visit) _____ (DD) (MM) (YYYY)
5. Type of crime being reported:	Rape__ Attempted rape__ Other sexual assault __ Domestic Violence__ Other __ Unknown/not reported __
6. Incident date and time (this incident):	_____ / _____ / _____ Time: _____ : _____ (DD) (MM) (YYYY) (hh) (mm)
7. Was this survivor brought to the TCC by the police?	Yes___ No___ Unknown___ Refused response ___
8. <i>If yes:</i> Police station where crime occurred :	
9. <i>If yes:</i> Police station where survivor resides :	
10. <i>If no:</i> Address/neighborhood where the crime occurred : Police station closest to that address/neighborhood:	
11. <i>If no:</i> Address/neighborhood where survivor resides : Police station closest to that address/neighborhood:	
12. Sex of survivor:	male___ female___
13. Age of survivor:	0-5 yrs___ 6-11 yrs___ 12-17 yrs___ 18-27 yrs___ 26-35 yrs___ 36-45 yrs___ 46-55 years___ 56 yrs or older___ dk___

14. Date of Birth of survivor:	_____/_____/_____ Unknown/refused ___ (DD) (MM) (YYYY)		
15. If no, who physically brought the survivor to the TCC?	N/A (brought by police) ___ Healthcare professional ___ Teacher ___ TCC Staff ___ Legal Professional ___ NGO worker ___ Family member/friend ___ Nobody (survivor came alone) ___ Other ___ Specify: _____		
16. Regardless of how the survivor arrived at the TCC, was the survivor referred or recommended to the TCC by any of the following? [Mark all that apply]	Police ___ Healthcare professional ___ Teacher ___ TCC Staff ___ Legal Professional ___ NGO worker ___ Family or friends ___ Other ___ None ___ Specify (NGO/Other): _____		
Services	Planned?	Completed?	Results Received?
17. Forensic exam	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
18. Consultation	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
19. Post-exposure prophylaxis	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
20. Litigation	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
21. Safe place to stay	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
22. Referrals made? If yes, to: _____ _____	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
23. Other, please specify: _____ _____	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___

IMPACT EVALUATION INTAKE FORM
PART 2 (2ND VISIT/2ND COUNSELING SESSION)

* TO BE COMPLETED WITH THE SURVIVOR (OR PARENT/GUARDIAN/FAMILY MEMBER) IF HE/SHE IS WILLING. MUST BE ADMINISTERED **IN PRIVATE**.

1. The respondent is: The survivor ___ Parent/guardian ___ Other family member ___ Other ___

2. Date survivor *first* presented to TCC: _____/_____/_____
 (DD) (MM) (YYYY)

3. Survivor Date of Birth: _____/_____/_____
 (DD) (MM) (YYYY)

Please ask the survivor (or parent/guardian/family member) the following questions.

Question	Response
4. In the past three months, have you heard or seen any advertisements, announcements, or spots promoting awareness of resources available to survivors of sexual violence?	Yes ___ No ___ Unknown ___ Refused response ___

[If no, skip to question 6]	
<p>5. If yes, what were the main messages do your remember? <i>[Do not prompt, mark all that apply.]</i></p>	<p>Awareness of sexual assault as a problem ___ Where to seek help ___ Rights of victims ___ Messages to deter perpetrators ___ Other ___ Unknown ___ Refused response ___ Specify (Other): _____</p>
<p>6. What are the main difficulties that you and people you know encounter in accessing TCCs?</p>	
<p>7. Has the TCC been open during the times you have wanted to come to the TCC?</p>	<p>Yes ___ No ___ Unknown ___ Refused response ___</p>
<p>8. How did you get to the TCC center?</p>	<p>Public transport ___ Private car ___ Walked ___ Driven by police ___ Other ___ Specify (Other): _____</p>
<p>9. Have you told teachers or any adult at school about this incident (if in school)?</p>	<p>Yes ___ No ___ Unknown ___ Refused response ___ N/A ___</p>
<p>10. Have you told police about this incident?</p>	<p>Yes ___ No ___ Unknown ___ Refused response ___</p>
<p>11. How would you rate the level of respect shown to you by the police? <i>[Go to end]</i></p>	<p>Disrespectful ___ Somewhat disrespectful ___ Respectful ___ Very respectful ___ Refused response ___</p>
<p>12. Why did you not go to the police? <i>[Do not prompt. Mark all that apply]</i></p>	<p>Transportation challenges to the police station ___ Fear that the police will not believe you ___ Feeling the police cannot be trusted ___ Feeling that police reporting is not useful ___ Feeling ashamed or embarrassed ___ Fear that others in the community would find out ___ Fear that the attacker would find out ___ Fear that the attacker will punish you ___ Fear that you will not receive the support you need from the police ___ The TCC is more helpful ___ The offer of money not to report this to the police ___ Other ___</p> <p>Specify (other): _____</p>

NGO Interview Guide

(Please remember, this is just a guide. Please be sure to follow-up on interesting points with additional questions.)

- Basic information about the NGO:
 - Please tell me about what your organization does with respect to survivors of sexual assault and gender-based violence?
 - Phone number and days/hours of operation
 - What is your organization's relationship with the TCC?
- TCC capacity:
 - What is your general impression of the capacity of the _____ TCC?
 - Do you think the TCC is understaffed or under-resourced in any way?
 - Is the TCC able to meet the needs of the survivors who present there?
 - Is the TCC able to meet the needs of this community with regard to sexual assault and gender-based violence?
 - What challenges do you think the TCC experiences in serving survivors?
- Current TCC use:
 - What do survivors who need help after hours working hours usually do? (e.g., go the hospital, wait in police station, etc.) On a weeknight? On Friday? On weekend?
 - How do survivors get to the TCC – what are the transport options? Which proportion of survivors use each method of transport? Do you think survivors view transportation as a barrier? How do they pay for it? Does the TCC reimburse transport expenses for survivors?
 - What is the typical time a survivor waits to be helped by TCC staff? And the longest time? For those with long wait periods, what is the reason?
 - How well known is the TCC in the surrounding communities?
 - Do people understand the services offered there?
 - Are there any common misperceptions about the TCC that you know of?
 - Why do you think some survivors do not go to the TCCs?
 - Do you have a sense of how frequently survivors go to the TCC because of a professional referral? What kinds of professionals are these? Which are the most common?
 - Are survivors sometimes taken to the TCC by other organizations/non-profits? If so, which NGOs help survivors who come to your TCC?
 - How often do female survivors over the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of female/adult survivors)
 - How often do female survivors under the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of female/child survivors)
 - How often do male survivors over the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of male/adult survivors)
 - How often do male survivors under the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of male/child survivors)
 - How often do lesbian/gay/bisexual/transgender (LGBT) survivors come to the TCC for assistance? (Typical number of cases per week/month; percentage of LGBT survivors)
 - Do you think the majority of all survivors feel comfortable going to TCC?
 - Do some types of survivors experience higher barriers/challenges to seeking help than others? Which groups experience the most barriers? Why do you think that is?

- What particular features of the community have the largest impact on sexual assault and gender based violence (GBV)? Are there certain aspects of the cultural context in community that you can describe that affect GBV prevalence?
- Are there certain survivor needs that the TCC is not able to address? What are some examples of these needs?

TCC Interview Guide

- Protocol for TCC Baseline Visit
- Prepare for TCC visit
 - A data collection firm researcher will call the TCC in advance of fieldwork to set an appointment for a visit, which is expected to take approximately half a day. The purpose of the visit will be briefly described and availability of data to be obtained during the visit should be confirmed. Contact information for the staff at each of the TCCs will be provided by SI. A letter of support from NPA will also be sent to the TCC contact person to confirm approval for the visit. The visit should be reconfirmed the day prior and rescheduled, if necessary.
- Visit TCC
 - A flash drive and secure folders should be brought to the visit for downloading data and/or transporting hard-copy data.
 - When the researchers arrive at the TCC, they will contact the primary point-of-contact to explain the purpose of the visit and show documentation of NPA's support for the visit (i.e., support letter). At this time, the researchers should also explain the agenda for the meeting:
 - Collect basic information about the TCC. (See questions on tablet.)
 - Explain the Supplemental Intake Form.
 - Data: Ask the TCC staff if any electronic records are available. If so, the data download process should be started at the beginning of the visit to ensure that the data copying can be completed before the visit is over. Names of survivors should be removed prior to download. If electronic data is not available, then hard copies of the files should be copied or scanned.
 - TCC information: Interview the TCC staff to collect relevant information about the TCC, posing the questions listed below. This interview should be audio recorded.
 - Supplemental Intake Form: While the data is being downloaded, invite all TCC staff present and available to join a short training on the new data collection tool. Explain the Supplemental Intake Form and answer any questions that may arise. Ensure that additional questions are added to existing Intake Forms and that columns are added in existing electronic databases to accommodate the new information (if the TCC enters data into the computer). Both hard and soft copies of the new questions should be provided.

Interview Guide:

- Basic TCC information:
 - Phone number and days/hours of operation
 - Staff positions at the TCC, which ones are currently filled and when they were filled (by anyone, not necessarily when the existing staff joined).
 - How long has the TCC been adequately staffed?
 - TCC resources (i.e., computer, internet, phone, office supplies, medical supplies, examination office, consultation space, waiting room, information for survivors, etc.)
 - Notes:
- TCC capacity:
 - Are there currently plans to add any staff to this TCC? If so, what positions.
 - Are there enough staff at this TCC to serve survivors who come here?
 - Which staff would you like to see added, if any? (List positions)

- If you know, can you please tell me who provides the funding for the staff of TCC? (e.g., donors, government)
- Does this TCC have sufficient resources to meet the needs of survivors who come here? [Select one: Never, Rarely, Sometimes, Often, Always]
- What are the main challenges this TCC experiences in serving survivors?
- General notes on capacity:
- Current use:
 - What do survivors who need help after hours working hours usually do? (e.g., go the hospital, wait in police station, etc.) On a weeknight? On Friday? On weekend?
 - Is a survivor required to file a police report before receiving service from the TCC? What happens if a survivor comes to the TCC without filing a police report? Is s/he taken or asked to go to the police station or can s/he be treated first? Can a survivor refuse to file a police report and still get service from the TCC?
 - Here we have a list of police stations and satellite stations serve your TCC. Are there any others? Are some of the police stations more active in helping survivors? Can you discuss the differences?
 - How do survivors get to the TCC – what are the transport options? Which proportion of survivors use each method of transport? Do you think survivors view transportation as a barrier? How do they pay for it? Does the TCC reimburse transport expenses for survivors?
 - What is the typical time a survivor waits to be helped by TCC staff? And the longest time? For those with long wait periods, what is the reason?
 - How well known is the TCC known in the surrounding communities?
 - Do people understand the services offered here?
 - Are there any common misperceptions about the TCC that you know of?
 - Why do you think some survivors do not come to the TCCs?
 - Do you have a sense of how frequently survivors come to the TCC because of a professional referral? What kinds of professionals are these? Which are the most common?
 - Are survivors sometimes taken to the TCC by other organizations/non-profits? If so, which NGOs help survivors who come to your TCC?
 - How often do female survivors over the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of female/adult survivors)
 - How often do female survivors under the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of female/child survivors)
 - How often do male survivors over the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of male/adult survivors)
 - How often do male survivors under the age of 18 come to the TCC for assistance? (Typical number of cases per week/month; percentage of male/child survivors)
 - How often do lesbian/gay/bisexual/transgender (LGBT) survivors come to the TCC for assistance? (Typical number of cases per week/month; percentage of LGBT survivors)
 - Do you think the majority of all survivors feel comfortable coming to TCC, or do some types of survivors experience higher barriers to seeking help than others? Which groups experience the most barriers? Why do you think that is?
 - What are particular features of the community that have the largest impact on gender based violence (GBV) in this area? Are there certain aspects of the cultural context in community that you can describe that affect GBV prevalence?
 - Are there certain survivor needs that the TCC is not able to address? What are some examples of these needs?

ANNEX III: SOURCES OF INFORMATION

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ANNEX IV: WOMEN'S SURVEY SAMPLING PROTOCOL

Sampling sectors and subsectors

The Stakeholder Engagement Officer, a former member of SAPS will access precinct maps from police stations to establish:

- The sectors and subsectors within the precincts.
- Insights from maps and police officials which will enable the determination of:
 - Areas in the precincts that are primarily industrial. These areas will be excluded. If a sector (or subsector) is partially industrial and partially residential, the entire sector (or subsector) is not excluded. Rather, the industrial area within that sector/sub-sector should be excluded.
 - Areas in the precincts that are inhabited by affluent residents who would have private insurance and therefore not use a TCC (mostly former white-only suburbs, with higher income residents). These areas will also be excluded. If a sector (or subsector) is partially high-income and partially low-income, the entire sector (or subsector) was not excluded. Rather, the high-income area within that sector/sub-sector is to be excluded.
- The sample should be derived from the remaining sectors and subsectors that were not excluded.

Sampling individual households

Procedures followed for Individual Households:

- In cases where the number of sub-sectors were **less than 15**, 1 household should be selected from each of the available sub-sectors of a precinct and an additional 4 households selected from 4 randomly selected precincts from the same 11 precincts. In cases where the sub-sectors per precinct are **more than 15**, 15 sub-sectors are to be randomly selected and one household selected from each sub-sector following the procedure outlined above. These 15 sub-sectors should be evenly distributed between sectors (e.g. in cases where there are 3 sectors, 5 sub-sectors are drawn from each). One exception to this rule is when the urban/rural weighting rules suggested otherwise. For example, if 3 urban households and 12 rural households are selected and one sector is distinctly urban and the other two are distinctly rural, according to weighting data only 3 households should be selected from the urban sector and 12 from the rural sector.
- Sampling procedures for each precinct should always be discussed and approved by the team **BEFORE** sampling is done by the Fieldwork Coordinator, and cross-checked for adequacy before the fieldworkers were deployed. This requires constant communication between the Fieldwork Coordinator and the Fieldwork Manager, with oversight guidance being provided by the Project Leader.
- Before data collection, the sampled HH coordinates are submitted and approved by SI.

In-house sampling

- In households where there were 2 or more eligible females, a raffle is conducted to randomly select a participant.
- Every female (aged 18 to 49) who resided in the selected household during the time of the visit must be included in the raffle. If the selected person is not available the team should come back at a later stage when they are available. A total of 3 attempts are made to reach the sampled individual before resampling a secondary individual.

ANNEX V: COMPLETENESS OF SERVICE PROVIDER DATA

Variable	n (observations with non-missing data)	# of missing responses	% of responses missing
A3	1,737	52	3%
A4	1,753	36	2%
A5	1,735	54	3%
A7	1,753	36	2%
A8	1,754	35	2%
A10	1,756	33	2%
A11	1,762	27	2%
A12	1,737	52	3%
A13	1,695	94	5%
A14	1,686	103	6%
A15	1,676	113	6%
A16	1,710	79	4%
A17	1,707	82	5%
B1	1,682	107	6%
B2	1,663	126	7%
B3	1,638	151	8%
B4	1,657	132	7%
B5	1,664	125	7%
B6	1,657	132	7%
B7	1,612	177	10%
B8	1,644	145	8%
B9	1,663	126	7%
B10	1,673	116	6%
B12	1,619	170	10%
B14	1,699	90	5%
C1	1,739	50	3%
C2	1,732	57	3%
C3	1,721	68	4%
C4	1,720	69	4%
C5	1,724	65	4%
D1	1,640	136	8%

D2	1,736	49	3%
D3	1,710	70	4%
D4	1,695	86	5%
D5	1,687	87	5%
D6	1,708	73	4%
D7	1,682	95	5%
D8	1,684	96	5%
D9	1,675	99	6%
E1	1,706	75	4%
E2	1,684	95	5%
E3	1,687	90	5%
E4	1,687	91	5%
E5	1,670	107	6%
E6	1,628	150	8%
E7	1,649	131	7%
E8	1,646	134	7%
E9	1,652	123	7%
E10	1,101	688	38%
F1	1,717	72	4%
F2	1,721	68	4%
F3	1,706	83	5%

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