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

ENDLINE IMPACT EVALUATION REPORT

January 2017

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The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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An impact evaluation of this scope and rigor required the collaboration and contribution of many individuals and organizations. USAID's Center of Excellence for Democracy, Human Rights and Governance played an essential role in promoting and ensuring a rigorous evaluation that not only tested impact, but tested two rival approaches to achieving impact. USAID/South Africa and the implementing partners of FPD, Soul City, and Sonke collaborated throughout the entire process and rolled out their programing in accordance with the randomization procedures required by the evaluation. With the support of the National Prosecuting Authority, TCC staff throughout the country collected data on utilization that was shared with the evaluation team and provides the backbone of this evaluation. Finally, a number of individuals participated in the design of the evaluation and the data collection. In short, this evaluation is the product of several years of hard work by many individuals. In particular, the authors would like to thank the following people and organizations for their generous support and contributions: Morgan Holmes and Vy Lam of USAID's Center of Excellence for Democracy, Human Rights and Governance; Laura Berger and Paula Van Dyk at USAID/South Africa; Ria Schoeman and Gustaaf Wolvaardt at FPD; the staff of Soul City Institute and Sonke Gender Justice; the South Africa National Prosecuting Authority and TCC directors and staff; Mzikazi Nduna of the University of the Witwatersrand; Dr. Maximillian Kasy of Harvard University; Craig Carty; Aidan Connolly, Tronny Mawadzwa, Patrick Chiroro, Charles Katsande, William Muhwava, Charlene Flavell and all of the great field staff at Impact Research International; and Alison Miranda of Social Impact.

ACRONYMS

APD	Association of Persons with Disabilities
CAPI	Computer Assisted Personal Interviewing
CLR	Cluster Level Reliability
DiD	Difference-in-Difference
DOH	Department of Health
DOJ/CD	Department of Justice and Constitutional Development
DRG-LER	Democracy, Rights, and Governance – Learning, Evaluation, and Research
DSD	Department of Social Development
FAMSA	Families South Africa
FPD	Foundation for Professional Development
GBV	Gender-based Violence
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
NVCS	National Victims of Crime Survey
PCA	Principal Component Analysis
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
USAID	United States Agency for International Development
USAID/SA	United States Agency for International Development/South Africa
VAO	Victim Assistant Officer
VEP	Victim Empowerment Programs
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 (Gender Links and Medical Research Council, 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). While the implementers had developed a suite of demand-side outreach activities, this evaluation focused specifically on testing the effect of community dialogues designed to provide information about SGBV and TCCs. The second is a supply-side intervention implemented by the Foundation for Professional Development (FPD) which included multi-disciplinary trainings for service providers in the TCC referral and care networks.

This IE aims 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.

EVALUATION QUESTIONS AND DESIGN

This IE utilizes a randomized control trial (RCT) design to assess the independent effects 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. While the implementers of this intervention requested that the IE be conducted with the treatment defined as a holistic suite of program activities, as this was the intervention designed at the procurement stage, it was ultimately decided that the IE would study the impact of the components separately to better understand what approach works best and why. Unfortunately, due to sample size and resource constraints, it was not possible to test the combined effect of both interventions administered simultaneously and test for independent program effects. In addition to separating out program components, there were several ways in which the intervention had to be accommodated to permit an impact evaluation.

[1] Thuthuzela is a Xhosa word meaning "to comfort."

The IE was designed to address the following evaluation questions: Do the interventions:

1. Increase utilization of TCCs?
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, with each of the three precincts randomly assigned to one of the three study groups—control, demand-side Treatment 1, or supply-side Treatment 2.[3] The communities selected for the evaluation were thus distributed 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 no programming and serve as the control group.

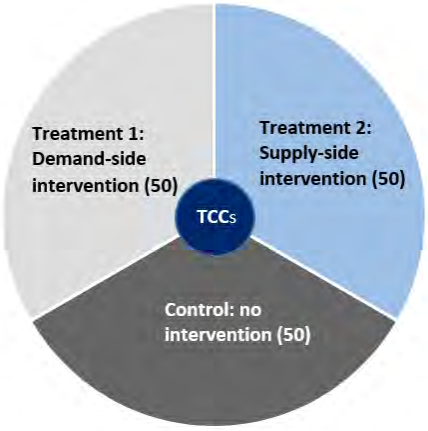

Figure 1: Treatment and control groups

The measurement of evaluation outcomes for this IE relies on administrative and government secondary data, and quantitative and qualitative data collected as part of the evaluation. At the precinct level, the evaluation team worked in collaboration with the NPA and the TCCs to collect precinct specific administrative data on the use of TCC services. As suggested by Table 1, by comparing these TCC records across the treatment and control precincts, the evaluation tests whether, and by how much, each of the two interventions increased use of TCC services (Hypothesis 1). These quantitative data were complemented by qualitative data collected through interviews. A total of 94 baseline 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. Follow-up interviews were also conducted with each TCC as part of endline data collection. Forty-eight endline interviews were conducted with TCC senior staff, while three TCCs were unwilling to participate in the endline.

[2] Since the beginning of this IE, three more TCCs were constructed. These are not included in this 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: Interventions cause an 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: Interventions cause an 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: Interventions cause an improvement in attitudes toward SGBV	Community perceptions of SGBV	Women's survey
		Service providers' perceptions of SGBV	Service provider survey

To test whether the interventions increased knowledge of SGBV and TCCs (Hypothesis 2) and/or changed attitudes toward SGBV (Hypothesis 3), the evaluation collected baseline and endline data through surveys in communities where dialogues were held (Treatment 1) and comparison communities, and among service providers participating in trainings (Treatment 2). Specifically, the evaluation tested whether community outreach campaigns increased community knowledge of and attitudes toward SGBV through 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. The evaluation also tested whether service providers' knowledge, attitudes, and self-reported behavior changed following the trainings through a pre- and post-training survey of participating service providers. Of the total 1,908 training participants, 1,789 (94 percent) participated in the evaluation at baseline and 1,347 (71 percent) participated at endline.[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.

A number of limitations to this IE should be acknowledged. First, TCC compliance in completing supplemental intake forms was lower than anticipated. Three TCCs did not submit any supplemental intake forms to the evaluation team. Of the remaining 47, 31 reported using intake forms with 90-100 percent of survivors. Moreover, aggregate numbers reported by the NPA are notably higher than the number of cases recorded in the supplemental intake forms (see Annex IX). However, this limitation does not appear to bias the IE findings as underreporting would affect both control and treatment areas. Second, the theory of change linking the community dialogues, which only targeted a limited number of participants, to increases in knowledge and changes in attitudes in the community as a whole was not strong enough; the results could have been different had a more robust demand-side intervention been tested. Third, respondents were sampled based on treatment and control locations and survey data were not weighted, thus household survey data cannot be considered nationally representative of women in South Africa, nor representative at the provincial level. Fourth, the data collection team experienced some barriers to entry in four police precincts near Cape Town due to high levels of violence and crime coupled with racial tensions in those areas. 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, and paper-based data collection was used in these areas due to the security challenges. Finally, while most TCC staff were receptive to qualitative interviews, several refused to participate at some point during the study. It is likely that some respondents did not feel they could speak freely, despite assurances

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

that the audio recording and interview notes would be kept confidential.

FINDINGS AND CONCLUSIONS

TCC capacity concerns

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

- **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 employees. 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 to 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. Some 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.
- **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**: Interview respondents cited numerous factors that pose barriers to TCC utilization. Respondents observed that survivors were not aware of TCC services and had misperceptions about the type of services provided. 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. While this appears to have been done by design to prevent perpetrators from finding the TCCs, this is likely to severely undermine TCC utilization. Insufficient access to transportation was also cited as a barrier.
- **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.

No impact of community dialogues and service provider training on TCC utilization

Supplemental intake data collected from the TCCs show that TCC use is low, with a median of 12.7 survivor cases per month per TCC across the evaluation period.[6] Both the full and reduced samples of control and treatment precincts were balanced at baseline on the dependent variable and the relevant control variables. Difference-in-difference regression analyses show no significant impact of the community dialogues or service provider training on TCC utilization. Statistically significant explanatory variables for

[6] The median of 12.7 cases per month is on the restricted sample of 24 TCCs that were estimated to have collected data consistently with at least 90% of survivors. As a likely result of inconsistent data collection, the average of the full sample is somewhat lower. The NPA reports a notably higher median of 22.5 cases per month among these 24 TCCs (see Annex IX).

TCC use include population size of the precinct, rate of sexual offences, and rate of murders.

No impact of community dialogues on community knowledge and attitudes

Logistic regression was used to test the impact of community dialogues on awareness of TCCs. The result reveal that knowledge of TCCs in sampled communities was statistically similar at baseline and endline. Moreover, knowledge levels between treatment and control communities are statistically equivalent, indicating that there was no positive treatment effect of the community dialogues on knowledge of TCCs or services available to survivors of SGBV. This finding suggests that community dialogues by themselves are insufficient to have a multiplicative effect and influence the larger community in which they are held. This is perhaps not surprising and suggests the need to test the effect of a more robust demand side intervention, consistent with the full ISSSASA program, but focused locally and more intensely targeted to reach a critical mass of community members with repeated messaging.

This is unfortunate, as the survey demonstrates that knowledge of the TCCs is low (around 18 percent) and perceived to be the greatest barrier to TCC use. Instead, of treatment, province is the strongest and most significant predictor of familiarity with TCCs, with knowledge lowest among women in Gauteng and highest in Eastern Cape. One potential explanation for this variation is that Thuthuzela is a Xhosa word, which would be most familiar in Xhosa speaking areas such as the Eastern Cape. Sexual assault prevalence and perception of sexual assault as a problem are also significant in predicting knowledge of TCCs, and women who reported knowing someone who has been raped or sexually assaulted were more likely to know of the TCC. Respondents with low tolerance for violence toward women were also slightly more likely to know of TCCs. Women who are older, more educated, and with higher household income are more likely to have heard of TCCs.

Regression analysis was also used to test whether women in treatment precincts scored higher on an attitudinal SGBV index than women in control precincts after the intervention. The survey shows most respondents have normatively desirable attitudes toward gender roles; however, some respondents still engage in victim blaming and there is still evidence to suggest that social stigmas represent a barrier to TCC usage. The regression estimate shows a slight improvement in attitudinal scores from baseline to endline, in the treatment group relative to the control group; however, this relationship is not statistically significant. Variables that are statistically significant and positively associated with more normatively desirable SGBV attitudes scores are: age, Zulu, higher income, and knowing a woman or girl who has been raped or sexually assaulted.

Positive impact of training on service providers' knowledge and attitudes

Service providers attending the FPD training completed a pre- and post-training survey to measure changes in knowledge, attitudes, and self-reported practices. At endline, service providers were statistically significantly more likely to report knowing what services were available for survivors of SGBV in their communities, what services were provided by the TCCs, and the location of TCCs.

The service provider survey also included a series of questions designed to assess attitudes toward gender equity norms. At baseline, many professionals revealed moderate levels of victim-blaming. A third of respondents believed that women provoke rape by their appearance or behavior and nearly half indicated that the extent of a woman's resistance should be the major factor in determining if a rape has occurred. Statistically significant positive changes were observed on seven of nine measures of victim-blaming and

tolerance of violence against women, one measure showed a negative change,[7] and one measure remained at similar levels observed at baseline.[8]

The evaluation also sought to measure whether Treatment 2 training participants adopted behavior changes in how they interact with SGBV survivors by asking what actions they had taken to assist SGBV survivors in the last 60 days. At endline, no positive changes were observed over time in most of the practices included in the survey, although more respondents reported taking someone to a TCC and informing a victim about TCC resources, with the latter measure being statistically significant.

RECOMMENDATIONS

Based on the findings and conclusions from this impact evaluation of the ISSSASA activity, the evaluation team recommends that USAID, the NPA, and other stakeholders consider the following areas of intervention to continue developing the system of care for survivors of sexual assault.

- **Support TCC capacity.** TCCs reported various areas of need for support across staffing, facilities, and supplies. In a resource-constrained environment and given the relatively low levels of TCCs use justification for added staffing or other resources may be a challenge. On-call staff that are available 24 hours a day seven days a week, for example, as opposed to staff sitting at the TCC around the clock may be a more reasonable use of resources, especially in areas with lower TCC use. Continuing to encourage partnerships with NGOs and community organizations, which we find to be providing important complementary services and filling resource voids, is another promising area for intervention. The findings above indicate some changes that would be effective while expending minimal resources. For example, the policy of keeping TCCs' locations somewhat secret undermines utilization and should be reconsidered.

- **Test the effects of a more broad-based, social marketing approach to raising awareness about TCCs and SGBV.** Given continued low awareness of the TCCs within surrounding communities and continued apprehension about reporting SGBV, more intensive outreach efforts should be tested. The broader ISSSASA program includes a television drama series, a school based intervention engaging children in grade 7, a radio public service announcement campaign, and a digital and social media campaign. Efforts to increase awareness and change attitudes should build on best practices in social marketing and be designed to reach and influence a wider audience with sustained and repeated messaging via a "saturation" approach. Such an approach would be amenable to a follow-on impact evaluation using the same survey methodology applied here and could even be focused on communities with the greatest perceived need. The intervention would require a stronger theory of change that would be likely to produce a change detectable in a random sample of women in targeted communities. As one reviewer noted in comments, "…social change at the community level often occurs gradually and over a more protracted period of time and with repeat exposure as opposed to a one-off exposure to an intervention."

  Furthermore, given that the TCCs report limited to no direct community outreach activities at present, the evaluation team recommends that TCC staff engage directly with communities, thereby building connections with schools, clinics, police, community organizations, and community members themselves. These direct relationships have the potential to improve the status of the system of care, build trust, and increase awareness. Data from this evaluation shows that few TCC staff were available to participate in community dialogues or service providers'

[7] This negative change could be explained by the wording of the question, which could have confused respondents.

[8] Negative change was observed on *"women do not provoke rape by their appearance or behavior,"* and no change was measured for *"women often claim rape to protect their reputations."*

trainings due to their responsibilities at the TCC or lack of transportation. Human resource limitations remain a challenge at the TCCs; however, centralized staff could help coordinate outreach efforts. Where it is not possible to send TCC staff into communities for outreach, consider technology, social media, or radio as a means for TCC staff to engage with communities.

- **Adopt a train-the-trainer approach to community dialogues.** Community dialogues are an attractive option towards meeting the goals to decrease SGBV incidence and increase support for survivors, as they allow for a more in-depth discussion of SGBV issues, which is likely necessary to change attitudes and reduce stigma. Nonetheless, these dialogues are only able to reach a small number of participants, and we did not find evidence that they were effective in achieving the objectives tested in this evaluation. As such, they should either be used strategically as part of a "saturation" strategy in targeted communities, or they should be scaled-up dramatically. As part of the latter approach, we would recommend adopting a train-the-trainer or promoter-based approach. There is some precedent for this, as Soul City has been working to establish clubs of young women who could lead their own dialogues. Participants should be provided with the skills and materials to encourage information proliferation while ensuring fidelity to the established approach.

- **Formalize SGBV training for police and other professionals in the system of care**. Participants in the Integrated Management training were recruited via open invitations to service providers at targeted institutions. As such, participants self-selected into the program and many had a strong interest in SGBV or were already working on SGBV. In fact, at baseline, 80 percent of service providers already knew of SGBV services and 65 percent had informed a victim about the TCCs in the last 60 days. This could explain why the intervention did not increase referrals from this group. It seems probable that a training could be most beneficial if it were provided to service providers who likely have contact with SGBV survivors but are not knowledgeable about such issues nor the services that exist to address them. These individuals would be less motivated to attend a three-day training, but a shortened training could be offered to a wider audience of service providers with a heavy emphasis on follow-up action.

  Police would be an obvious target for such training; however, USAID/South Africa reports that it is difficult to work with the South Africa Police Service in such capacity due to Leahy Law requirements for training. Training nurses in making referrals would be an attractive alternate target group, as these professionals often interact with survivors. While nurses have many demands on their time, they might be amenable to such a training because the TCCs offer a support service that can make their jobs easier. If this were to occur, we would recommend conducting the same pre- and post-survey. Some of the knowledge and attitude gains might be lower with a less motivated group; however, a well delivered training could lead to greater awareness throughout the service provider community and increase referral sources.

- **Use these data to inform future programming**: The survey data demonstrate a number of knowledge gaps, important perspectives, and potentially problematic attitudes that could help USAID, the NPA, and the IPs improve their programming. For example, while the survey reveals generally progressive attitudes, it also shows that many individuals think there are limits on a woman's right to refuse sex and there is evidence of victim blaming in certain situations. These statistics should be incorporated into curriculum, discussed, and addressed.

INTRODUCTION

This report presents the final results of the impact evaluation of USAID/South Africa's (USAID/SA) Increasing Services for Survivors of Sexual Assault in South Africa (ISSSASA) Program, under the Democracy, Rights, and Governance – Learning, Evaluation, and Research (DRG-LER) activity. The ISSSASA project is a five-year, $10 million cooperative agreement managed by USAID/SA's Democracy, Human Rights, and Governance Office that began in June 2012 and is scheduled to run through June 2017. The objective of this program is to improve service provision and community awareness of services for survivors of sexual assault by expanding TCC services, as well as raising public awareness of TCCs, TCC services for survivors of sexual assault, and sexual and gender-based violence (SGBV) in general.

1.1 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 and increasing public awareness and understanding of SGBV and resources available to survivors. Results from this study are intended to 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 aims 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 also have implications for funding decisions bearing on accountability and other development objectives.

1.2 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 both intimate partners and strangers, and while both men and women experience and perpetrate SGBV, it is most commonly perpetrated by men against women. In all 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. In 2014/2015, the sexual offences rate in South Africa was 99.3 per 100,000 people nationwide (Institute for Security Studies, 2015). The Statistics South Africa's National Victims of Crime Survey (NVCS) found that most victims of any type of assault knew their perpetrator, who were either from the same community (34.2 percent), a spouse or lover (16.8 percent), or a relative (9.2 percent) (Institute for Security Studies, 2015). Moreover, the NVCS also shows that the rate of reporting assaults to the police has been declining in South Africa in recent years. Best estimates indicate that at most only one in nine rapes are reported to authorities (Jewkes and Abrahams, 2002). Together, these signal that the true rate of sexual assault in South Africa is likely much higher than official crime statistics indicate.

One in 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 percent of men disclosed having perpetrated intimate partner violence and almost 28 percent 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 percent perpetrated their first rape before age 20. In addition to perpetrating sexual violence, young people are particularly likely to be victimized; 60 percent of survivors presenting at TCCs are under 18, and 40 percent 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 under-studied 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 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. TCCs provide a comprehensive portfolio of services to survivors of sexual violence, 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 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 seven percent 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 (Gibbs et al., 2014), 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 impact evaluation (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 only a portion 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.

The theory of change posits that the demand-side community dialogues and supply-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.

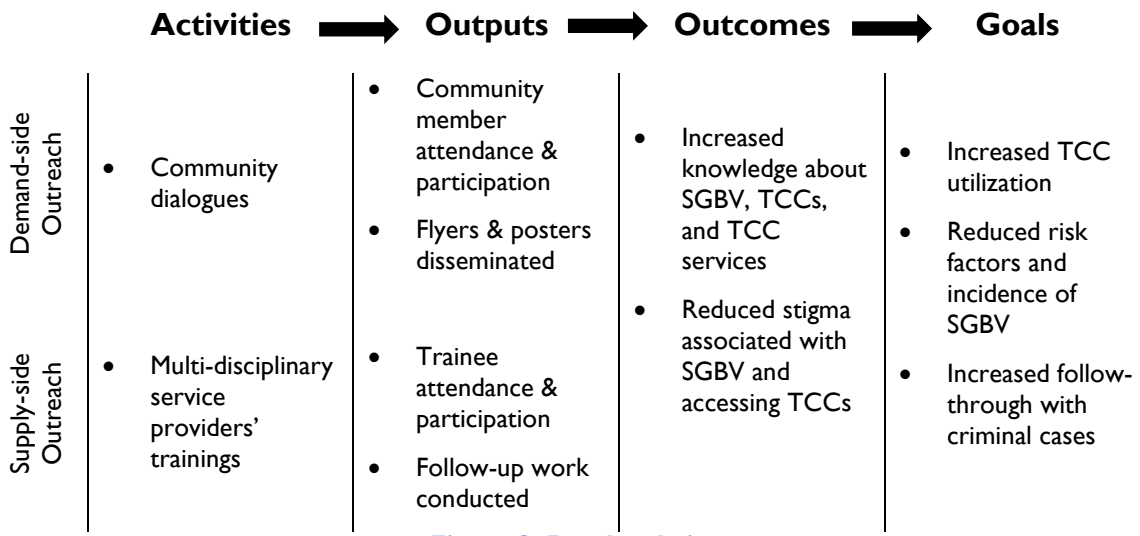

Figure 2: Results chain

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 independent 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.

It should be noted that the implementers of this intervention expressed concern about testing the independent effects of these two interventions, and had preferred that the IE focus on the suite of program activities intended to work together. Interventions like the ISSSASA program are often holistic programs with a number of complementary elements. While it is possible to conduct an evaluation of a multipronged approach, it becomes difficult to interpret the implications of the findings. For example, if the impact is found to be positive and significant, should the whole approach be scaled up or exported or are the advances driven by a particular element? Alternatively, if no impact is found, are there parts of the intervention that might be working? To avoid this challenge, USAID's Center of Excellence on Democracy, Human Rights, and Governance has favored evaluating specific aspects of an intervention and attempting to measure independent effects, and this is the approach that was adopted in this evaluation. The risk with such an approach, however, is that individual activities might be insufficient to produce an effect on their own even if they might be an effective complement to other efforts. In this case, the theory of change linking the community dialogues, which only targeted a limited number of participants, to increases in knowledge and changes in attitudes in the community as a whole was not strong enough; the results could have been difference if a more robust demand-side intervention were tested. Furthermore, in an ideal scenario, the evaluation would have included a third treatment arm to measure the effectiveness of combining robust demand-side and supply-side approaches; unfortunately, due to sample size and resource constraints, this was not possible. In addition to separating out program components, there were several ways in which the intervention had to be accommodated to permit an impact evaluation.

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 hypotheses[9] 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

[9] Discussions with the implementing partners and USAID revealed concerns over the ability of the intervention to measurably impact stigma associated with SGBV or follow-though with criminal cases. Accordingly, the evaluation team considers Hypotheses 1 and 2 as primary, and Hypothesis 3 as secondary.

SGBV, TCC presence and TCC services.

H3: Interventions will improve 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.[10] A schematic diagram of this design is shown in Figure 3.

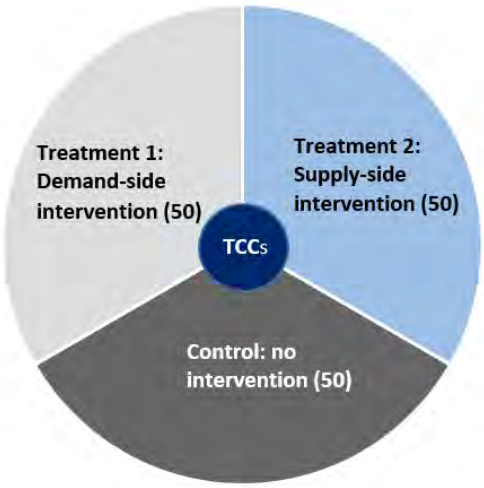

Figure 3: Treatment and control groups

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 is 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.

[10] 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.

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

To answer Hypotheses 2 and 3, the evaluation team collected baseline and endline surveys in communities where dialogues were held (Treatment 1) and comparison communities, and among service providers participating in trainings (Treatment 1). Specifically, we tested if community outreach campaigns increase community knowledge of and attitudes toward SGBV through 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.[11] The evaluation team also tested whether service providers' knowledge, attitudes, and self-reported behavior changed as a result of trainings through a pre- and post-training survey with participating service providers. Of the total 1,908 training participants, 1,789 (94 percent) participated in the evaluation at baseline and 1,347 (71 percent) participated at endline.[12]

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;[13] with each TCC serving from one to 18 police precincts and 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.[14] A sophisticated balanced assignment technique developed by Maximillian Kasy was applied to select three precincts within

[11] This IE was initially designed to evaluate knowledge and attitude changes among men and women. However, due to resource constraints, the final design opted to focus on the female community members only, to maximize the sample size of female respondents and maximize the MDES for that group. We recognize that men's knowledge and attitudes are an important area for future studies since prevailing norms among men are critical in understanding and decreasing SGBV.

[12] Excludes participants from Margate precinct in KwaZulu-Natal province. This precinct was not included in the evaluation due to delays in implementation.

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

[14] 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.

each TCC catchment area and to assign each precinct to one of three groups: control (no treatment), demand-side Treatment 1, or supply-side Treatment 2.[15]

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, specifically: population size, sexual assault rate, homicide rate, and percentage of the population that is rural.[16] 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 2013). Using the regression specification above, the treatment assignment with the lowest value for the objective function was selected (Kasy 2013). 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 allows the IE to assess the independent effects of each of these approaches for the precinct-level outcomes. Initial power calculations conducted at the design phase (see Annex 1) indicated that the study would have the power to detect moderately large average program effects (0.53 to 0.65 standard deviations); with a recognized risk that the study would find moderate but statistically insignificant impacts due to the modest sample size. The ICCs and MDES values were generally found to be within the range of what was expected at the design phase (see Table 3).

[15] 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.

[16] The randomization technique employed was developed by Dr. Maximilian Kasy at Harvard University's Department of Economics, and is based on a working paper (Kasy 2013).

Table 3: Assumptions for power calculations, precinct-level outcomes

	Treatment 1 & Control		Treatment 2 & Control	
	Full Sample	Reduced Sample	Full Sample	Reduced Sample
Alpha	0.05	0.05	0.05	0.05
Power	80%	80%	80%	80%
Cluster level Reliability (CLR)	0.70	0.70	0.70	0.70
Clusters (J)	71	45	74	47
Blocking variables (K)	2	2	2	2
ICC	.27	.14	.25	.21
MDES	0.51	0.68	0.50	0.65

2.2.2 Individual level

The individual-level design, involving women as the unit of analysis in Treatment 1 precincts and service providers as the unit of analysis in Treatment 2 precincts, was originally developed as a two-armed RCT in which the independent effects of each of the two programs on the proposed hypotheses could be tested against a control group. 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, while the supply-side intervention (Treatment 2) would be evaluated with a simple pre-post design.

For the demand-side community dialogue intervention, 15 women were randomly selected to participate in a women's survey, one 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 a *random walk* technique. Annex IV presents the random walk protocol. After household selection within each sampled precinct, an individual female respondent within each sampled 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, the household sample was stratified by percentage of the precinct population categorized as urban, rural, or tribal, according to SAPS 2013 data. The household sample was drawn to be representative of the precinct on the distribution of population across urban, rural, and tribal types.[17] Second, households were stratified geographically according to the 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 sampled households were distributed equally amongst the sectors and subsectors, with consideration to above mentioned distribution across rural, urban, or tribal group types.

Some sectors or subsectors were excluded from the sample frame as they 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

[17] For example, if 20 percent of the precinct population is categorized as urban and 80 percent as rural, three urban households and twelve rural households would be selected.

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 to expect that women in these households would attend a community dialogue or visit a TCC. The survey was also limited to those between the ages of 18 and 49.

The power calculations indicate that the individual-level design, unlike the precinct-level design, would have the power to detect relatively small average program effects. Table 4 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 was estimated to have the power to detect an effect of 0.24 standard deviations (e.g., in knowledge of TCCs or other sexual assault centers). The ICCs and MDES values were found to be within the range of what was expected at the design phase.

Table 4: Assumptions for power calculations, individual-level design

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

This IE relied on administrative and governmental secondary data and primary quantitative and qualitative data collected by the IE team. We discuss each data source in turn:

2.3.1 Police records

Crime statistics for each of the sampled precincts were collected from the SAPS. These data were used to balance the precinct sampling and assignment described above and were used as control variables during data analysis (i.e., in the precinct-level regressions).

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 with police precinct information were not available at the vast majority of TCCs. Since these data are crucial for testing Hypothesis 1, 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 was to be filled out by TCC staff for every survivor when she/he first presents at the TCC. Part I contained 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 recordkeeping. The supplemental TCC intake form is presented in Annex II. At endline, 47 of 50 TCCs submitted supplemental intake forms.

This data collection process confronted a number of challenges. Some TCC respondents reported the intake form was difficult to complete, as survivors had recently experienced trauma, were tired, and had already answered many questions. One Site Coordinator said:

> *"Some of them [survivors] are not interested in having the forms filled in because they already come from two other offices, coming from counselling sessions and things like that. … [And] on the second visit people are usually … not emotionally stable because they are coming from long sessions, so … you have to explain this to them and then they get bored with you or irritated."*

Several TCC staff interviewed at baseline said the intake forms were very time-consuming and duplicative of their existing data collection processes. One Site Coordinator said, "The other day I received a new intake form from NPA which is going to take a lot to fill out, so it is difficult when you have somebody in front of you to be filling in this form then afterwards another form." Qualitative reports suggest that other TCC staff were not adequately and consistently trained to use the intake forms. Furthermore, respondents reported that the forms were less likely to be completed when the Site Coordinator (or the trained staff member) was not at the TCC, especially during nights and weekends. One Site Coordinator said other stakeholders (such as NGO employees providing after-hours support) did not fill out the forms because "people don't want to do other people's work. ... People [are] saying I am making them do my work, so at this point in time I am the only person who has to fill in those forms." Another Site Coordinator said, "Other stakeholders are not willing to participate because it is something that has been approved by the NPA and they are working for other departments, so they won't do it."

These types of challenges were anticipated by the evaluation team, and a number of data quality verification measures were conducted to encourage accurate and reliable data. SI's data collection partner followed up with each TCC twice during the data collection period. The first follow-up was a phone call to each TCC approximately one week after the initial baseline visit. The second was a follow-up visit to each TCC approximately one to three months after the baseline visit to visually check for compliance and to address any issues or concerns. At the time of the second follow-up, 42 of the 50 participating TCCs reported using the supplemental intakes with at least 90 percent of survivors presenting at their TCC. Those TCCs with lower compliance were reminded of the data collection activities and any questions were addressed. Unfortunately, compliance dropped further by endline. At endline, 47 of 50 TCCs submitted supplemental intake forms. Of these, a lower 31 reported use of the intake forms with 90 percent to 100 percent of survivors. In addition, to these verification exercises, the evaluation team also compared TCC utilization figures provided by the NPA with intake data provided by the TCCs (see Annex IX).

Following an analysis of these different sources of data, we concluded that there were concerns with data from 19 TCCs and that data from another 28 TCCs was sufficiently accurate for purposes of the evaluation. In some cases, the data provided by the 28 cases might not be 100 percent complete; however, the missing data appears random and not likely to influence the outcome of the study. For example, one TCC collected data systematically; however, personnel did not collect data for one month, reportedly because they were out of paper. This gap in data collection is expected to affect all police precincts equally and as such should not affect the evaluation. In fact, based on the concerns identified above, we do not expect missing data to be correlated with police precinct or the intervention. As such, in the analysis that

follows we present separate analyses of the full sample of 45 TCCs with police precinct data[18] and the 28 TCCs for which we have a higher level of confidence in the data.

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 at baseline and endline. 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 one randomly selected adult woman in each of the 15 randomly selected households in Treatment 1 and control households using Computer Assisted Personal Interviewing (CAPI). As the respondents were selected based on treatment and control areas, the study is not intended to be nationally representative, or representative of province, and the data presented below are unweighted. Since the evaluation is nationwide, the survey was translated to all 12 official languages in South Africa, and it was administered by regionally-based teams of fieldworkers who were 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 tensions in those areas. 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 percent response rate for trained professionals at baseline; however, each respondent did not complete all questions at baseline resulting in missing data, which ranges from two percent to ten percent for most questions (see Annex V). Of those trainees who completed a baseline survey, 75 percent were reached for an endline survey, for an overall response rate of 71 percent of trainees.[19]

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 at baseline. Follow-up interviews were attempted with each TCC as part of endline data collection. Forty-eight endline interviews were conducted with TCC senior staff, while three TCCs were unwilling to participate in the endline. Interview questions focused on awareness and utilization of

[18] This number drops from 47 to 45 TCCs because forms from two TCCs did not contain police precinct data, and are thus unusable for precinct-level analyses.

[19] The response rate on this survey is a bit lower than hoped. The main reasons for non-response at follow-up are: respondent did not provide a phone number; respondent was no longer available at the phone number listed; and refusal. Up to 10 attempts were made to reach professionals who were simply unavailable at the time of the call.

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 has been used to construct several TCC capacity indicators, which are used as control variables in regression analysis on TCC utilization. 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 to participate 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 stated that there was continued pressure from NPA officials *not* to participate in evaluation activities, despite NPA assurances to the contrary.

In addition, some TCC staff were reluctant to participate in the research even when NPA support was clear. It is likely that some 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.[20] As previously mentioned, three TCCs refused the endline interview, citing a lack of permission from superiors to participate.

2.3.6 Training, piloting, and data collection

Baseline and endline data collection took place on a rolling basis over a 14-month period from August 2014 to October 2015, in tandem with the implementing partners' implementation schedule across all nine provinces in South Africa. [21] Prior to the start of data collection, fieldworkers from SI's data collection partner, Impact Research International (IRI), were trained for one week on the details of administration of the survey 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.[22] 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 data collection 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.

[20] Specifically, this TCC requested that they be allowed to review and verify the transcribed notes taken after the interview. 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.

[21] Baseline data collection took place in each TCC catchment area two months or less prior to the start of the intervention and endline took place three months after the completion of the intervention in that TCC catchment area.

[22] To pilot the service provider survey, the data collection firm gathered a group of known service providers representing each of the professions of interest. The study was explained to the group and they were asked to self-administer the survey. After completion, a debriefing focus group was held to elicit feedback and revisions were made, accordingly.

FINDINGS

3.1 TCCS

Qualitative research was utilized to contextualize quantitative data and delve more deeply into TCC operations and the perceptions of TCC staff. Qualitative data on TCC capacity and utilization were collected via in-depth, targeted interviews at baseline and endline. Initially, interviews were only planned with TCC staff, but at the beginning of data collection, the research 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 (DSD). As such, interviews were conducted with TCC Site Coordinators, TCC Victim Assistant Officers (VAO), and TCC case managers, as well as NGO management staff, nurses, clinicians, and social workers. Written informed consent was obtained from each participant before each interview was conducted. Respondents were presented an informational pamphlet about the study, asked if the interview could be recorded, and given a formal NPA research endorsement letter. They were then asked to review and sign the informed consent document. If respondents were unavailable during in-person site visits, interviews were conducted by phone. Prior to each phone interview, the study purpose was shared with the respondent and the consent form was to be signed.

Ninety-four baseline interviews were conducted across all 51 TCC catchment areas. Interviewees included senior staff from 51 TCCs, 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.[23] Figure 4 and Figure 5 show the locations of baseline interviews with TCC staff, NGO staff, and counsellors.

Figure 4: TCC interview sites

[23] 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 interview sites

Follow-up interviews were attempted with each TCC as part of endline data collection to assess changes in TCC capacity, perceived changes in TCC utilization since baseline, and use of intake forms. Forty-eight endline interviews were conducted with TCC senior staff, while three TCCs were unwilling to participate in the endline. Where possible, endline interviews were conducted with the same TCC respondent interviewed at baseline. If the baseline respondent was unavailable for endline data collection (e.g., if the respondent no longer worked at the TCC), another senior TCC employee who had worked at the TCC at baseline was interviewed instead.

Interviews were digitally recorded and transcribed, and both voice and text data were uploaded to a shared and encrypted server. To ensure consistent interpretation, a team of researchers reviewed the qualitative data for quality control, paying particular attention to the accuracy of interview transcriptions. For interviews conducted in languages other than English, a native speaker translated the interview 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 software, an online, cross-platform application for mixed methods research. The same two individuals completed coding of all transcripts to mitigate concerns of inter-rater reliability.

3.2. TCC CAPACITY

Factors considered in the assessment of TCC capacity included location, days and hours of operation, appearance and quality of facilities, services provided, staffing, recordkeeping practices, and available resources.

3.2.1 Days and hours of operation

At baseline, 23 TCCs were open Monday through Friday and 20 were open seven days a week. At endline, one TCC had extended its hours of operation to weekends and was open seven days a week. Twenty-five TCCs provided services 24 hours a day at baseline. At endline, five more TCCs provided services 24 hours a day, for a total of 30 TCCs. No other TCCs reported any changes to their operating schedule between baseline and endline. Operating hours for TCCs that were not open around the clock ranged from 7:00 AM to 7:00 PM, with the majority open during standard business hours (8:30 AM to 4:30 PM). Many TCCs that did not operate on a 24-hour schedule referred survivors to external partners for services after regular business hours.

3.2.2 After-hours services

Most TCCs with on-site after-hours services received staffing support from NGOs and the DOH. Many had all staff members present during regular business hours, and only limited staff available after-hours, or had on-call staff that report to the TCC if a survivor presents after-hours. TCCs without on-site after-

hours services referred survivors to the casualty department of the nearest hospital for care. The hospitals then instruct survivors to return to the TCC during normal operating hours for follow-up, including counselling and other services the hospital does not provide.

TCCs without on-site after-hours services are less equipped to provide comprehensive care, as one 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." Many respondents highlighted lack of follow-up as one of the key challenges they continued to face at endline.

When asked how after-hours intake and services differ from operations during regular business hours, a 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 won't be done the same. In this one we rely mostly on [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 TVP, a local NGO, also provides staff (trauma counsellors, victim advocates and general staff members), who perform housekeeping and cooking duties. Other TCCs reported similar arrangements, with NGOs providing staff support during both regular business hours and after-hours.[24]

3.2.3 Staffing

> *"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 says 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

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 baseline interview, and ten other TCCs had one or more unfilled staff positions in the months preceding the baseline interview. The length of these vacancies ranged from four to 41 months. Many respondents were unable to estimate vacancy lengths due to the 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, police liaisons, social workers, and support staff. Some positions were temporarily vacant due to staff resignations, but others reported not having the budget for full-time positions in those areas.

Staffing shortages in all positions remained an important concern during endline interviews. Efforts to fill vacancies were mixed—some TCCs had hired new employees and were fully staffed at endline, while others still reported openings, including vacant positions of VAOs, case managers, counsellors, and nurses. Respondents reported that staffing shortages force existing staff members to perform dual roles or take on activities outside their scope of work. A Site Coordinator said she is "used to dividing myself now in all those roles, I have to juggle between those roles. … I try very much to be [superwoman]."

Lack of and inefficient coordination among stakeholders are two driving factors leading to long-term vacancies. Respondents highlighted that multiple stakeholders are responsible for filling specific positions, increasing the bureaucracy of the hiring process. For example, the NPA oversees the hiring of Site Coordinators and VAOs, DSD oversees the hiring of social workers, and DOH oversees the appointments of doctors and nurses. One Site Coordinator expressed frustration about her inability to fill open positions, saying she could not hire anyone because the TCC must take "instructions from the National Prosecuting Authority. Most of the things are beyond my control because we are taking instructions from

[24] NGO-provided services, as well as more detail about the relationship between TCCs and NGOs, are discussed in more detail in the "Role of NGOs as Service Providers" section of this report.

them. The new one is from DSD and she is here because she was sent by DSD. So it's out of my hands."

Another concern with the staffing structure interview respondents raised was the gender of the TCC staff working with survivors. While 36 Site Coordinators were women, only 16 VAOs were women. None of the interviewed staff were able to report that the TCC staff members had completed gender-sensitivity training. The majority of survivors are female and are frequently forced to interact with a male TCC employee, regardless of their comfort with this arrangement. Qualitative reports also suggest that space constraints may contribute to secondary victimization if a male TCC employee treats a female survivor 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."

3.2.4 Location

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 six cases, employees at the reception desk of the hospital within which the TCC was located were unable to direct the team to the TCC. At baseline, only 34 TCCs had a sign on the building/facility in which it is located, but by endline, all but one TCC had been signposted. This appears to have been done by design to prevent perpetrators from finding the TCCs; however, this is likely to severely undermine utilization. All TCCs remained in the same physical locations at endline as baseline.

3.2.5 Ability to meet survivor needs

At baseline, few Site Coordinators expressed high levels of confidence in their TCC's overall capacity and ability to meet survivor needs. During baseline interviews, respondents were asked to rate their TCC's overall capacity on a four-level scale ranging from "fully adequate" to "not at all adequate." Only one respondent rated their TCC's capacity as fully adequate, while 23 rated their TCC as mostly adequate, 19 as somewhat adequate, and 4 as not at all adequate. One respondent who rated their TCC's capacity as mostly adequate also 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. Twenty-three said their TCC's ability was mostly adequate, 22 said their TCC's ability was somewhat adequate, and four respondents said their TCC's ability was not at all adequate. Baseline and endline numbers are reported in Figure 6.

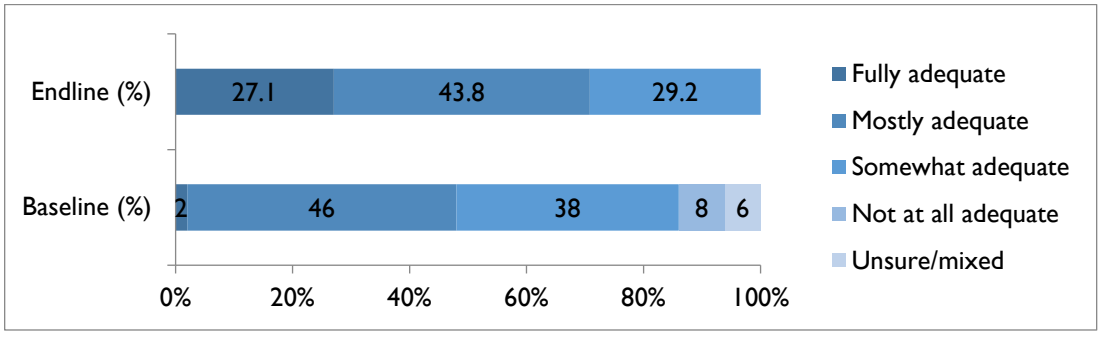

Figure 6: Assessment of TCC ability to meet survivor need

Fourteen TCCs believed their ability to meet survivor needs had improved between baseline and endline, while 23 thought that their ability to meet survivor needs remained mostly unchanged from baseline. Only three TCCs responded that their ability to meet survivor needs had declined, which they attributed to staff departures and diminished NGO support. Research staff also independently assessed each TCC's ability to meet survivor needs at endline on a four-part scale from "fully adequate" to "not at all adequate"

Thirteen TCCs were rated fully adequate, 21 were mostly adequate, and 14 were somewhat adequate, which represent a notable improvement from baseline. Overall, improvements in ability to meet survivor needs and TCC capacity were reported by both TCC staff and the data collection team.

3.2.6 Communication and collaboration with stakeholders

Many TCCs at endline reported increased communication and collaboration with stakeholders, including the NPA, SAPS, DOH, NGOs, and hospitals, as a factor that improved their TCC's ability to meet survivor needs. Nearly all respondents reported strengthened relationships and more frequent communication with stakeholders. At baseline, many TCCs reported holding regular implementation meetings during which stakeholders come together to discuss TCC issues and challenges. At endline, these meetings were repeatedly cited as one of the key factors that contributed to improved TCC service delivery. One Site Coordinator said, "wherever there are problems, we try and actually discuss and actually come out with resolutions as to what we need to do to move forward, so most of the stakeholders are aware of what things are happening at Thuthuzela."

One TCC created a "cluster reporting template whereby each and every stakeholder will actually report based on that particular template and we will take it as our report card to our monthly and implementation meetings." No other respondents reported using such a template, but most identified increased communication and collaboration with stakeholders as a catalyst for better survivor care. One Site Coordinator explained:

> *"Last week when we were doing our year plan, we were emphasizing that we do things together, let's invite each other when we have campaigns, when we have issues. When one has a challenge, let's liaise so that the very same victim gets necessary services. … [If] we don't work together the same victim might not get the very same service."*

Another Site Coordinator described how they overcome challenges with stakeholders and balance competing organizational interests:

> *"We [are] bound to clash when we have different norms and values from our different departments. But at same time we remind ourselves that as much as my values, my objectives are from my department are same, convert and whatever and use to give medical care but at the end of the day we still have to provide good service to the victims. Let's combine that and give them good service."*

In addition, increased Internet connectivity at TCCs facilitated stakeholder engagement since this allowed them to communicate with stakeholders by email.

3.2.7 Space constraints

Some TCCs reported deficient facilities as a barrier to fully meeting survivor needs, and insufficient space was repeatedly cited as a significant problem. Only four TCCs rated their space as fully adequate, 20 as mostly adequate, 14 as somewhat adequate, and 12 as not at all adequate. At endline, research staff independently assessed each TCC facility's space, finding 16 TCCs to have fully adequate space, 20 as mostly adequate, eight as somewhat adequate, and four as not at all adequate, as outlined in Figure 7.

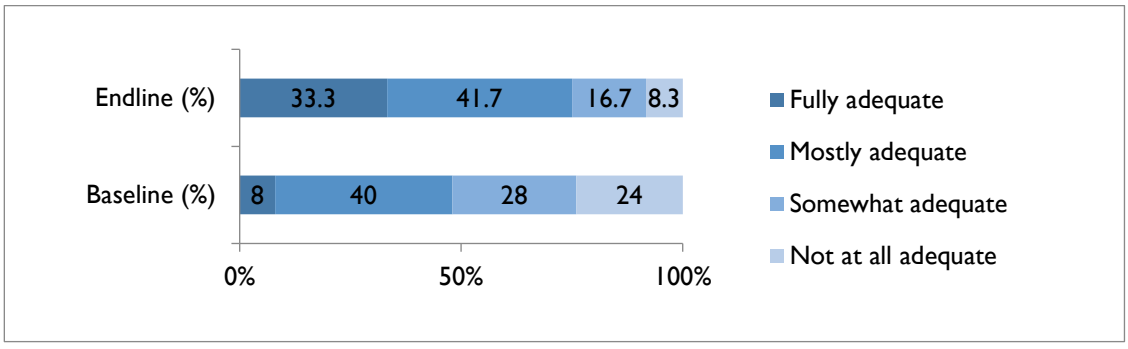

Figure 7: Independent assessment of TCC space

While the research staff's assessment indicates that improvements had been made by endline, but respondents underlined the numerous problems inadequate office space creates. For example, when police bring suspected perpetrators to the TCC for forensic examination and evidence collection, sometimes survivors and suspected perpetrators must wait in the reception area at the same time, as a Site Coordinator explained:

> *"We have only one examination room and we still get perpetrators that come in for DNA, and 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."*

Space constraints lead to administrative offices being used for multiple purposes, including as examination or consultation rooms. One Site Coordinator explained that their TCC was not built according to NPA specifications, which has caused privacy concerns:

> *"The Thuthuzelas are built according to a certain blueprint and this one that we have here is not built according to the Thuthuzela blueprint. So we have been trying to negotiate to have a Thuthuzela built for us here. You see, when a victim comes to the reception, this is the counselling room and there is always a clinic as you can see the chairs outside there. … There is no privacy."*

At endline, a TCC Site Coordinator explained that they were still operating out of a temporary office space:

> *"We are working in a park home, I believe this is a temporary measure, definitely we would want a permanent structure maybe with rooms where we can have a rest room for our victims while they are waiting for assistance from the sisters and the doctors. … it becomes very hot in here even when we have the [air conditioning], therefore if we have a permanent structure we can be able to engage with the hospital to come and install maybe a smaller dispensary area whereby we know that when our victims comes in they don't have to walk to the hospital pharmacy for medication, but can have all the medication they need here and everything is done here, rather than having them walk to the hospital and maybe see the perpetrator and experience secondary victimization."*

3.2.8 Facility appearance and supplies

The condition and upkeep of facilities is also a source of concern. At baseline and endline, research staff independently ranked the appearance of each TCC on a four-level scale ranging from "very nice" to "poor," as shown in Figure 8. At baseline, 12 TCCs were assessed as very nice, 15 as somewhat nice, 12 were in some disrepair, and eight were in poor condition. However, the overall appearance and upkeep of the facilities considerably improved by endline, with the majority (42) rated as very nice or somewhat nice. Only two remained in some disrepair and three were in poor condition at endline.

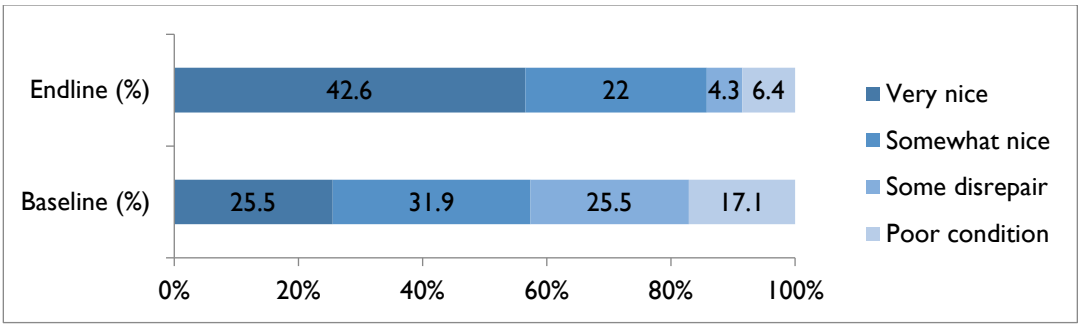

Figure 8: Independent assessment of TCC appearance

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 intentionally omitting the grass in front of the TCC when mowing. 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 issues were repeatedly reported 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 percent of TCCs were deemed to have inadequate connectivity (both phone service and Internet connections) at baseline. Some TCCs are not equipped with landline phone service, so staff must 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. By endline, many TCCs had Internet access or had plans to install it in the near future. Some TCCs had increased phone service, but others were still using personal cell phones. By endline, 27 TCCs reported receiving new resources (e.g., computers, fax machines, photocopiers, office supplies, etc.) while the remaining 21 TCCs reported that they had not received any new resources since baseline. The research team independently assessed the overall adequacy of each TCC's supplies at endline, the results of which are compared in Figure 9: 22 were fully adequate, 18 were mostly adequate, and eight were somewhat adequate, an improvement from baseline.

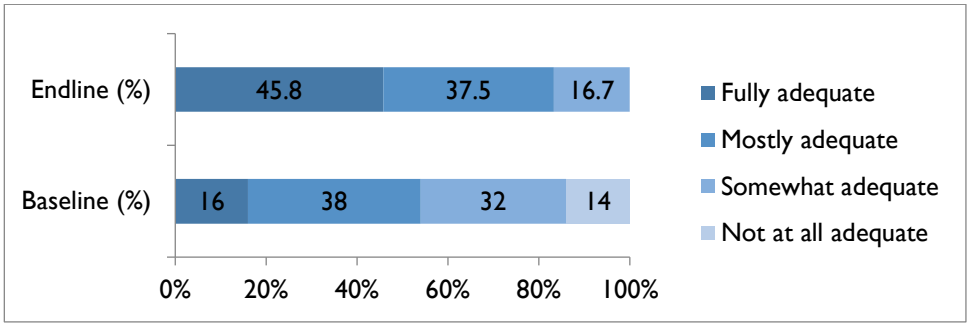

Figure 9: Independent assessment of TCC supplies

3.2.9 Medical supplies, clothing, and food

Most TCCs were adequately stocked with medical supplies, which are provided by DOH and the hospitals. Two TCCs did not have colposcopes (a specialized medical camera used to photograph genital injuries

invisible to the unaided eye) at baseline, but one of these TCCs had received a colposcope by endline. Nearly all TCCs reported having sufficient supplies of comfort packs, which include personal hygiene items and underwear. Comfort packs are typically provided by DOH, NPA, and NGO (and occasionally corporate donors such as Nivea and Colgate, which were reported at endline), but they do not generally include clothing other than underwear. Many survivors come to TCCs with dirty or bloody clothing, which must be collected as evidence if they choose to file a police report, yet most TCCs do not have a sufficient supply of clothing to offer 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 are not allowed to solicit donations because they are 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

Food supplies are also largely inadequate. The NPA previously supplied groceries to some TCCs, but it has largely ceased that practice. One TCC employee said that RTI International used to provide their groceries, but that support has also 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 [a 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 do provide food service utilize hospital kitchens to prepare it. However, that option is not readily available outside of regular business hours or to TCCs that are not located in hospitals. Several TCC staff members reported purchasing food for survivors with their own money.

Survivors who first report to a police station and those who 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 PEP medications should be taken on a full stomach. PEP must be taken within 72 hours of a sexual assault to reduce the likelihood of HIV transmission, but can have negative side effects if taken on an empty stomach.

3.2.10 Transportation

Survivors' difficulties in getting to the TCCs and a lack of funding for transportation were repeatedly cited as one of the TCCs' most pressing challenges. If a survivor does not have access to transportation, s/he may be unable to come to a TCC for an initial visit or may not 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 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."*

Certain transportation costs are reimbursed, but generally only for survivors traveling to and from court to testify or attend legal proceedings. TCCs do not have the budget to reimburse survivors for follow-up visit transportation expenses. Failure to return for follow-up can have serious health implications, as survivors may not take the full course of PEP. Most survivors receive a PEP starter pack during their initial visit and are required to return to receive the remainder of the PEP medication. Some TCC staff reported giving survivors the full course of PEP if they know they will not be able to return to the TCC, although this practice is not common. One Site Coordinator explained this as follows:

> *"[Survivors] have to come for follow-ups and their problem would be that they are not working and they don't have money. We are also unable to go to them. Other TCCs have NGOs that give them money so that they come back for follow-ups. Here we don't have that, and we are unable to go them because we don't have transport, we also don't have resources to get to them."*
>
> -TCC Site Coordinator

> *"Sometimes a person will come only for the first visit and don't do their follow ups. We still have that challenge but when it comes to the initial visit we try to help them. Actually the policy says we must give them prophylaxis for three days or five days then when they come back and finish the course so we decided not to give it to them because if we give them for three to five days and they don't come back it means they will default and it might happen that they are infected. Now we have a strategy to give them for the whole 28 days on the initial visit."*

Lack of transportation also inhibits the TCCs' ability to conduct outreach activities and awareness campaigns around the community.

3.2.11 Funders and supporters

At endline, respondents were asked if their TCC had any new funders or supporters. Very few TCCs reported any changes in their sources of funding or support. Some respondents did not know details about the sources of their funding, but most respondents who were able to describe their funding structure identified South African government agencies (e.g., DOH, DSD, NPA) as their main funders. Several TCCs cited funding and/or support from local NGOs, international organizations (e.g., UNICEF), and foreign governments (e.g., the Danish Embassy).

3.3 TCC UTILIZATION

3.3.1 Survivor demographics

The age and sex of survivors utilizing TCC services varies significantly between TCCs and even within individual TCCs over time. Some TCCs report that children ages 0-12 make up the largest group of the survivors they serve, with some estimating youth under the age of 18 comprised as much as 80 percent of all survivors. The other most common survivor demographic is females over the age of 18.

Adult males are the least frequent users of TCCs. One TCC said they would sometimes serve one or two adult males a month, but it was common to not serve any adult male survivors for months at a time. Many adult male survivors are 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 rarely reported to TCCs for care. 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 is no recorded data for this demographic group. It is likely underreported due to social and cultural stigma of 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."

At endline, nearly all TCCs reported that the volume of survivors presenting at the TCCs for care was either similar to baseline levels or slightly higher. Many respondents mentioned that the number of survivors reporting to TCCs fluctuate by season, and is higher around the time of various events when people may be more vulnerable (e.g., festivals). A Site Coordinator explained the differences in vulnerability between child and adult survivors and how vulnerability changes 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."*

Some TCCs that reported increases in the number of survivors reporting to their facility credited outreach activities for increasing awareness of TCCs and their services: "Sometimes during events, you see massive public awareness campaigns on the media, like 16 days of activism and so forth, that is when you find people coming forward to report, not knowing if this is created by the media hype or what, or the reasons are the awareness campaigns." A few respondents attributed outreach activities as the cause of reduction in overall prevalence of SGBV in their communities.

3.3.2 Referrals to TCCs

Survivors are referred to TCCs from a variety of sources, including police, hospitals, clinics, schools, NGOs, social workers, and churches. Some TCCs cited schools (teachers, Department of Education social workers, and school social workers) as their primary referral source 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." Some respondents indicated that teachers might be hesitant to report cases because they are afraid of getting involved in the legal process:

> *"Let's say a child has disclosed to the caregiver at school or a caregiver has identified a case of an abused child and that child speaks out, you find that that caregiver is afraid to report the case, they are afraid to be the first reporter because they are afraid to go to court ... they would say that there is such and such a case but I want to be anonymous."*

Another respondent said primary healthcare clinics have a poor understanding of where to refer suspected victims of sexual violence because:

> *"they are not part of the [implementation] meetings, so they do not know where to refer exactly, that is why you will find that some of them will refer just to the hospital, … we need to also bring them in as part of the stakeholders, as much as they see our patients if they come across such problems they need to be able to know where to refer and what is it that they should not do."*

At endline, TCC respondents described targeting awareness campaigns and outreach activities to potential referral sources, like schools and clinics. These activities were designed to teach stakeholders to identify potential SGBV survivors and know when to refer them to the TCC. Respondents underscored the need for continued stakeholder engagement and education to address these misperceptions and gaps in knowledge, and indicated that their efforts have been successful so far: "Other stakeholders now have a better understanding of the TCC model because we do presentations, meetings to explain the importance

of referring victims to the TCC. We have better communication channels and everybody seems to be on board."

The police are another significant referral source, with one TCC estimating approximately 90 percent of its cases are brought in by police. TCCs work extensively with SAPS, because the police are 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 are subsequently brought to a TCC for examination. If survivors first present to the TCC, the police are usually called, but survivors are 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 observed that the police's 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.

By endline, 67 percent of TCCs reported that police precincts were bringing or referring more survivors for treatment. Some respondents identified higher crime rates in certain precincts as the reason for the increase, but others pointed to the increased collaboration and outreach activities:

> *"For the past few months the police service had a lot of awareness-raising campaigns, but also clinics, and even the FPD and Soul City together with us, we also had our awareness-raising campaigns these past few months, [which] make people aware that there is such a service like the TCC."*

3.3.3 Barriers to accessing TCCs

Respondents identified numerous factors that pose barriers to access and utilization of TCCs. TCC location and access to transportation are two barriers that were discussed in more detail in section. Respondents also noted a lack of knowledge about TCCs more generally—many people are not aware that TCCs exists or have misperceptions of what services TCCs provide. A VAO explained that some hospitals refer people who have not experienced sexual violence to TCCs for general counseling or social work services. A TCC Site Coordinator said, "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."

> *"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

This problem is demonstrative of 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 South African Social Security Agency (SASSA) 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.

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.

Stigma and fear were two of the most cited barriers to TCC utilization. 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 also presents a barrier and can be especially challenging for survivors who live near their attackers because they must continue to interact with them after the attacks. Survivors also fear not being believed. A Site Coordinator explained how these two fears are related:

> *"We found that a lot of our survivors, the perpetrators were related to them or they were their husbands, fathers, stepfathers of 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 prescribing 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 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."

3.3.4 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 for support. TCCs partner with many NGOs that extend and integrate services throughout the community. Representative organizations include Mosaic, an 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 are after-hours support, psychosocial counselling, and outreach activities. Some NGOs provide temporary housing or shelter to survivors. LifeLine and ChildLine are two NGOs with which TCCs frequently partner. A counsellor said LifeLine "helps the broken souls, abused children, and women. … We are dealing with abuse, marriages, divorces and different types of counseling, trauma and debriefing." ChildLine provides similar services, but

for youths 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.

> *"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."*
>
> -NGO Social Worker

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 NGO respondents reported similar attitudes. A Lifeline Site Manager said that the TCC she works with uses their monthly implementation meetings (also discussed in section 3.2.6) to air any grievances and work collaboratively to find solutions to problem. These meetings facilitate dialogue and give NGO staff a better understanding of TCC constraints. A lack of resources, such as telephones and transportation, can negatively affect patient care, but coordination with external stakeholders, like NGOs, can help alleviate these problems. An NGO counsellor commended TCC employees for their hard work despite their 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 are not always able to address and improves the overall quality of care given to survivors. A LifeLine social worker described how LifeLine and other stakeholders 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 holistic care. 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."

3.4 IMPACT OF INTERVENTIONS ON TCC UTILIZATION

3.4.1 Description of supplemental intake data submitted by TCCs

As part of the data collection for this evaluation, TCC staff were asked to complete a supplemental intake form for each survivor presenting to the TCC between the baseline and endline TCC visits. Of the 51 TCCs, 47 submitted supplemental intake data to the evaluation team. According to these records, TCCs together served 3,125 survivors, an average of 74 survivors per TCC, over the approximately five-month evaluation period. The range varied dramatically with six TCCs reporting an aggregate of fewer than 10 cases over the 5-month period and 10 TCCs reporting over 100 cases. Amongst this full sample of TCCs, this is a median of 10.6 cases per month. As the rate of TCC use was lower than anticipated, the evaluation team undertook a series of data verification analyses, detailed in section 2.3.2, which included historical data from some TCCs. These historical data corroborate the levels of use measured through this IE for those TCCs we have kept in our sample.

Based on data verification analyses, the data from 19 of these TCCs was deemed to be less reliable as these TCCs were believed to have completed intake forms for fewer than 70 percent of the survivors presenting at their TCC. For the descriptive analysis, we restricted the sample of remaining 28 TCCs further, to 24 TCCs that are estimated to have completed the supplemental intake forms for at least 90 percent to not present underestimates in TCC utilization. The larger sample of 28 TCCs was used in the regression analysis for reasons explained in section 2.3.2 of this report.

Among the reduced sample of 24 TCCs that are believed to have kept accurate intake records, intake of survivors is still fairly low, with most TCCs receiving fewer than 20 survivors per month with a median of 12.7 cases, averaged across all months between the TCC baseline and endline visits (see Figure 10). As is also evident from Figure 10, the caseload varied substantially from just 4 survivors per month in one TCC to 48 survivors in another. It should be noted that NPA data indicate higher monthly caseloads, with a median of 22.5 cases per month (see Annex IX).

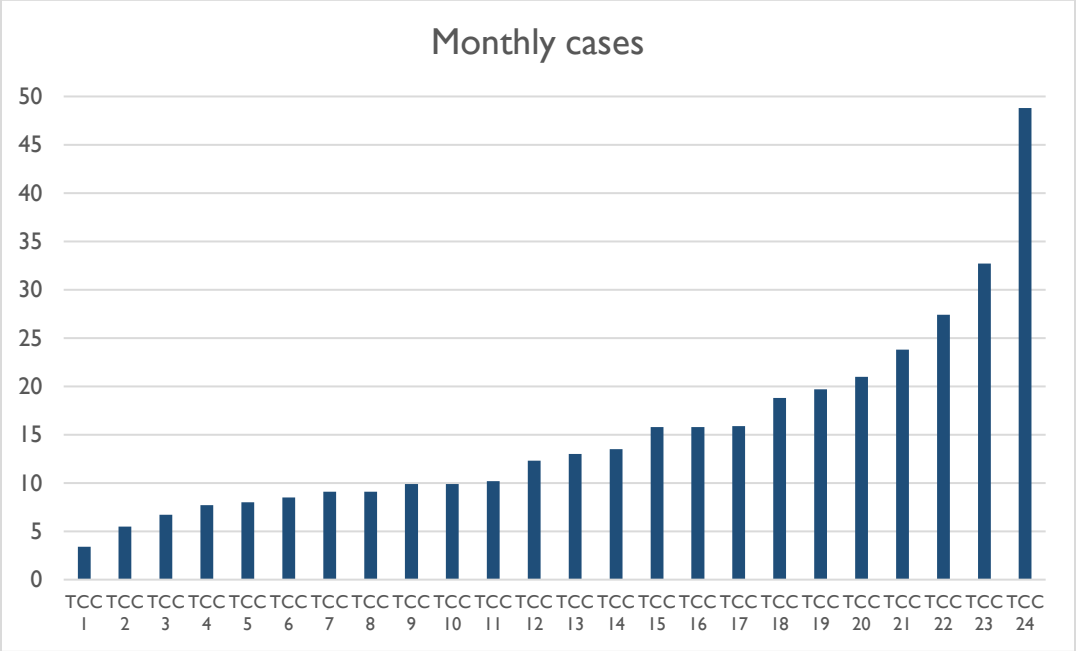

Figure 10: Average number of survivors presenting to each TCC per month (n=24)

3.4.2 Balance statistics at baseline

First, we examine whether the Treatment 1, Treatment 2, and the control samples are comparable on key variables. As explained in section 2.2.1, precinct-level (cluster-level) sampling and random assignment was designed to balance the treatment and control groups on four variables of interest: population size, sexual assault rate, homicide rate, and percentage of the population that is rural. As such, the Treatment 1, Treatment 2, and control precinct sample sub-groups are balanced on these four characteristics. Given that data quality concerns required us to limit the sample in some of the models in the analysis to a subset of precincts, there was a risk that the final samples of treatment and control precincts would be unbalanced. This risk was mitigated by the design, which clustered treatment and control precincts around TCCs. If a TCC is excluded from the analysis sample, an equal number of treatment and control precincts would thus be excluded from the analysis. As such, the balance statistics for the reduced sample shown in Table 5 also show balance on all key variables.

Ideally, the sample would also have been balanced on the number of survivors presenting to the TCC in each precinct at baseline. However, this information was unknown before this evaluation; thus, it was not possible to balance on this important characteristic. Fortunately, balance statistics for both the full sample and the reduced sample confirm that our treatment and control groups are statistically similar on this key variable. Results from independent sample t-tests are displayed in Table 5 and show that, as was the case of our original sampled precincts, the reduced sample of Treatment 1, Treatment 2, and control precincts is balanced on all key variables.

Table 5: Balance statistics for the reduced sample at baseline

	Treatment 1 (n=44)			Treatment 2 (n=47)		
	Control (%)	Treatment (%)	p-value	Control (%)	Treatment (%)	p-value
Survivors per month	3.3	4.6	.230	3.9	3.1	.573
Population	66,467	86,717	.147	66,447	73,993	.581
Sex crimes	151.8	153.0	.958	151.8	151.8	.999
Murders per 100K	35.6	37.0	.837	35.6	30.6	.475
Rural (yes)	.09	.06	.582	.09	.08	.831

3.4.3 Impact of community dialogues on TCC utilization

Multiple regression analysis using the difference-in-difference (DiD) method was conducted to test whether the community dialogues (Treatment 1) led to increased use of TCCs, as measured by the average number of survivors per month presenting to the TCC before and after the intervention in Treatment 1 and control precincts. Since the distribution of TCC utilization was skewed and due to a curvilinear relationship with some variables, the log of the average number of survivors treated per month and several control variables was used in the analysis presented in Table 6.

The analysis also controls for the rate of sexual assault in the precinct, population size, and the murder rate, as another measure of crime prevalence. In addition to these, the qualitative observational data collected at TCCs was used to construct several indicators of TCC capacity to include in the analysis. These comprised a facility assessment, supplies assessment, space assessment, and overall assessment of the ability to meet the needs of survivors. SI's local researcher scored each of the TCCs on a scale from 1 (not adequate) to 4 (fully adequate) based on observational data from the qualitative interview

transcripts.[25] Also included was a measure of whether the TCC reported having one or more positions unfilled at the time of the baseline interview and if the TCC operates 24 hours a day every day.

Four different model specifications are presented in Table 6. Models 1 and 3 use the full sample of 45 TCCs that submitted data to the evaluation team with control variables. Models 2 and 4 only include those 28 TCCs for which we have greater confidence in the reported utilization. The first and second models present the full and reduced samples, respectively, but exclude control variables. Since we randomly assigned precincts to treatment and control groups and our groups balance on these variables, control variables are not technically necessary. In models 3 and 4 we include control variables to better understand what factors do explain utilization and to increase our power. Regardless, as we would expect, the treatment effect estimates under models 1 and 2 are very similar to those in models 3 and 4.

The DiD treatment effect variable in Table 6 provides the test of our Treatment 1 hypothesis. This variable shows no impact of the community dialogues on TCC use across all four models. Because the coefficients in Table 6 are based on the logged average number of survivors per month, Figure 11 translates these regression coefficients to real effect sizes in an easy to interpret format. At baseline using the full sample, control precincts had 3.3 cases per month on average while treatment precincts had 3.9 cases. At endline, the control precincts had 2.7 cases per month on average and treatment precincts had 3.5 cases, an overall drop of 0.2 cases per month in Treatment 1 precincts relative to control precincts from baseline to endline. The observed general time trend of declining cases from baseline to endline in the full sample is likely attributable to declining compliance on the part of TCCs in using supplemental intake forms rather than a true decline in TCC use and should thus be interpreted as such. Nonetheless, as previously stated, this should not differentially affect our treatment or control precincts and therefore the estimated treatment effect.

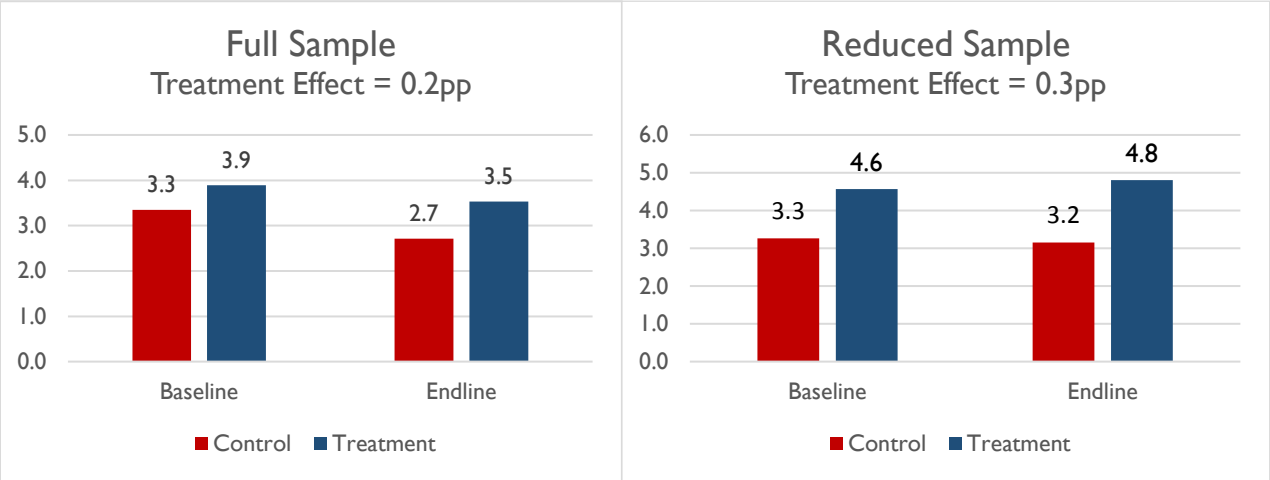

Figure 11: Difference-in-difference estimate of the effect of community dialogues on TCC use

Several control variables were statistically significantly associated with higher TCC use. Population size of the police precinct was the strongest driver of TCC use across both model 3 and model 4 ($p<.001$). The official rate of reported sex crimes was a statistically significant predictor of TCC use in model 3 ($p=.068$), but not in model 4. The murder rate, which is included as a proxy measure for actual sexual assault rates given underreporting, is also highly statistically significant in both model 3 ($p=.014$) and model 4 ($p=.009$).

Several of the TCC capacity indicators were significant predictors of TCC use. Those TCCs deemed to have more adequate facilities had higher TCC reporting than those with less adequate facilities in model

[25] The inclusion of these variables does introduce a slight autocorrelation problem as multiple precincts share the same TCC.

1 (p=.032). Contrary to expectation, those TCCs that reported having one or more staff positions unfilled at the time of interview had statistically significantly higher TCC use, on average, than those fully staffed TCCs in model 4 (p=.062). This is likely a case of reverse causality, as high usage in some TCCs has generated an unfulfilled need for new staff. Also surprising is that those TCCs perceived to be meeting the needs of survivors had lower TCC use, which is perhaps indicative of those TCCs with higher caseloads finding it more difficult to meet the needs of survivors.

Table 6: Regression results for impact of Treatment 1 on the logged average number of survivors using the TCC per month

VARIABLES	(1) Full sample, no controls	(2) Reduced sample, no controls	(3) Full sample	(4) Reduced sample
DiD Treatment Effect (0-1)	-0.12	-0.19	-0.12	-0.15
	(0.29)	(0.36)	(0.27)	(0.31)
Treatment Status (0-1)	0.32	0.52**	0.33*	0.45**
	(0.21)	(0.26)	(0.19)	(0.22)
Data collection period (0-1)	-0.016	0.14	-0.021	0.14
	(0.21)	(0.25)	(0.19)	(0.21)
TCC understaffed (0-1)			0.041	0.48*
			(0.17)	(0.25)
TCC operates 24 hours (0-1)			-0.14	0.13
			(0.18)	(0.23)
Facilities assessment (1-4)			0.20	0.44**
			(0.15)	(0.20)
Supplies assessment (1-4)			0.083	-0.16
			(0.092)	(0.13)
Space assessment (1-4)			0.10	0.15
			(0.090)	(0.11)
Meets survivor needs assessment (1-4)			-0.39**	-0.35
			(0.18)	(0.24)
Population size (log)			0.43***	0.47***
			(0.10)	(0.12)
Sex crimes per 100k (log)			0.32*	0.17
			(0.17)	(0.20)
Murders per 100k			0.011**	0.013***
			(0.0043)	(0.0049)
Constant	0.98***	0.97***	-5.68***	-6.02***
	(0.15)	(0.18)	(1.40)	(1.63)
Observations	142	90	142	90
Adjusted R-squared	0.005	0.032	0.182	0.282

Note: Standard errors in parentheses. Unit of analysis is a police precinct.
*** p<0.01, ** p<0.05, * p<0.1

3.4.4 Impact of service provider training on TCC utilization

Multiple regressions analysis using the difference-in-difference (DiD) method was also carried out to test the effect of service provider trainings (Treatment 2) following the same procedures and using the same four model specifications. As above, the DiD treatment effect variable in Table 7, our variable testing the treatment hypothesis, shows no impact of the service provider training on TCC use across all four models. Figure 12 shows that, at baseline, there were, on average, 4.7 survivor cases from control precincts and 3.0 cases from Treatment 2 precincts under the full sample model specification, and this dropped to 3.5 and 2.4 cases, respectively, at endline. As above, this decline is believed to be a drop in compliance in the use of supplemental intake forms and not necessarily indicative of a decline in TCC use. As this decline in compliance should affect the treatment and control precincts equally, we are still able to offer a test of the service provider training hypothesis. This DiD estimate indicates a small, positive gain of 0.6 cases per month in Treatment 2 precincts relative to control precincts from baseline to endline, though as previously noted, this difference is not statistically significant.

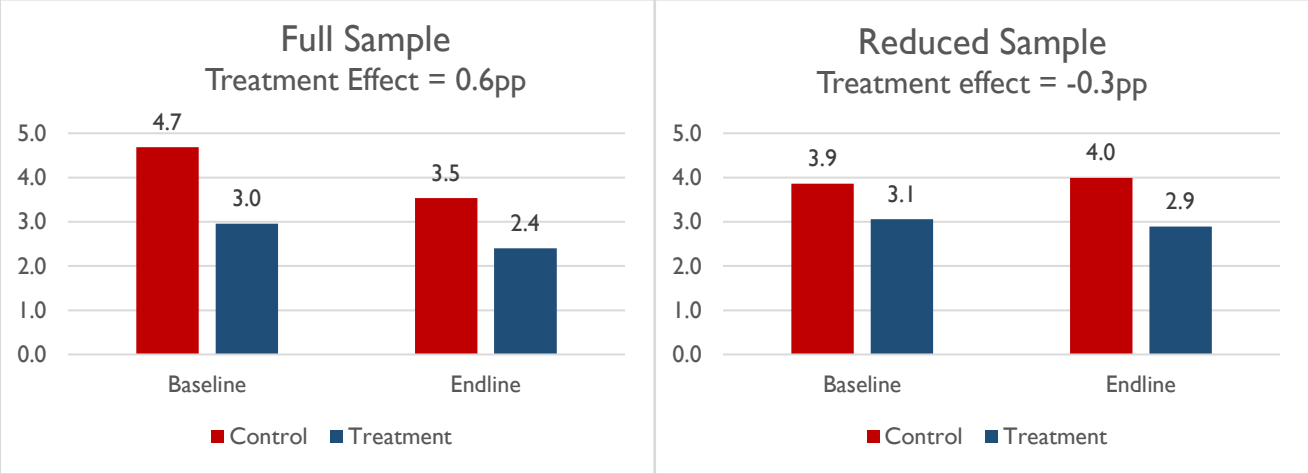

Figure 12: Difference-in-difference estimate of the effect of service provider training on TCC use

Precinct population size is a strong and statistically significant predictor in the model 3 regression (p=.003) as is the rate of sex crimes (p=.040), though these variables are insignificant in model 4. Three of the TCC variables statistically significantly predict TCC use in model 4: supplies assessment (p=.035), space assessment (p=.008), and if the TCC operates 24 hours a day (p=.070).

Table 7: Regression results for impact of Treatment 2 on the logged average number of survivors using the TCC per month

VARIABLES	(1) Full sample, no controls	(2) Reduced sample, no controls	(3) Full sample	(4) Reduced sample
DiD Treatment Effect	-0.065	-0.28	-0.054	-0.29
	(0.29)	(0.36)	(0.28)	(0.33)
Treatment Status	-0.19	-0.020	-0.18	-0.054
	(0.20)	(0.25)	(0.20)	(0.24)
Data collection period	-0.035	0.29	-0.043	0.27
	(0.21)	(0.25)	(0.20)	(0.23)
TCC understaffed			-0.11	0.28
			(0.19)	(0.28)
TCC operates 24 hours			-0.071	0.44*
			(0.19)	(0.24)
Facilities assessment (1-4)			0.032	0.33
			(0.14)	(0.21)
Supplies assessment (1-4)			0.037	-0.29**
			(0.10)	(0.13)
Space assessment (1-4)			0.12	0.32***
			(0.098)	(0.12)
Meets survivor needs assessment (1-4)			-0.16	-0.27
			(0.18)	(0.25)
Population size (log)			0.34***	0.20
			(0.11)	(0.14)
Sex crimes per 100k (log)			0.37**	0.30
			(0.18)	(0.20)
Murders per 100k			0.0020	0.0034
			(0.0038)	(0.0043)
Constant	1.21***	1.05***	-4.34***	-3.23*
	(0.15)	(0.18)	(1.51)	(1.85)
Observations	148	95	148	95
Adjusted R-squared	-0.002	-0.009	0.078	0.146

Note: Standard errors in parentheses. The unit of analysis is the police precinct.
*** p<0.01, ** p<0.05, * p<0.1

In summary, supplemental intake data collected from the TCC show that TCC use is low, with a median of 12.7 survivor cases per month per TCC across the evaluation period. Both the full and reduced samples of control and treatment precincts were balanced at baseline on the dependent variable as well as relevant control variables. Regression analyses using difference-in-difference show no impact of the community dialogues or service provider training on TCC use. Statistically significant explanatory variables for TCC use include population size, rate of sexual offences, and rate of murders. There is also some indication that TCC capacity influences utilization; however, the effect of various measures of TCC capacity, such as staffing, after-hours operation, facilities, and supplies, is not consistent across the models and should be interpreted carefully.

3.5 IMPACT OF COMMUNITY DIALOGUES ON COMMUNITY KNOWLEDGE AND ATTITUDES

Women's survey data was collected at households within the selected communities near each TCC to measure women's knowledge of TCCs and SGBV, and attitudes toward SGBV. The women's survey was administered to a cross-section of 1,500 women across Treatment 1 (community dialogue) and control police precincts in all nine provinces in South Africa before and after community dialogues, which were implemented by Sonke and Soul City. The evaluation tests whether communities that received outreach efforts realized a positive change in knowledge and attitudes *vis a vis* the control communities. Table 8 shows the distribution of women's survey respondents by province.

Table 8: Number of women's survey respondents by province

Province	Frequency	Percentage	Cumulative
Eastern Cape	480	16	30
Free State	240	8	38
Gauteng	420	14	14
Kwa-Zulu Natal	420	14	52
Limpopo	300	10	62
Mpumalanga	300	10	72
North West	270	9	81
Northern Cape	270	9	90
Western Cape	300	10	100
Total	**3,000**	**100%**	**100%**

Note: Including both baseline and endline. The sample is not intended to make national or provincial generalizations.

3.5.1 Balance statistics

In randomized samples of individuals, people are randomly selected into control and treatment groups such that—provided a large enough sample size—any differences observed between the two groups would be a product of random chance. However, because random assignment was at the precinct level and since there were only a limited number of precincts, there was a risk that sampled Treatment 1 and control groups would be systematically different from one another on key characteristics. Fortunately, the balance statistics of the final sample confirm that the selection and random assignment process was successful in creating 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. The results are presented in Table 9. While several small but statistically significant differences were observed between the treatment and control groups in the baseline sample, the treatment and control groups were statistically equivalent on all demographic variables in the endline sample.

Table 9: Balance statistics between endline Treatment 1 and control samples (n=1,500)

Variable	Treatment (%)	Control (%)	p-value
Age	33	33	0.815
Black	86	85	0.509
Coloured	11	11	0.805
Zulu	19	19	0.793
Xhosa	19	19	0.895
Tswana	16	15	0.667
Afrikaans	12	12	0.937
Other language	33	35	0.355
Less than elementary education	1	1	0.615
Elementary	23	22	0.757
Secondary	67	67	0.826
Higher than secondary	9	10	0.541
Monthly income less than or equal to 1,000 R	8	9	0.712
Monthly income between 1,000-5,000	61	59	0.399
Monthly income higher than 5,000	31	32	0.541

The sample of women surveyed for this IE should not be considered representative of all women in South Africa, but rather 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), and as such, are not the targeted beneficiaries of the TCCs. The demographic characteristics of the endline sample are shown in Figure 13. On average, women in the endline sample were 32.5 years old, identified themselves as black, had attained a secondary education, and reported a household income of 1,001 to 5,000 Rand ($66 to $329 USD) per month.

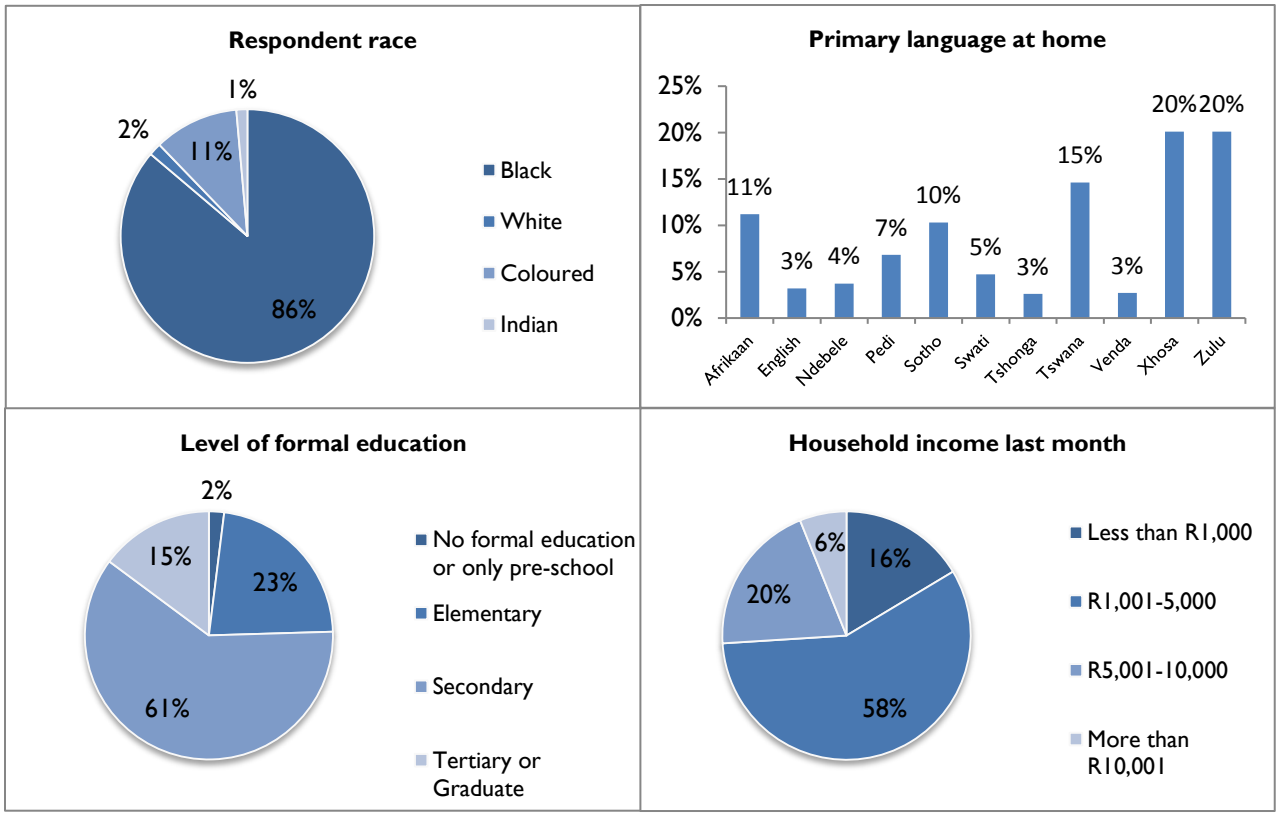

Figure 13: Endline respondent demographics (n=1,500)

3.5.2 Knowledge of TCCs and other services in the community to victims of sexual assault

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. At baseline, only 18 percent of respondents reported knowledge of the TCC.

At the beginning of each baseline and endline survey, respondents were asked to identify services to victims of sexual assault in their communities, and their providers. At baseline, 21 percent of respondents said there are services to victims of sexual assault in their communities, compared to 20 percent at endline. Those respondents who reported knowledge of such services were then asked to identify the service providers without being prompted. Most respondents were not able to identify a provider, and few mentioned the TCC, although more respondents mentioned the TCC at endline compared with baseline. As shown in Figure 14, there were no meaningful differences in service provider identification between the treatment and control areas.

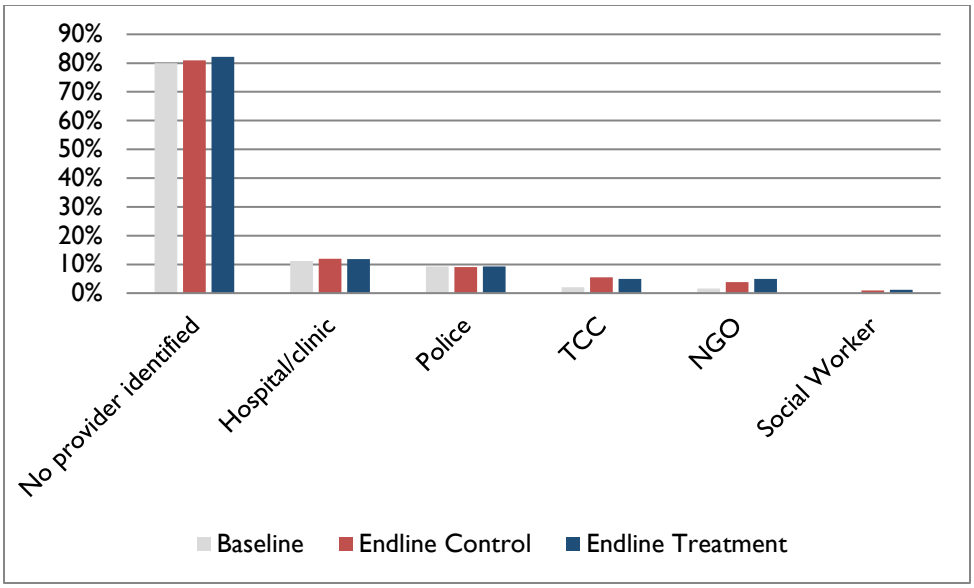

Figure 14: Identification of service providers to victims of sexual assault (n=302 at baseline and 279 at endline)

The respondents who reported knowledge of services for SGBV survivors were also asked to identify the types of support provided in the community to victims of sexual assault. At endline, the share of respondents in the treatment group who knew of medical services was 14 percent, emotional/ psychological services was 12 percent, and legal services was eight percent. The treatment group was no more knowledgeable than the control group with regards to services provided in the community.

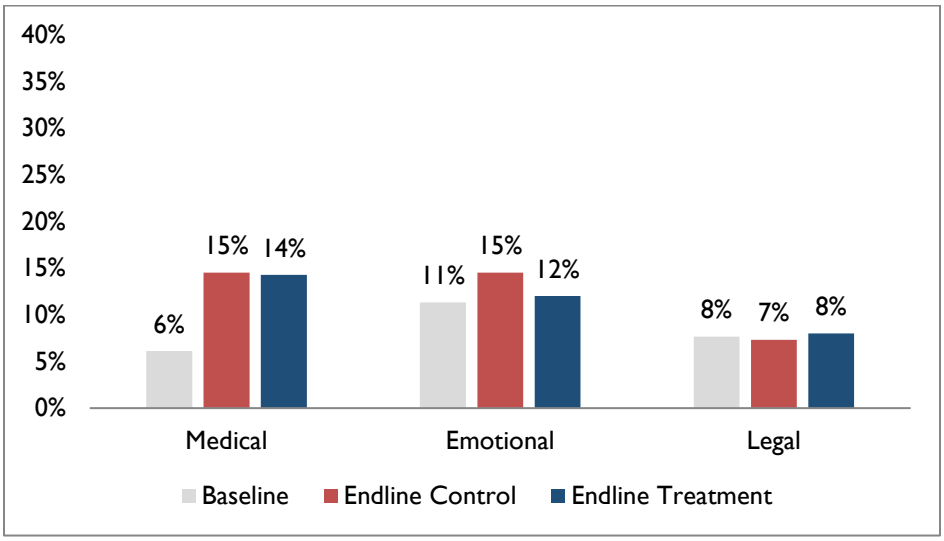

Figure 15: Type of support services provided in the community (n=301 at baseline and 277 at endline)

When women were asked where they would go first to report a sexual assault, less than one percent said they would first report a sexual assault to a TCC and more than 70 percent at endline cited the police as the first point of reporting. Qualitative data reveal that most victims brought to the TCCs are brought by the police. As such, reporting to the police should result in the survivor ultimately arriving at the TCC for services; however, as we know, many survivors do not report SGBV to the police.

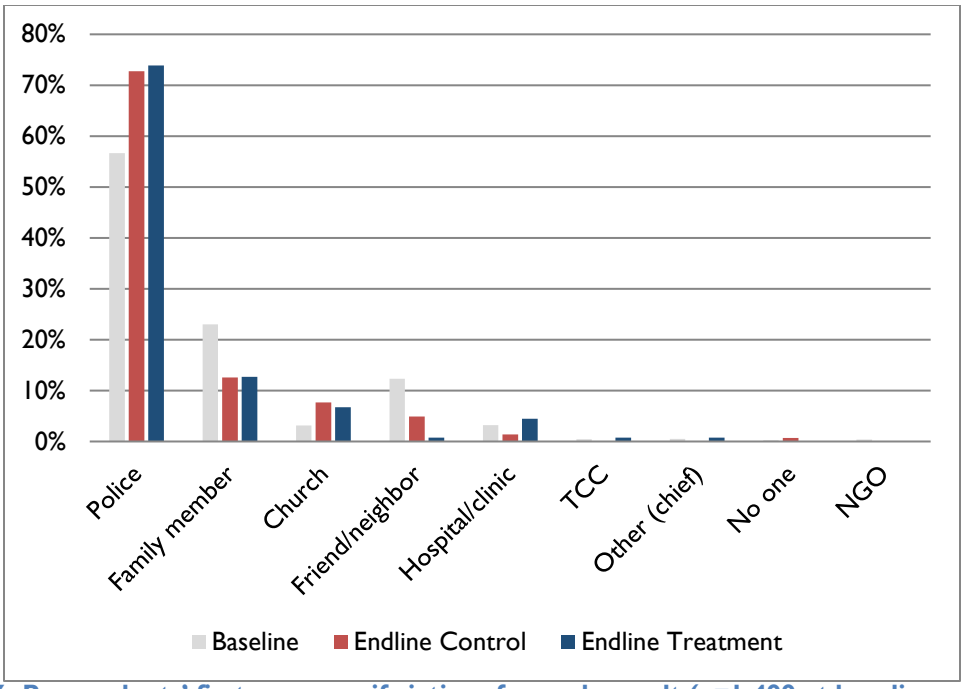

Figure 16: Respondents' first response if victim of sexual assault (n=1,499 at baseline and 277 at endline)[26]

As shown in Table 10, knowledge of TCCs is relatively low, with between 16 percent and 19 percent of respondents reporting awareness of the TCCs across condition groups and time. Simple bivariate regression analysis using a difference-in-difference model was conducted to measure changes in knowledge of TCCs and resources available to survivors of SGBV in treatment and control communities from baseline to endline. At endline, levels of knowledge of TCCs in sampled communities is statistically similar to baseline (p=0.606), indicating no positive general time trend in awareness of TCCs or services available to survivors of SGBV across these communities over the evaluation period. Moreover, knowledge levels between treatment and control communities are also statistically equivalent at endline within both models: using a first difference (p=0.840) and difference-in-difference (p=0.903) regression model, indicating the absence of a positive treatment effect of the community dialogues on knowledge of TCCs or services to survivors of SGBV. Summarized results are presented in Table 10. Treatment effects from regression results are presented as odds ratios.[27] All odds ratios are at or near one, indicating no treatment effect.

[26] At endline, this question was only administered to those who answered "yes" *to "are there services available in your community for victims of sexual assault?",* thus, the large discrepancy in sample size and in results.

[27] Odds ratios are another way to interpret the coefficients of a logistic regression; odds are defined as the ratio of the probability of success and the probability of failure. For example, an odds ratio greater than 1 indicates that the odds are more likely that the treatment had a positive effect on a given outcome, whereas an odds ratio less than 1indicates that the treatment likely had a negative effect on a given outcome.

Table 10: Respondent has heard of the TCC (n=1,500 at baseline and endline)

	Treatment		Control		Diff-in-diff	Treatment effect*	p-value
	Baseline	Endline	Baseline	Endline			
Has heard of the Thuthuzela Care Center (TCC)	17%	16%	19%	17%	1pp	1.03	0.903
Has heard of a place like the TCC in the community	2%	3%	5%	4%	2pp	1.16	0.542
Knows of services available in her community for survivors of GBV	20%	20%	22%	21%	1pp	0.96	0.882
Knows of care centers run by NGOs	20%	17%	21%	17%	1pp	1.09	0.874

* Odds Ratio

The sample was not designed to be representative at the province level; but it is possible that the effects of the intervention vary geographically. Province-disaggregated regression analyses suggest variation in treatment effects across provinces; however, the observed differences are generally statistically insignificant. Women surveyed in treatment communities in North West, for example, were 2.08 times as likely to have heard of the TCC than women surveyed in control communities at endline; however, this relationship is statistically insignificant (see Table 11). Conversely, women in treatment communities in Western Cape were significantly less likely (OR=.33) to have heard of the TCC than women in control communities at endline (p=.065).[28]

Table 11: Knowledge of TCCs by province (n=1,500 at baseline and endline)

		Treatment		Control		Diff-in-diff	Treatment effect+	p-value
Province	n	Baseline	Endline	Baseline	Endline			
Gauteng	210	2%	3%	2%	5%	-2pp	0.56	0.675
Eastern Cape	240	34%	23%	41%	21%	8pp	1.35	0.514
Free State	120	37%	13%	33%	12%	-2pp	1.09	0.890
Kwa-Zulu Natal	210	10%	24%	6%	31%	-11pp	0.42	0.336
Limpopo	150	15%	32%	9%	19%	8pp	0.83	0.860
Mpumalanga	150	8%	8%	7%	5%	1pp	1.16	0.865
North West	135	20%	19%	25%	17%	7pp	2.08	0.269
Northern Cape	135	20%	12%	24%	15%	1pp	1.54	0.476
Western Cape	150	13%	8%	23%	24%	-7pp	0.33	0.065*

+ Odds Ratio

Figure 17 shows logistic regression results for the effect of the community dialogues on knowledge of TCCs while controlling for province, demographic characteristics, measures of sexual assault prevalence, and other explanatory outcome variables. Each variable in the figure has a dot that indicates the estimated effect of the independent variable on the odds (technically the logged odds) of knowing of a TCC. The blue line surrounding the dot indicates the confidence interval, which considers random error in the data.

[28] One potential explanation for the considerable variation across provinces is that Thuthuzela is a Xhosa word, which would be most familiar in Xhosa speaking areas such as the Eastern Cape.

If the blue line overlaps the red line for a particular variable, this means that we cannot reasonably rule out the chance that there is no relationship between the variable and knowledge of the TCC. When the blue line does not overlap the red line, then we are reasonably confident that a relationship exists. The x-axis of the figure is an odds ratio. When the odds ratio equals one then a change in the value of independent variable is not expected to produce a change in the odds of knowing a TCC. With the value rises to a two it means that a change in the value of the independent variables produces a doubling of the odds of knowing a TCC. An odds ratio of less than one implies a negative relationship. Figure 17 confirms the finding above, that treatment is not a significant predictor of familiarity with the TCCs.

While the sample is not intended to be representative at the provincial level, province is the strongest and most significant predictor of familiarity with the TCCs; however, we have opted not to include province in the figure because the effect sizes are so large. As shown in Table 11, knowledge of the TCCs was lowest among respondents in Gauteng. Sampled women in Eastern Cape were 17.1 times more likely to know of the TCC than women in Gauteng. Those in Limpopo were 7.7 times more likely, those in Free State were 7.2 times as likely, Northern Cape 6.5 times more likely, Western Cape 5.9 times more likely, North West 5.3 times more likely, Kwa-Zulu Natal 4.5 times more likely, and Mpumalanga, 2.6 times more likely than women in Gauteng to know of the TCC.

Sexual assault prevalence and perceptions of sexual assault as a problem also significantly predict knowledge of the TCC. Women residing in precincts with higher rates of sexual assault crimes are 1.3 times more likely to know of the TCC ($p=.017$). Similarly, women who reported knowing someone who has been raped or sexually assaulted were 4.8 times more likely to know of the TCC ($p<.001$), and women who perceived SGBV as a problem in their communities were 1.1 times more likely to know of the TCC ($p=.089$).

Women with low tolerance for violence toward women were also slightly more likely to know of the TCC ($p=.023$). Several demographic variables were statistically significant predictors of knowledge of the TCC: age ($p<0.05$), education ($p<0.001$), income ($p<0.05$), and primary language ($p<0.01$). Women who are older, have a secondary level of education or above, and have higher household income are more likely to have heard of the TCC. At baseline, knowledge of TCCs was also significantly associated with age ($p<.01$), income ($p<.05$), and primary language ($p<0.001$), again with older and higher-income respondents being more likely to know of the TCCs. Education was statistically significant at baseline only at the 10 percent level, with a p-value of 0.095. Full regression tables are included in Annex VI.

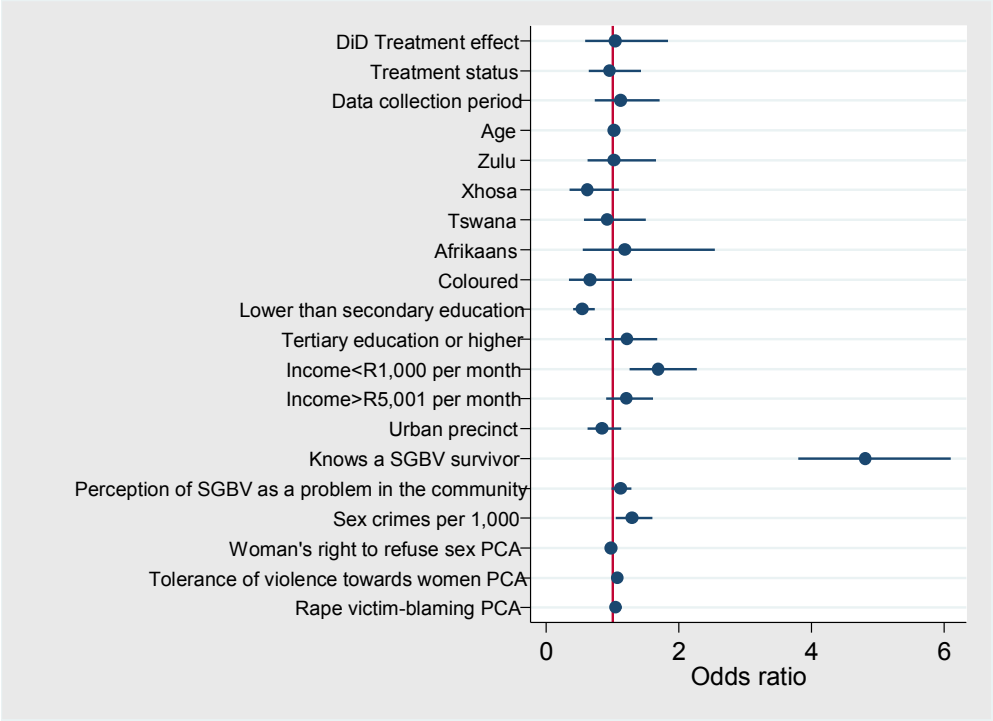

Figure 17: Logistic regression results for effect of Treatment 1 on knowledge of TCCs (n=2,950)

The 294 (16.5 percent) endline respondents who did report knowledge of TCCs or knowledge of a similar place in their communities 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 (88 percent) and the location of the nearest TCC (93 percent). Two follow-up questions were asked to assess possible response bias on these two items. The first question asked respondents to name the location of the nearest TCC: 258 out of 260 respondents who reported knowing the location of the nearest TCC were able to provide a specific location when asked, and 198 (76 percent) of these responses were correct. Figure 18 shows that there is no significant treatment effect across knowledge of services nor knowledge of location in Treatment 1 communities as compared to control communities.

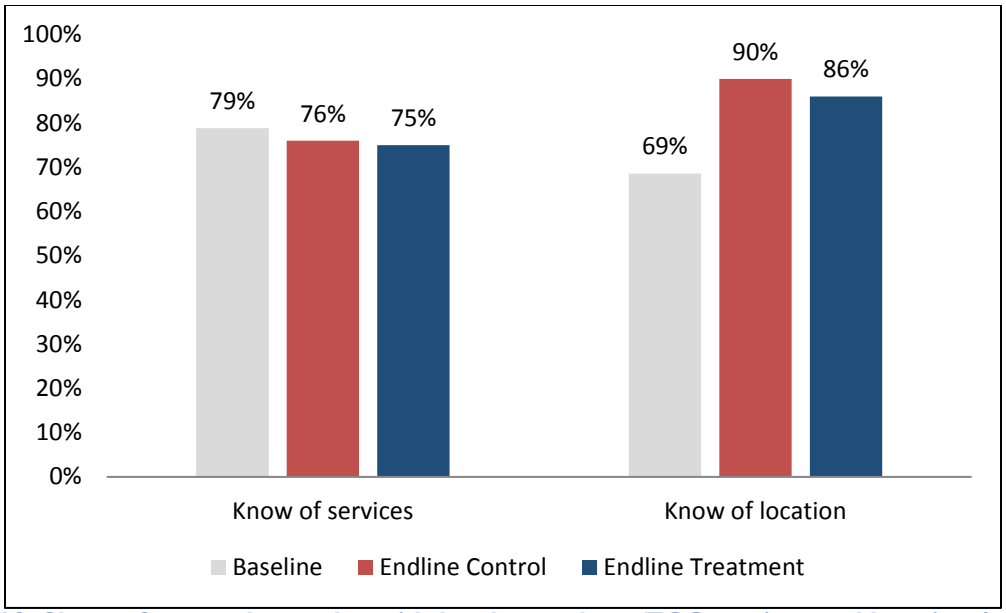

Figure 18: Share of respondents who said they know about TCC services and location (n=312 at baseline and 294 at endline)

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 and psychological services, and the vast majority reported knowledge of provision of legal services (Table 12). Few respondents reported knowledge of transportation services, both at baseline and at endline, though this did increase statistically significantly at endline (p=.069). 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 12: Knowledge of TCC services (n=244 at baseline and 223 at endline)

		Treatment Yes (%)		Control Yes (%)		
Knowledge of TCC services	**Correct response**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Diff-in-diff**
Transportation	Yes	7%	41%	13%	30%	17pp*
Medical assistance	Yes	98%	99%	100%	97%	3pp
Psychological and counseling service	Yes	99%	99%	100%	98%	2pp
Legal assistance	Yes	82%	88%	78%	91%	-8pp

Important misperceptions about the TCCs remained at endline; 87 percent of treatment respondents who claimed familiarity with TCCs or a similar place in their community incorrectly answered that clients visiting the TCC must report the name of her/his attacker, and 93 percent incorrectly believed that the TCC requires her/him to take legal action. These misperceptions are likely to dissuade victims from utilizing TCC services. Unfortunately, the intervention does not appear to have reduced these misperceptions (See Table 13). At endline, there had been minimal reductions in these misperceptions in the treatment communities, and respondents in treatment areas were actually less likely to know that people under the age of 18 are eligible to receive help from the TCC.

Table 13: Specific TCC knowledge (n=292 at baseline and 282 at endline)

	Treatment Agree (%)		Control Agree (%)		
	Baseline	Endline	Baseline	Endline	Diff-in-diff
A man can receive help from the TCC	84%	88%	82%	89%	-3pp
A child can receive help from the TCC	90%	57%	86%	52%	1pp
Clients do not have to pay for TCC services	96%	92%	98%	89%	5pp
Clients are not required to report the name of the attacker	23%	13%	20%	19%	-9pp
It is possible to file a police report at the TCC	77%	91%	80%	90%	4pp
The TCC does not require you to take legal action	12%	7%	14%	9%	0pp

To measure community awareness of TCCs, respondents in the subsample (those who have heard of the TCCs) were asked their perception of community knowledge of TCCs. As shown in Figure 19, few believe that most or all women are aware of these services. At endline, 87 percent of treatment respondents, and 88 percent of control respondents, believe that none or a few women know about the TCC.

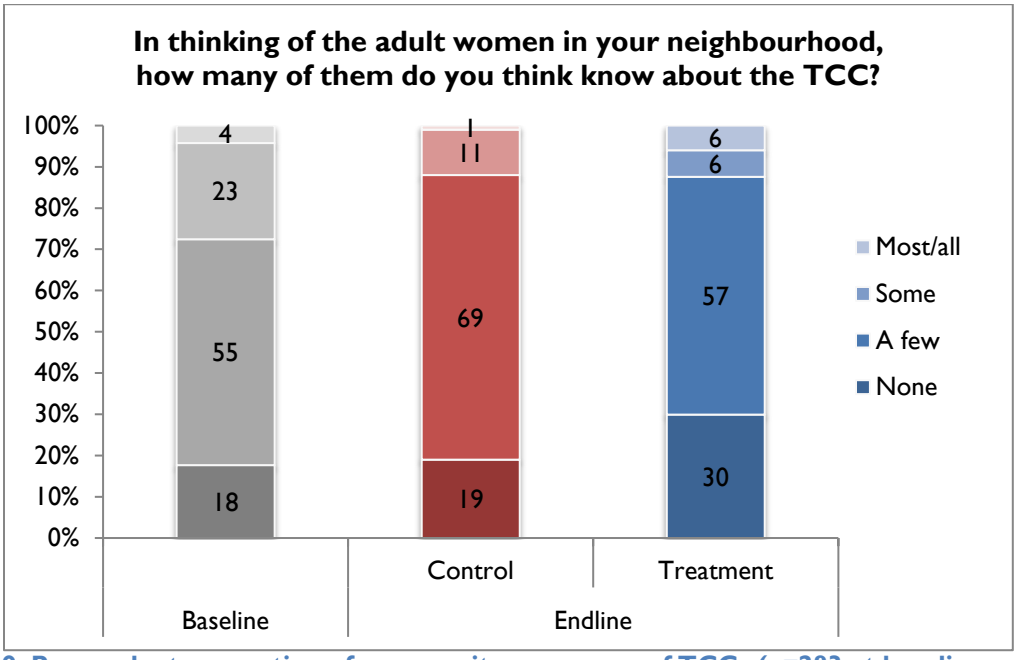

Figure 19: Respondent perception of community awareness of TCCs (n=283 at baseline and 194 at endline)

It was hypothesized that, through community dialogues, knowledge of the TCCs would spread throughout the community. As presented in findings throughout this section, women in treatment precincts generally did not have higher levels of knowledge about the TCCs after the community dialogues than women in control precincts. Thus, we are not able to reject the null hypothesis that the dialogues had no effect on women's knowledge in communities.

One possible explanation for these null findings is that the community dialogues did not reach enough women in the treatment precincts. Two survey questions were asked to estimate the programming's reach, and the results provided supporting evidence to this hypothesis. When asked whether in the past three months they had heard any announcements about sexual assault awareness or about resources

available to victims of sexual assault, respondents were no more likely to report having heard these messages at endline than baseline (see Figure 20), and those in the treatment group were no more likely to report awareness than those in the control group. Messages conveyed in the dialogues appear to not have spread widely enough in communities to have a meaningful impact on community knowledge. This finding has important policy implications. Even if Treatment 1 was very effective in increasing knowledge for dialogue attendees, we do not find evidence that such an approach is adequate in reaching the larger population and increasing community knowledge about TCCs.

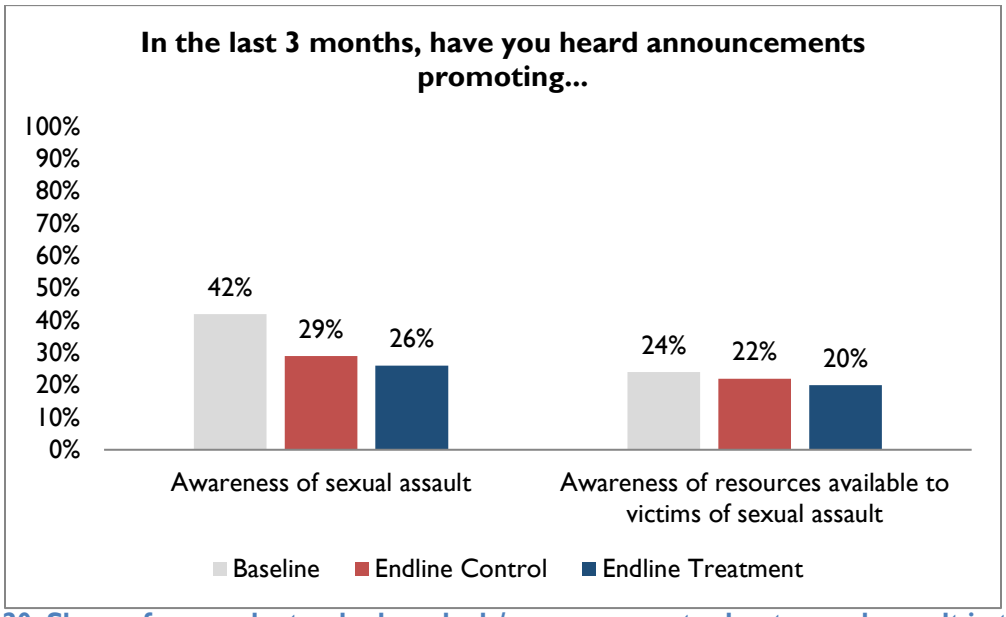

Figure 20: Share of respondents who heard ads/announcements about sexual assault in the last three months (n=1,495 at baseline and 1,498 at endline)

3.5.3 Perceptions of sexual assault and sexual assault reporting

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. Both at baseline and at endline, respondents were more inclined to report house-breaking or mugging as problems than sexual assault or domestic violence, even though sexual assault might be more prevalent (see Figure 21). According to SAPS crime statistics there were 53,439 instances of reported common robbery in South Africa in 2013 compared with 66,197 instances of reported sexual assault.[29] While both are likely to be underreported, the baseline findings suggested that it was necessary to continue to raise awareness about the extent and gravity of the problem of sexual assault. As expected, 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."

[29] South African Police Service (2014) Crime Situation in South Africa. http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2014/crime_stats.php

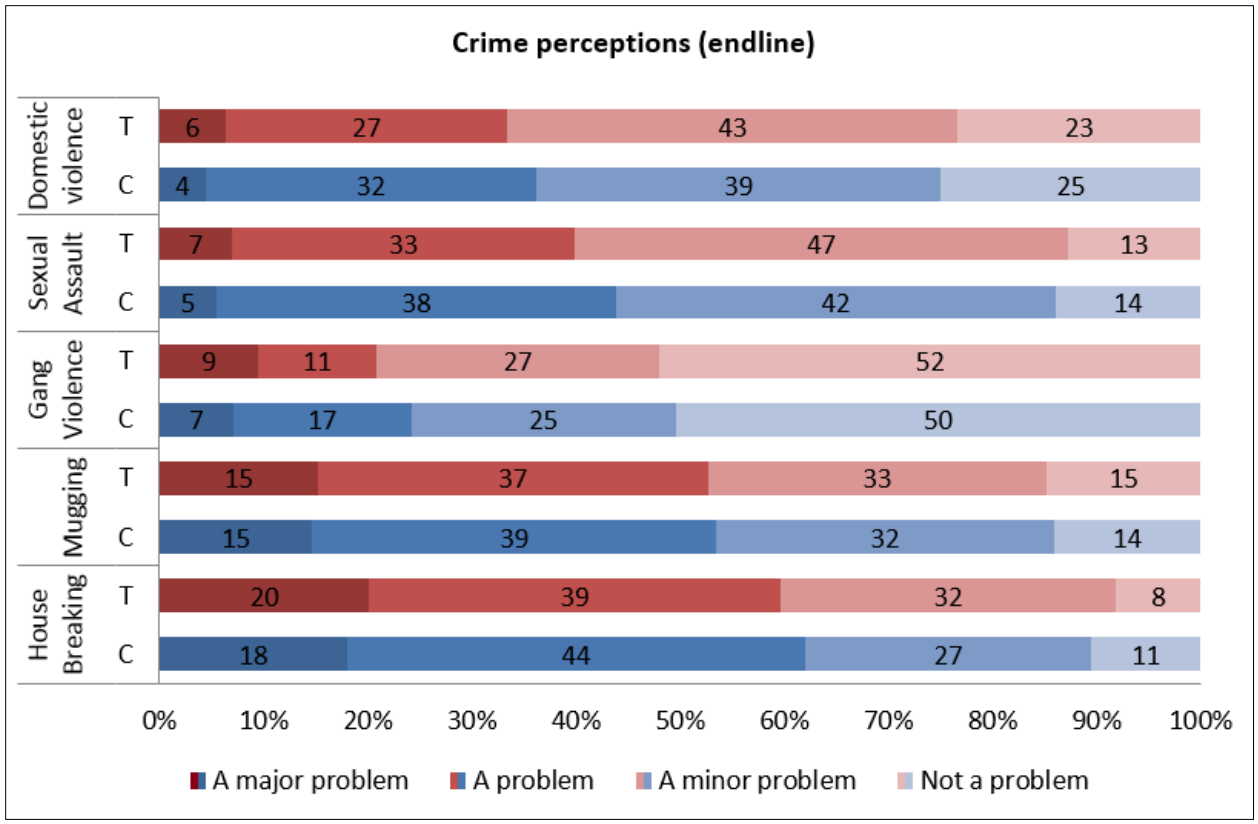

Figure 21: Respondent perception of crime problems at endline (n=1,500)

At endline, despite over half of respondents ranking sexual assault as "not a problem" or "a minor problem," 17 percent of respondents report personally knowing women or girls who have been raped or sexually assaulted in the last year, and 22 percent report personally knowing a woman or girl who has been raped or sexually assaulted in her lifetime (see Figure 22). On average, this sub-sample of respondents reported knowing 2 women or girls who had been assaulted in the last year, 2.7 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. Noting the decline in reporting over time we opted to examine this data further using logistic regression. The results (not presented here in full detail) show that across both treatment and control precincts, women were less likely to report knowing a victim of SGBV at endline, which is statistically significant across all three categories, indicating a possible decrease in incidents over the evaluation period. However, the difference-in-difference model finds no statistically significant effects in Treatment 1 precincts when compared with control precincts, indicating that this decrease cannot be attributed to the community dialogues.

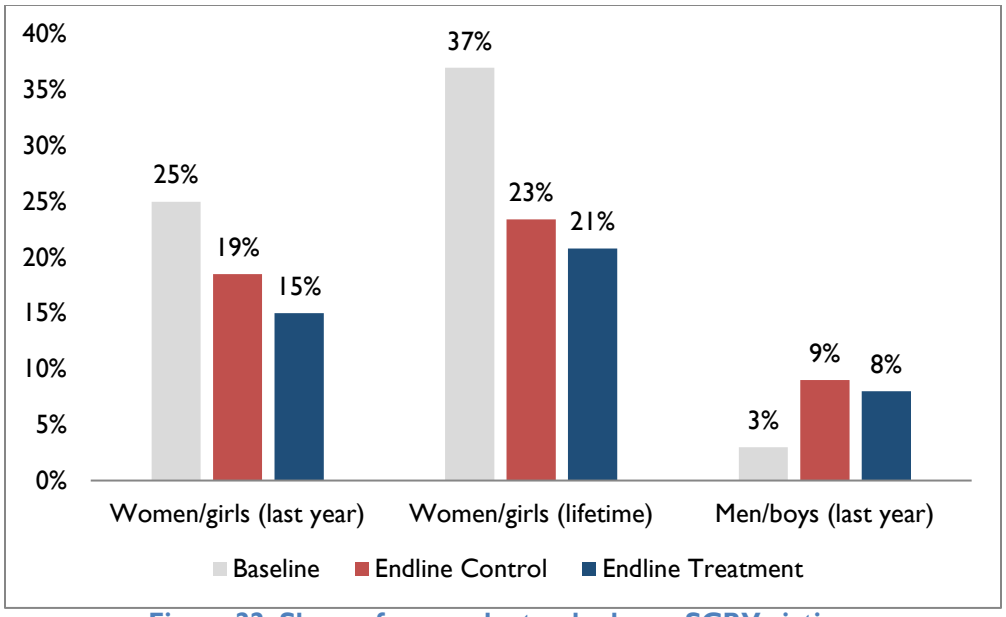

Figure 22: Share of respondents who know SGBV victims

Respondents in the subsample familiar with TCCs or similar places in their communities were asked how many women, men, girls, and boys they know personally who have visited a TCC. Results are presented in Table 14 and show that these respondents reported the highest rate of TCC use among girls under the age of 18. Endline respondents were less likely to know SGBV victims who have visited a TCC, irrespective of the victims' age, although this trend is observed both in treatment and control areas.

Table 14: Number of SGBV survivors the respondent knows who have visited a TCC (n=283 at baseline and 194 at endline)

How many... do you personally know that have visited a TCC?	Treatment (mean)		Control (mean)		
	Baseline	Endline	Baseline	Endline	Diff-in-diff
Women 18 and older	1.32	0.14	1.19	0.18	-0.16
Men 18 and older	0.15	0.01	0.15	0.00	0.01
Girls 18 and under	1.65	0.16	1.39	0.13	-0.23
Boys 18 and under	0.80	0.01	0.56	0.02	-0.25

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. At baseline, nearly three quarters of respondents reported that (lack of) awareness of the TCCs was a major barrier to visiting TCCs, which was the most common barrier reported. These results made clear the need for greater outreach to the communities about the TCCs and their services. At endline, a lack of awareness was still cited as the greatest barrier to visiting TCCs, with three quarters of respondents reporting it as such (see Figure 23). The second most prominent barrier was fear of punishment by the perpetrator, followed by the offer of money not to report the sexual assault.

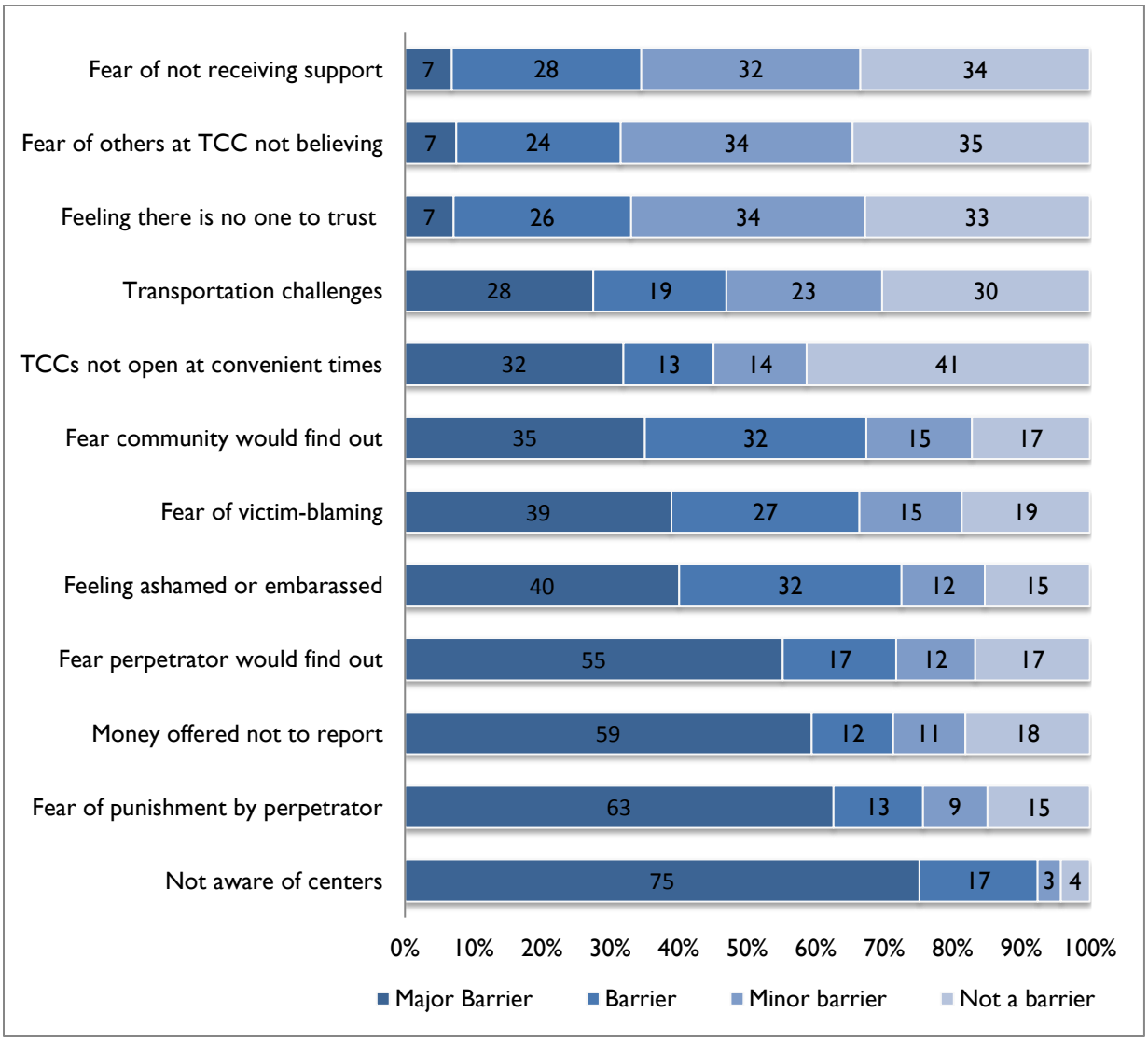

Figure 23: Respondent perceptions of barriers to visiting the TCCs (n=1,500)

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. At baseline, respondents reported fear of punishment by the perpetrator and a fear that the perpetrator would find out as the most significant barriers. At endline, fear of punishment by the perpetrator and money offered not to report were identified as the most serious barriers. Comparing the two figures reveals both the strengths and limitations of the TCC vis-à-vis the police. Fear that that they will not be supported, not be believed, or will not have anyone to trust is higher when asked about the police than when asked about the TCCs. Nonetheless, respondents reported similar level of fear that the community will find out about the assault or that the perpetrator will find out the assault was reported.

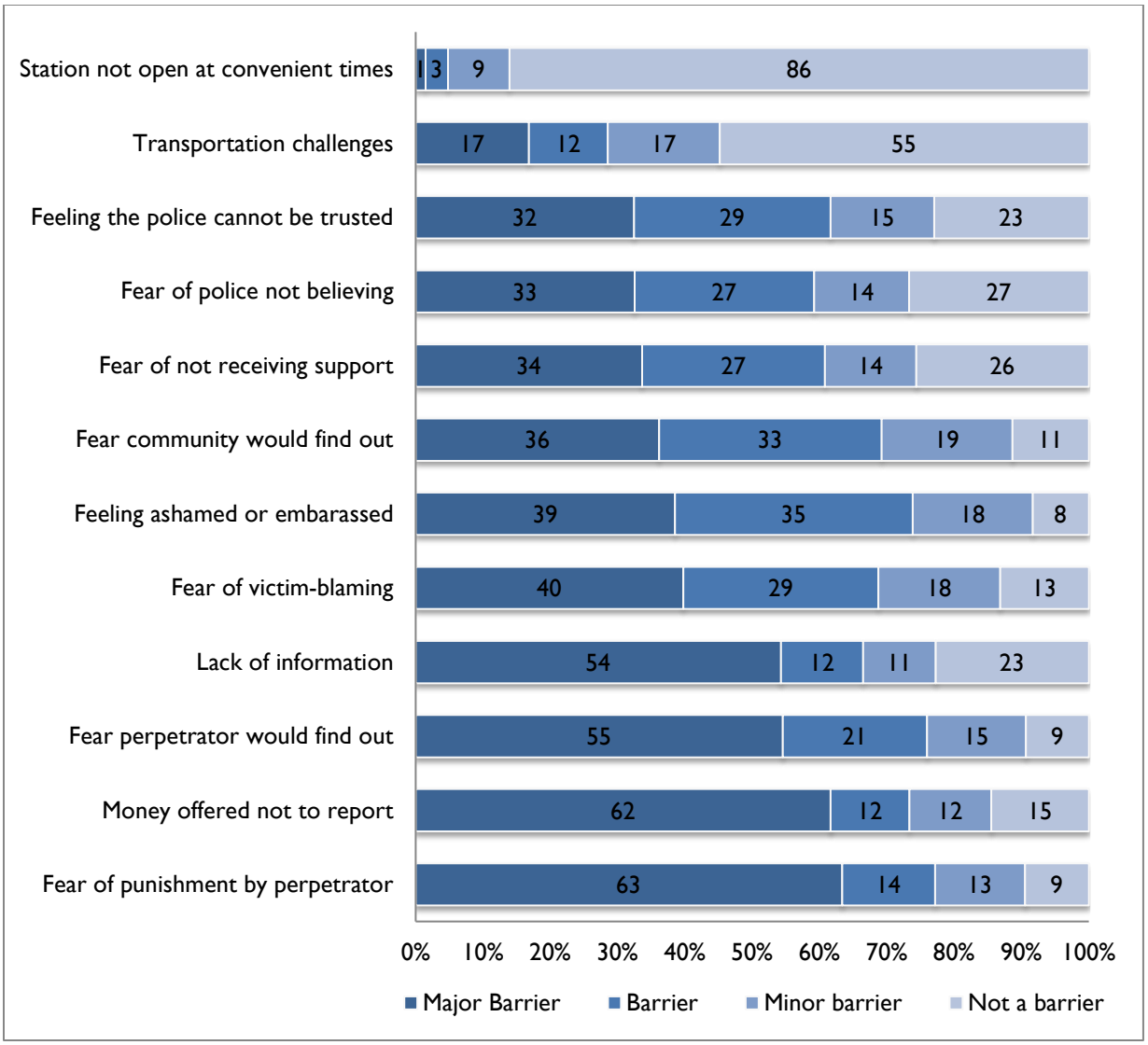

Figure 24: Respondent perceptions of barriers to reporting to the police at endline (n=1,499)

3.5.4 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 showed 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. Changes in observed attitudes between baseline and endline are show in Table 15. None of the observed difference in difference comparisons were statistically significant.

Table 15: Percentage of respondents indicating agreement with gender statements (n=1,500 at baseline and endline)

Gender Attitudes	Treatment		Control		Diff-in-diff	Desired & Observed Change
	Baseline	Endline	Baseline	Endline		
Rights for women mean that men lose out.	4.9	5.1	6.2	3.5	2.9	↓↑
There are times when a woman deserves to be beaten.	4	2.1	3.9	2.1	-0.1	↓↓
A man should have the final word about decisions in his home.	18.6	10	16.5	10.3	-2.4	↓↓
A woman should tolerate violence in order to keep her family together.	9.4	5.7	6.1	4.9	-2.5	↓↓
A man and a woman should decide together what type of contraceptive to use.	48	33	45.1	32.7	-2.6	↑↓
If a man sexually assaults his wife, others outside of the family should intervene.	70.2	64.3	72.1	61.6	4.6	↑↑
A man can hit a woman if…						
She does not complete her housework to his satisfaction.	0.9	0.1	0.7	0.3	-0.4	↓↓
She disobeys him.	4.6	2.8	2.3	3.5	-3	↓↓
She refuses to have sexual relations with him.	1.9	0.9	1.6	1.9	-1.3	↓↓
He suspects that she is unfaithful.	1.9	0.7	0.8	1.1	-1.5	↓↓
He finds out that she has been unfaithful.	9	4.8	5.1	5.9	-5	↓↓
A woman can refuse sex to her husband if…						
She doesn't want to.	55.2	81.6	60.3	85.5	1.2	↑↑
He is drunk.	65.3	87.2	67.4	90.1	-0.8	↑↓
She is sick.	75.4	96.1	76.9	96.1	1.5	↑↑
He mistreats her.	74.3	96.8	76.2	96.3	2.4	↑↑
When a woman is raped, she usually did something careless to put herself in that situation.	7.6	4.5	4.1	3.2	-2.2	↓↓
In some rape cases, women actually want it to happen.	6	5.7	4.7	4.8	-0.4	↓↓
If a woman doesn't physically fight back, you can't really say it was rape.	23.2	2.4	23.2	2.1	0.3	↓↑
In any rape case, one would have to question whether the victim sleeps around a lot or has a bad reputation.	28.3	32.6	28.3	28.8	3.8	↓↑

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 the respondent'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.*

At baseline, 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. As shown in Figure 25, respondents in the treatment group were no more likely to respond favorably to either of these scenarios.

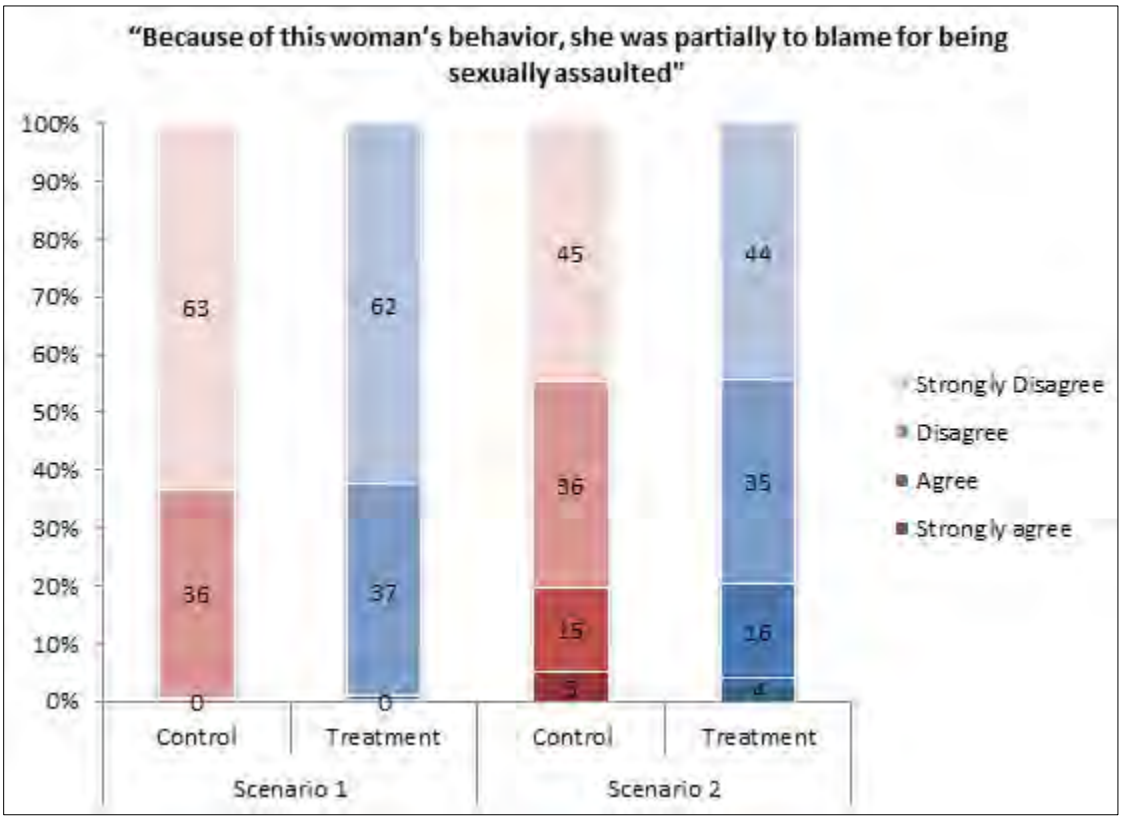

Figure 25: Prevalence of victim-blaming attitudes among respondents at endline, by scenario (n=1,500)

A SGBV attitudes index was constructed by combining responses from 21 survey items measuring attitudes toward gender roles, and the sexual assault scenarios, using Principal Component Analysis (PCA). A higher PCA score indicates progressive gender attitudes and lower tolerance of SGBV. We then conducted a multiple regression analysis to test whether the treatment produced higher PCA scores. Additional variables were added to the analysis to increase precision and better understand variation in SGBV attitudes. The DiD treatment effect variable provides a test of the effect of treatment. The estimate shows an improvement in attitudinal scores in the treatment group relative to the control group from

baseline to endline, although this relationship is not statistically significant (p=.235). As such, we cannot conclude that the intervention had an effect on attitudes in intervention communities.

Variables that are statistically significant and positively associated with more normatively desirable attitudes scores are: age (p=.002), Zulu (p=.002), higher income (p<.001), and knowing a woman or girl who has been raped or sexually assaulted (p<.001).

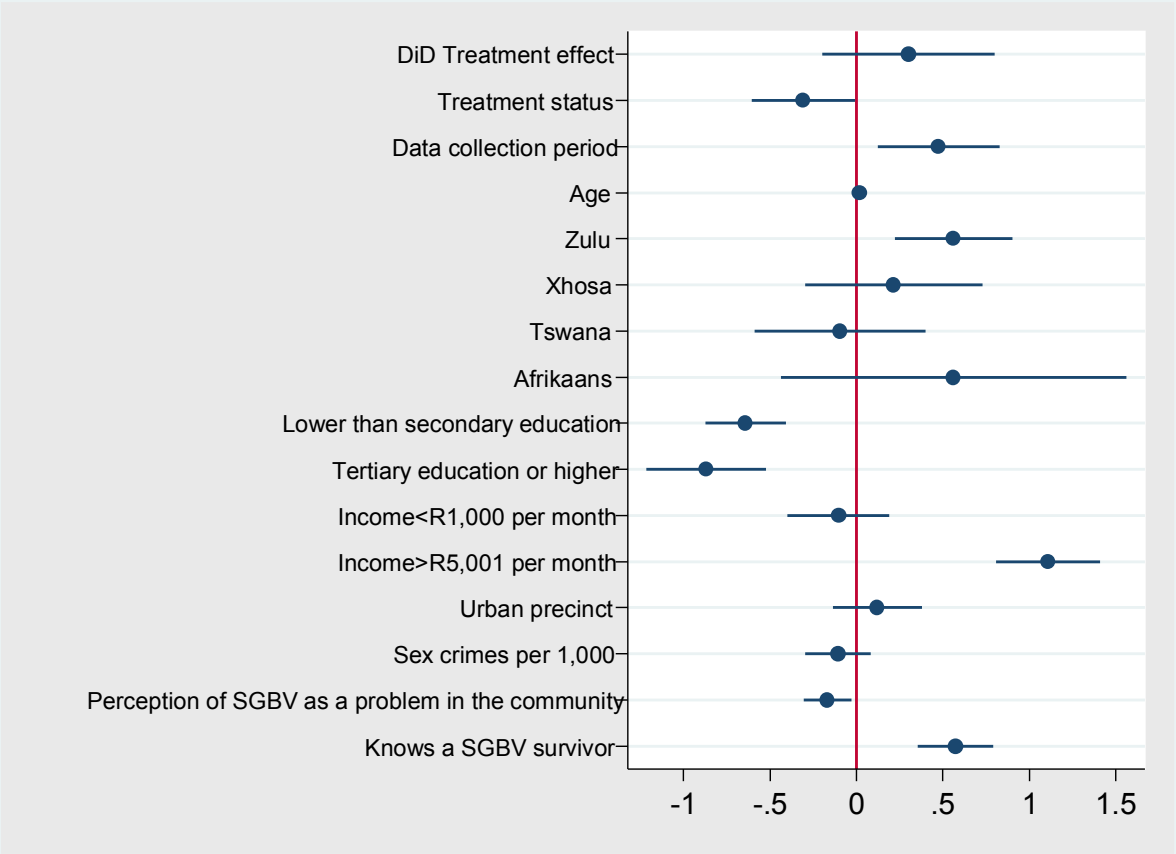

Figure 26. Regression results for impact of community dialogues on attitudes toward SGBV (n=2,931)

In summary, while the survey reveals that most respondents have normatively desirable attitudes toward gender roles and the sexual assault scenarios, some respondents still that engage in victim blaming and there is still evidence to suggest that social stigmas represent a barrier to TCC usage. Nonetheless, as with knowledge of TCCs above, there is no evidence that the intervention had an impact on community attitudes toward gender roles and sexual assault. As concluded above, even if Treatment 1 was very effective among those that attended the dialogues, such an approach is inadequate to reach the larger population and change community attitudes.

3.6 IMPACT OF TRAINING ON SERVICE PROVIDERS' KNOWLEDGE AND ATTITUDES

Pre- and post-training surveys were administered to service providers attending the FPD-led *Integrated Management of Sexual and Gender-Based Violence* (Integrated Management) training (Treatment 2). All training participants were requested to consent to and complete a brief, self-administered survey about their knowledge of TCCs and SGBV, perceptions, and recent practices with survivors of SGBV before the start of the first day of training. The evaluation team followed up with each service provider approximately three months later to test knowledge gains and changes in perceptions and practices with survivors of SGBV.

Table 16 shows the number of professionals attending the training in each province, the number of those professionals agreeing to participate in the evaluation at baseline, and the number reached for the follow-up survey at endline.[30] The data collection firm, IRI, attempted to reach each service provider surveyed at baseline for the follow-up survey. In total, eight attempts were made to reach a respondent for the endline survey. The following data analysis is conducted on the sub-sample of attendees for whom both a baseline and an endline survey were collected, yielding a sample size of 1,347 respondents, which represents 71 percent of the trained professionals.

Table 16: Number of professionals trained, surveyed at baseline and at endline

Province	# Trained	# Surveyed at baseline	% Trainees Surveyed at baseline	# Surveyed at endline	% Trainees Surveyed at endline
Eastern Cape	377	356	94%	228	60%
Free State	155	148	95%	112	72%
Gauteng	222	212	95%	145	65%
Kwa-Zulu Natal*	276	245	89%	251	91%
Limpopo	253	233	92%	155	61%
Mpumalanga	138	138	100%	120	87%
North West	226	214	95%	165	73%
Northern Cape	118	104	88%	78	66%
Western Cape	143	139	97%	93	65%
Total	**1,908**	**1,789**	**94%**	**1,347**	**71%**

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

As envisioned in the training curriculum, trainees represented a variety of professions, with the majority being NGO workers, social workers, police officers and health workers. Figure 27 shows the share of respondents by professions for those who were interviewed at baseline and endline (n=1,308). Of those attending the training, 36 percent reported having previously attended a training on sexual assault (out of n=1,321).

[30] Ninety-four percent of trainees consented to participate in the baseline survey; however, respondents often skipped questions on the self-administered baseline survey. As such, sample sizes vary somewhat from question to question, although for the majority of questions, data is not missing for more than 10% of respondents.

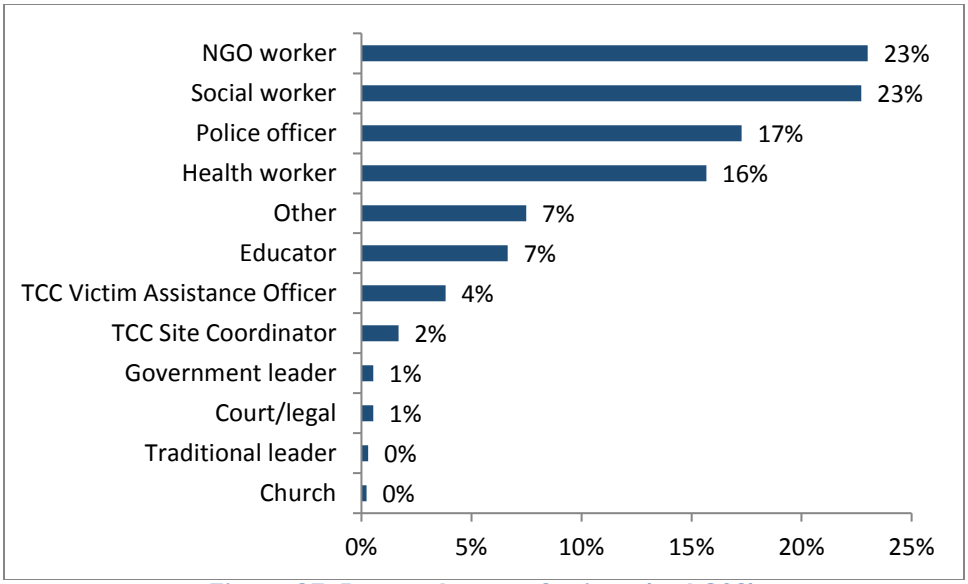

Figure 27: Respondent professions (n=1,308)

Three quarters of respondents in the sample who reported their sex (n=1,326) were female. Respondent ages are presented in Figure 28. The majority of respondents were under 40 years old.

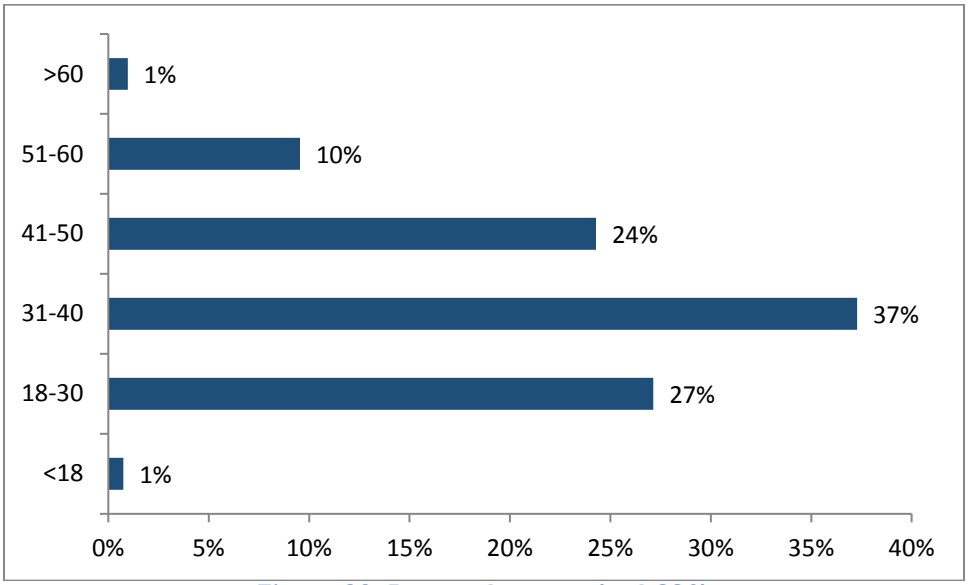

Figure 28: Respondent age (n=1,330)

3.6.1 Knowledge of TCCs

Respondents were asked a series of questions to test their knowledge of TCCs. Respondents were fairly knowledgeable about the TCCs at baseline, with 80 percent knowing of services for SGBV survivors. This is perhaps reflective of the fact that participants self-selected to participate in the training, ostensibly because of an interest in the issue. At endline, service providers were statistically significantly more likely to report knowing what services were available for survivors of SGBV in their communities, the services provided by the TCCs, and the location of TCCs (see Table 17).

Table 17: Knowledge of TCCs (n=1,347)

Respondents reporting…	Baseline (%)	Endline (%)	pp difference	significant at 95%
Services are available in my community for survivors of SGBV	80	89	9	*
I know what services the TCCs offer	81	99	18	*
I know the location of the TCC	78	98	20	*

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 at baseline (Table 18). Before the training, just over half of respondents correctly identified that TCCs provide medical assistance, while 77 percent correctly noted that TCCs provide psychological and counseling services. Notably, only 38 percent 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 for the TCCs via the police.

After the training, the percentage of respondents who knew that these services are provided increased dramatically, with nearly all reporting that TCCs offer medical assistance, counseling, and legal assistance. It should be noted however, that almost half still did not answer correctly when asked if the TCCs provide transportation services. Improvements on each of these items is statistically significant at the 95 percent confidence level.

Table 18: Knowledge of TCC services (n=1,347)

Knowledge of TCC services	Correct response
Transportation	Yes
Medical assistance	Yes
Psychological and counseling	Yes
Legal assistance	Yes

Table 19 shows responses to additional questions about TCCs before and after the training. Knowledge of these items also increased significantly from baseline to endline. After training, 99 percent of trainees were aware that men and those under the age of 18 can receive help from the TCC, and 95 percent knew that TCC services are free. Although respondents became better informed regarding these questions, 34 percent still believe that TCC clients are required to report the name of the attacker and 46 percent believe that TCC clients are required to take legal action.

Table 19: Knowledge of more specific TCC services (n=1,280 at baseline and 1,346 at endline)

Survey question	% responding correctly at baseline	% responding correctly at endline	PP difference	significant at 5%
A man can receive help from the TCC	88	99	11	*
A child can receive help from the TCC	89	99	10	*
Clients do not have to pay for TCC services	72	95	23	*
Clients are not required to report the name of the attacker	28	66	38	*
It is possible to file a police report at the TCC	49	82	33	*
The TCC does not require you to take legal action	27	54	27	*

Respondents were also asked to report how widely known TCCs are at their workplace. As shown in Figure 29, responses to this item varied substantially. There was high variability in TCC awareness between workplaces both across professions and within the same profession. After the training, respondents reported statistically significantly higher levels of TCC awareness in their workplaces, providing some evidence to suggest that the training might have a spillover effect on other colleagues.

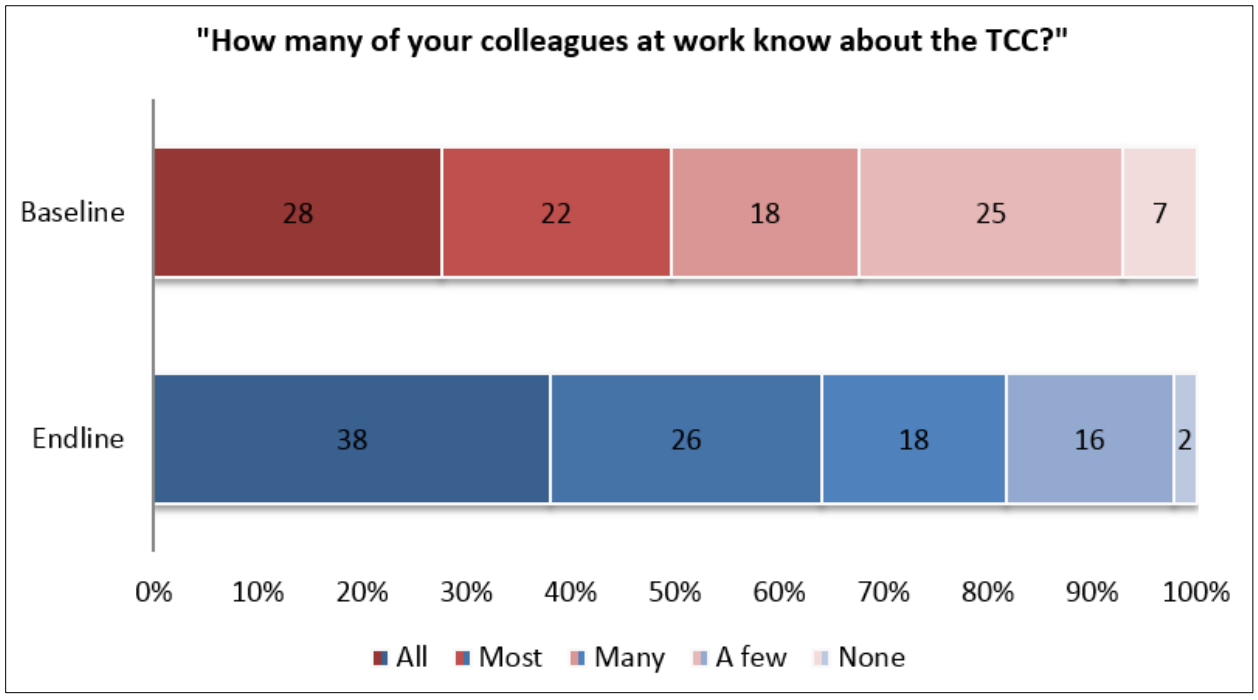

Figure 29: Respondent perception of colleagues' knowledge about the TCC (n=1,346)

3.6.2 Recent services provided to SGBV survivors

The evaluation also sought to measure if 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 were asked at baseline and endline what actions they had taken to assist SGBV survivors in the last 60 days. Actions presented in Table 20 include items such as identifying potential victims, informing victims about their rights, taking someone to a TCC. As illustrated in the table, we do *not* observe positive changes over time in most of the actions included in the survey. Many of the respondents already work with SGBV victims and reported supporting this group at baseline. While the

decrease in many actions is surprising (e.g., identification of victims, receiving a report of SGBV, and informing a victim about rights), it is possible that this change is unrelated to the intervention, and we do see a positive increase in the two actions directly related to TCCs. More respondents reported taking someone to a TCC and informing a victim about TCC resources, the latter of which is statistically significant. Interestingly, at baseline, 81 percent reported advising victims of their rights but only 65 percent reported advising them about TCCs. At endline, however, 74 percent of respondents reported both advising victims of their rights and the same percentage reported advising them about the TCCs, suggesting that TCCs are now part of the information participants provide to victims.

Table 20: Respondent recent practices with SGBV victims (n=1,346)

In the past 60 days, how often did you…	% reporting one or more times at baseline	% reporting one or more times at endline	pp difference	significant at 5%
Identify a student or client that you suspected to be a victim of SGBV.	66	55	-11	*
Have someone report SGBV to you.	72	64	-8	*
Inform a victim about her/his rights with respect to SGBV.	81	74	-7	*
Coordinate with another service provider to assist a victim of SGBV.	68	63	-5	*
Assess the level of danger a victim of SGBV was facing.	61	59	-2	
Document information about a case of SGBV.	63	61	-2	
Contact a service provider on behalf of a victim of SGBV.	65	64	-1	
Help a victim of SGBV in a dangerous situation establish a safety plan.	58	59	1	
Personally take someone to the TCC to get help.	41	44	3	
Inform a victim of SGBV about other resources.	65	70	5	*
Inform a victim of SGBV about resources available at the TCC	65	74	9	*

Of those professionals who contacted a service provider on the behalf of a victim, respondents were seven percentage points less likely to contact the TCC at endline than baseline, and seven percentage points less likely to coordinate with the TCCs at endline than baseline. However, respondents were less likely to contact other service providers in general at endline, and also less likely to coordinate with another service provider at endline, which could potentially be explained by trainees feeling more equipped to handle a SGBV case without the assistance of other providers. When we look at the share of respondents contacting the TCC compared to other service providers, we see that this share increased by three percentage points between baseline and endline. This implies that when a trainee did contact another service provider, s/he was slightly more likely to contact the TCC rather than another provider, although this relationship is not statistically significant. Similarly, the share of respondents coordinating with the TCC compared to other service providers increased by 4 percentage points between baseline

and endline, a statistically significant increase. Respondents were much less likely to contact or coordinate with the police at endline.

Table 21: Respondents' contact and coordination with other service providers (n=857)

If you contacted a service provider on behalf of a victim of SGBV, did you contact…	% Yes at baseline	% Yes at endline	pp difference	PP difference in ratio of total
TCC	43	36	-7*	3
Hospital or clinic	43	39	-4	5*
Police	69	42	-27*	-7*
Social workers/social development	8	10	1	3*
If you coordinated with another service provider on behalf of a victim of SGBV, did you coordinate with…	**% Yes at baseline**	**% Yes at endline**	**pp difference**	**PP difference in ratio of total**
TCC	43	36	-7*	4*
Hospital or clinic	49	38	-11*	2
Police	66	44	-22*	-2
Social workers/social development	9	7	-2	0

Service providers were also asked about their perceived level of difficulty talking with a victim about SGBV (see Figure 30). Of all the trainees responding to this question, 41 percent stated this is "difficult" or "very difficult" at baseline but only 21 percent said so at endline. The number of respondents who said this is "easy" or "very easy" increased from 26 percent to 57 percent at endline. These results suggest that the training has improved the service providers' comfort level in talking with victims about SGBV.

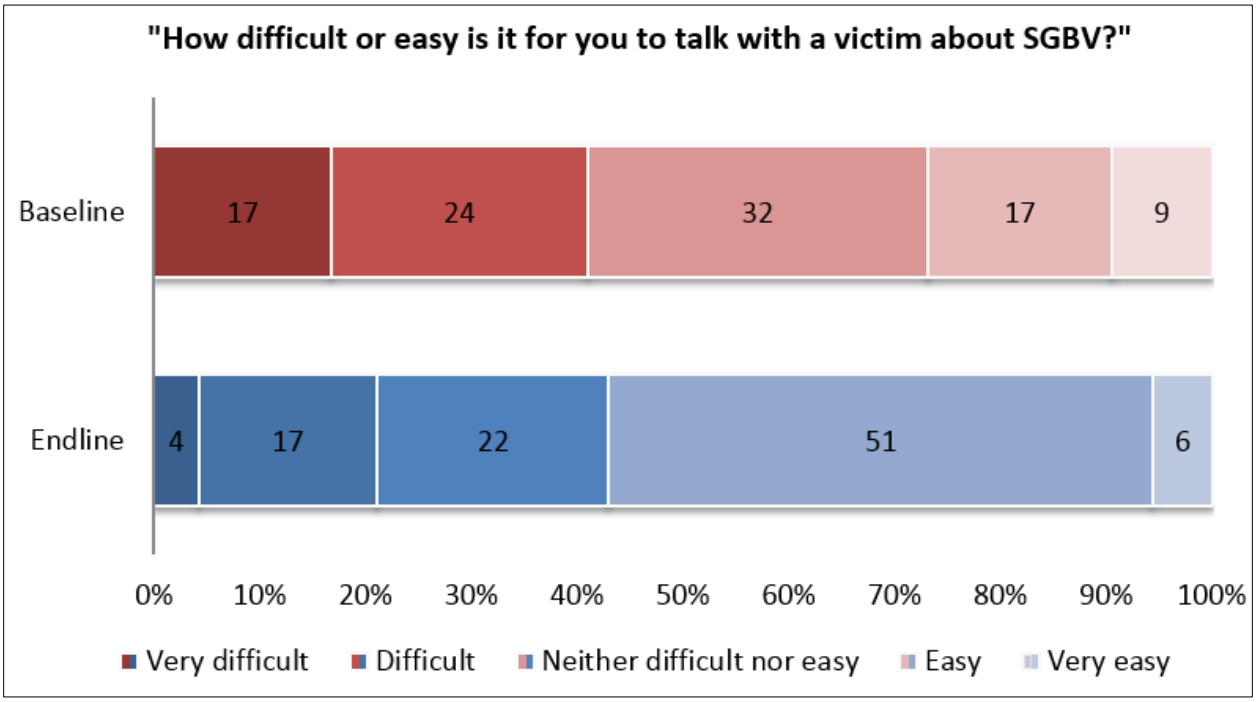

Figure 30: Respondent comfort level talking with victims about SGBV (n=1,290 at baseline and 1,345 at endline)

Respondents were also asked questions about SGBV laws in South Africa and perceptions of SGBV reporting and TCC use. At baseline, nearly all respondents (94 percent) knew that South Africa has laws that address SGBV; this percentage increased slightly by endline to 97 percent.

As shown in Figure 31, respondents perceived higher levels of under-reporting of SGBV cases at endline and lower incidence of false-reporting. Perceptions about how frequently survivors go to the TCC remained relatively unchanged from baseline to endline.

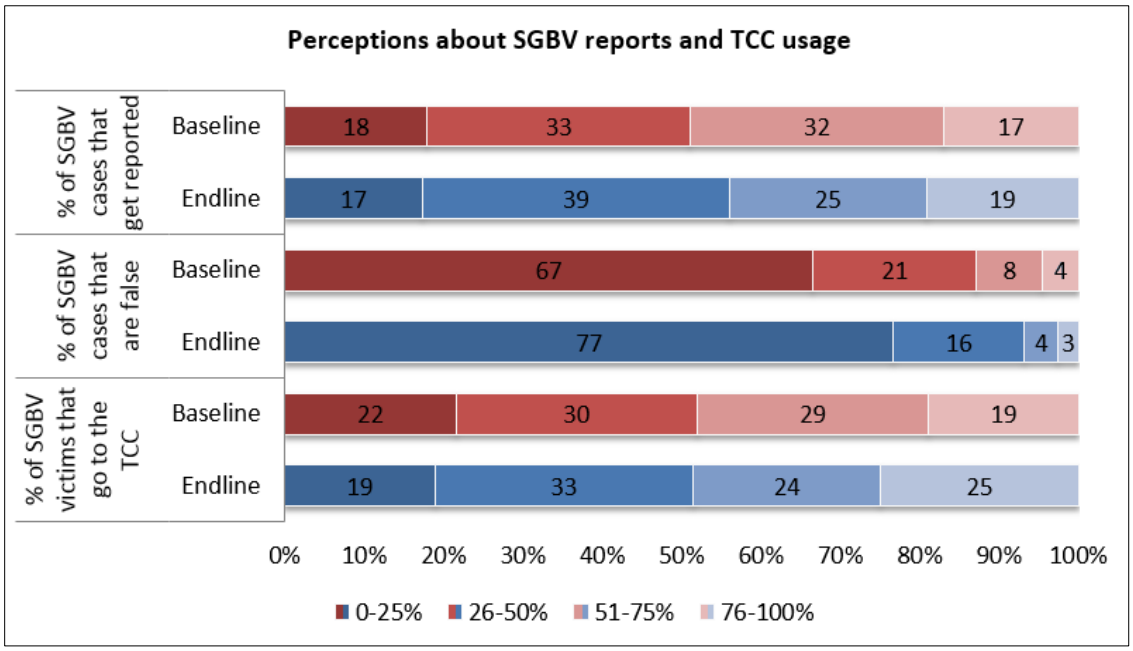

Figure 31: Perceptions about SGBV reports and TCC usage (n=1,263)

Surveyed trainees perceived higher levels of victim referrals to the TCC at endline than at baseline. The share of respondents who thought "all" colleagues were referring victims increased from 23 to 33 percent, and response for most colleagues increased from 20 to 32 percent (see Figure 32).

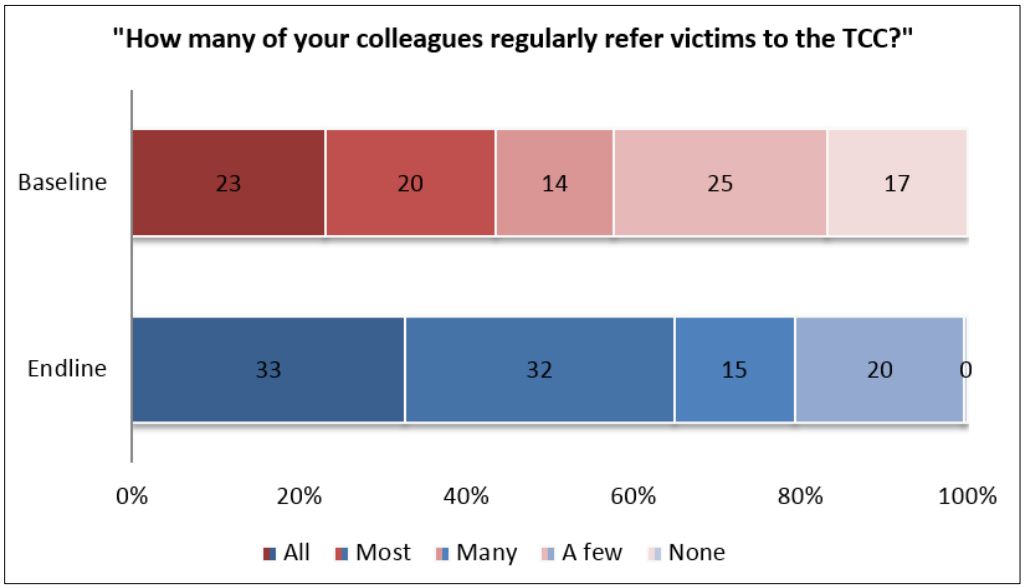

Figure 32: Perception about number of colleagues referring victims to the TCC (n=1247)

3.6.3 Attitudes about 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. A third of respondents believed that women provoke rape by their appearance or behavior and 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 as many rape victims are unable to resist or feel it would be futile to do so.

The training appears to have improved trainee attitudes in seven of nine categories evaluated (see Table 22). For example, the share of respondents who believe that the extent of a woman's resistance should be the major factor in determining if a rape has occurred went down from nearly half to a third, and the percent who agreed that, "many women claim rape if they have consented to sexual relations but have changed their minds afterwards," dropped by 13 percentage points. Contrary to expectations, agreement went down with one statement: "women do not provoke rape by their appearance or behavior." However, it is possible that asking respondents to agree with a negative statement created some confusion among respondents.

Table 22: Respondent attitudes toward SGBV (n=1313 at baseline and 1346 at endline)

SGBV Statement	Agree (%) at baseline	Agree (%) at endline	pp difference	Desired & Observed Change	Significance at 95%
The extent of the woman's resistance should be the major factor in determining if a rape has occurred.	47	34	-13	↓↓	*
Many women claim rape if they have consented to sexual relations but have changed their minds afterwards.	37	24	-13	↓↓	*
Accusations of rape by bar ladies, strippers, and prostitutes should be viewed with suspicion.	25	18	-7	↓↓	*
Many women invent rape stories if they learn they are pregnant.	19	15	-4	↓↓	*
Women who have had prior sexual relationships should not complain about rape.	10	7	-3	↓↓	*
Women who are raped while accepting rides from strangers get what they deserve.	6	4	-2	↓↓	*
Women often claim rape to protect their reputations.	29	30	1	↓↑	
Women do not provoke rape by their appearance or behavior.	66	55	-11	↑↓	*
A raped woman is usually an innocent victim.	70	74	4	↑↑	*

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 their 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 a minority of responses indicated some victim blaming, at baseline 86% of the respondents either disagreed (30 percent) or strongly disagreed (56 percent) that a woman in this scenario is to blame for the sexual assault. The percentage of aggregated disagreed/strongly disagreed responses increased to 92 percent after the training, indicating slightly less victim-blaming than at baseline. However, a large number of respondents changed their opinions from "strongly disagree" to "disagree," possibly indicating less certainty about the extent to which the woman is to blame than expressed at baseline.

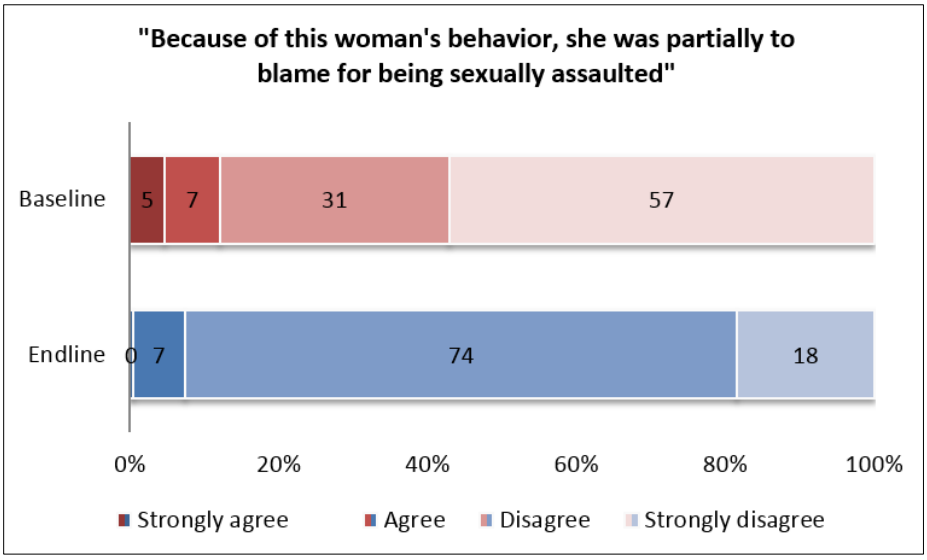

Figure 33: Respondent level of victim-blaming (n=1,274 at baseline and n=1,340 at endline)

When asked after the training whether this victim would file a police report, respondents were more likely to say "sometimes" or "often" instead of "always" (see Figure 34), indicating greater recognition of under-reporting of rapes in scenarios similar to this one. Respondents' answers changed in a similar way when asked if this victim would go to the TCC, with more respondents now saying "sometimes" or "often" instead of "always." These changes in perception might have occurred due to the training, as participants now have an increased awareness of the rates of police reports and TCC usage.

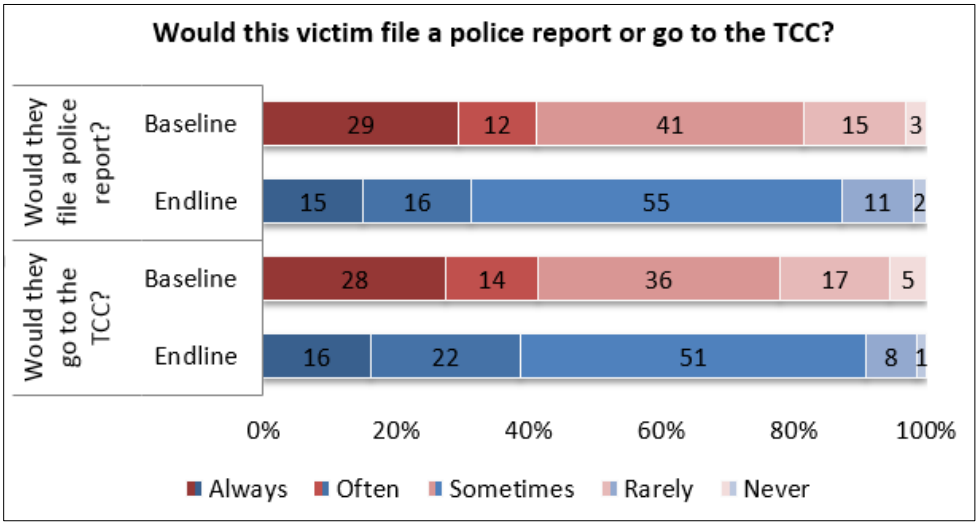

Figure 34: Perception of whether victims would file a police report or go to the TCC

After the training, fewer respondents think that reporting to the police would be very helpful in this case, from 72 percent to 30 percent. Most respondents answered that reporting to the police would be "helpful" (see Figure 35).

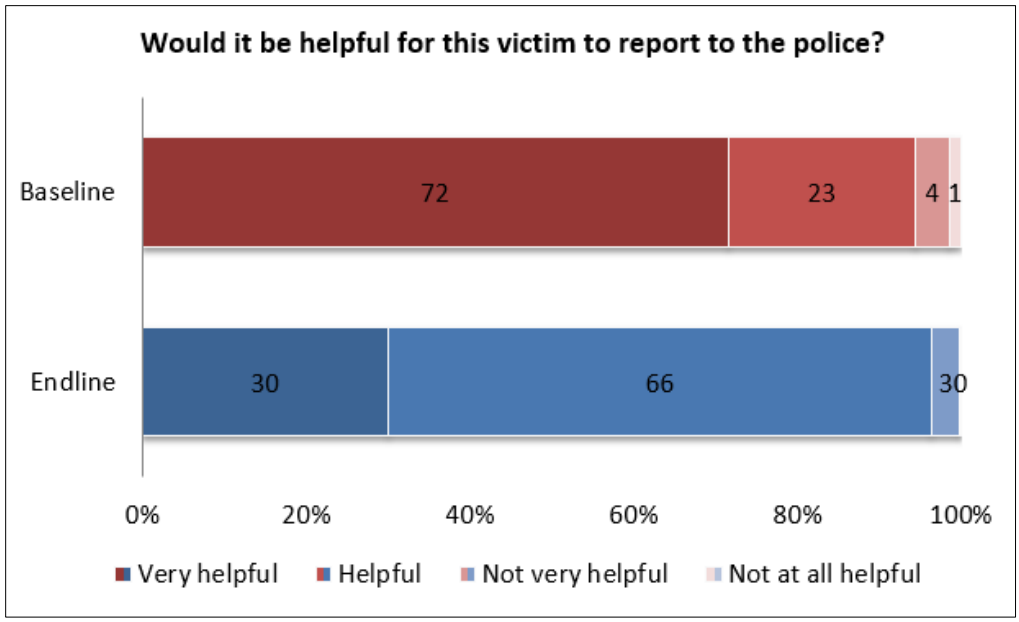

Figure 35: Perception of police helpfulness (n=1346)

Respondents then identified the main reasons they believed a victim in this scenario might not file a police report or visit the TCC for help. Fear of being blamed was most commonly identified as one of the main reasons for not filing a police report, by 47 percent of respondents. Lack of information was most commonly identified as one of the main reasons to not visit the TCC, by 71 percent of respondents. "Staff would not be helpful" was the least cited reason in both cases.

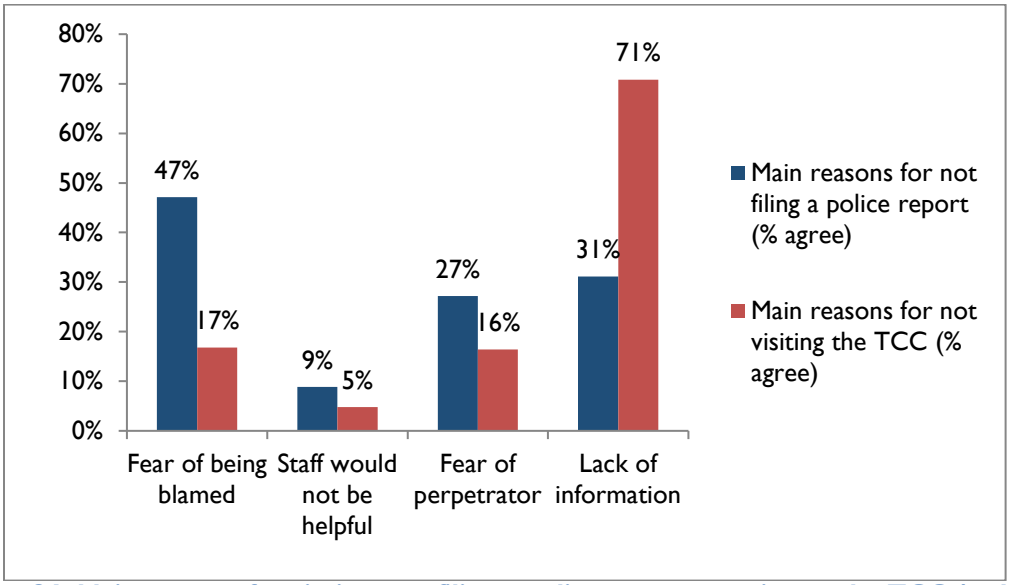

Figure 36: Main reasons for victims not filing a police report or going to the TCC (n=1345)

When asked whether the TCC would be helpful with medical, legal or psychological/emotional assistance, fewer respondents answered "not very helpful" or "not at all helpful,", and more respondents said "helpful"

than at baseline (see Figure 37). The share of professionals in our sample answering "very helpful" declined from 75 percent to 47 percent for medical services, from 61 percent to 45 percent for legal assistance, and from 78 percent to 47 percent for psychological/emotional assistance.

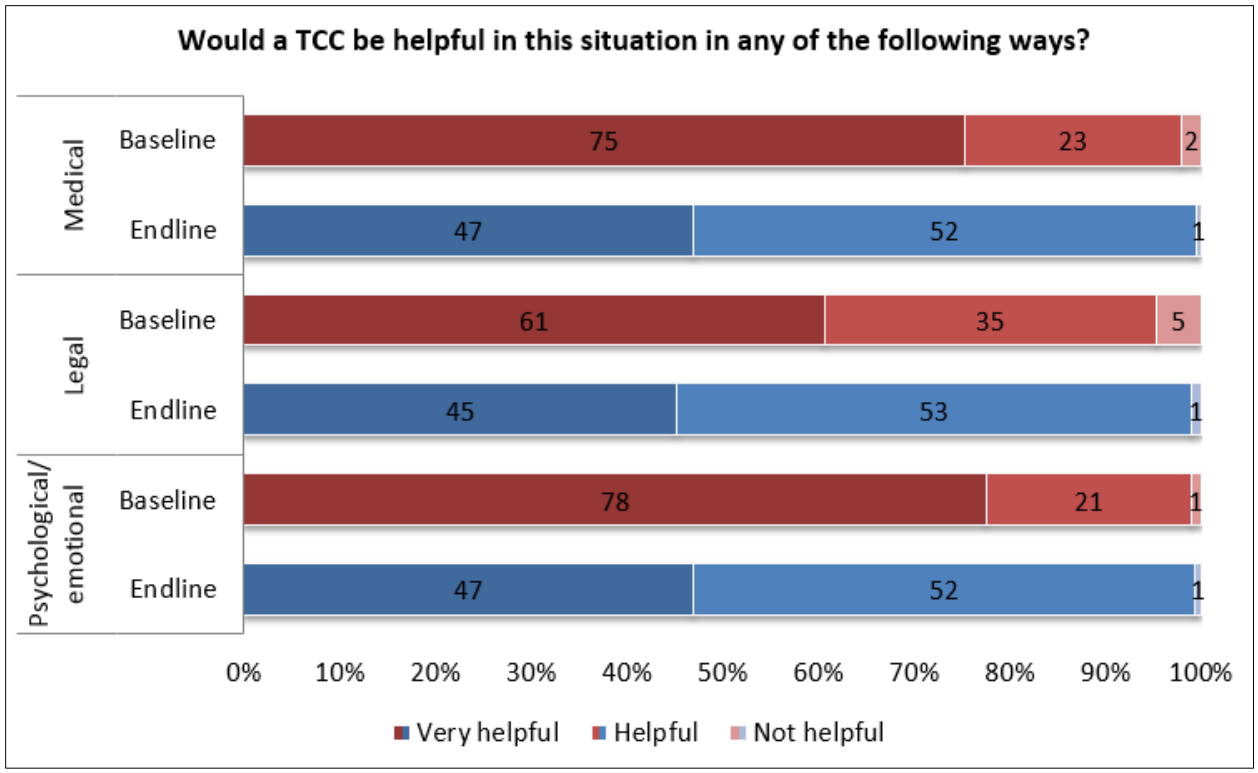

Figure 37: Perception of TCC helpfulness (n=1345)

3.6.4 Status of action plans

After the training, respondents were asked about their plans to implement SGBV projects in their facilities. Most (89 percent) said they planned to implement such a project, and three percent did not yet know. When asked whether they recalled the major tasks involved in selecting an appropriate SGBV project for their facilities, which were covered during the training, 80 percent of respondents said yes. Of those who answered yes, only 85 percent actually explained the process correctly. This means that 68 percent of trainees could recall the SGBV project selection process at the time of the survey.

Respondents who said they were planning to implement a SGBV project in their facilities were asked the status of project selection. A little more than a quarter (27 percent) of respondents had not yet started the process, but only two percent were not planning to do so. One-fifth (22 percent) of respondents had already completed their SGBV project selection.

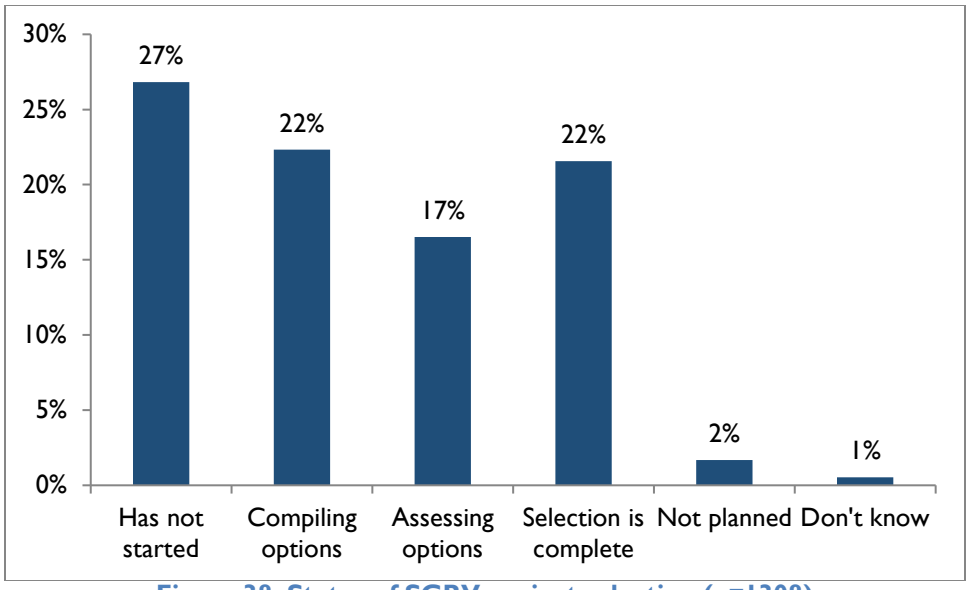

Figure 38: Status of SGBV project selection (n=1308)

Those respondents who said that SGBV project selection was complete were then asked about the following six activities: expansion of staffing and services; education of the community; re-routing of clients, continuity of care and follow-up mechanisms; setting up of referral mechanisms, protocols and policies; development of planning and monitoring tools, SGBV material and forms; and education of staff.[31] Most respondents planned to do all six activities and each was completed at the time of the interview for 22-26 percent of respondents.

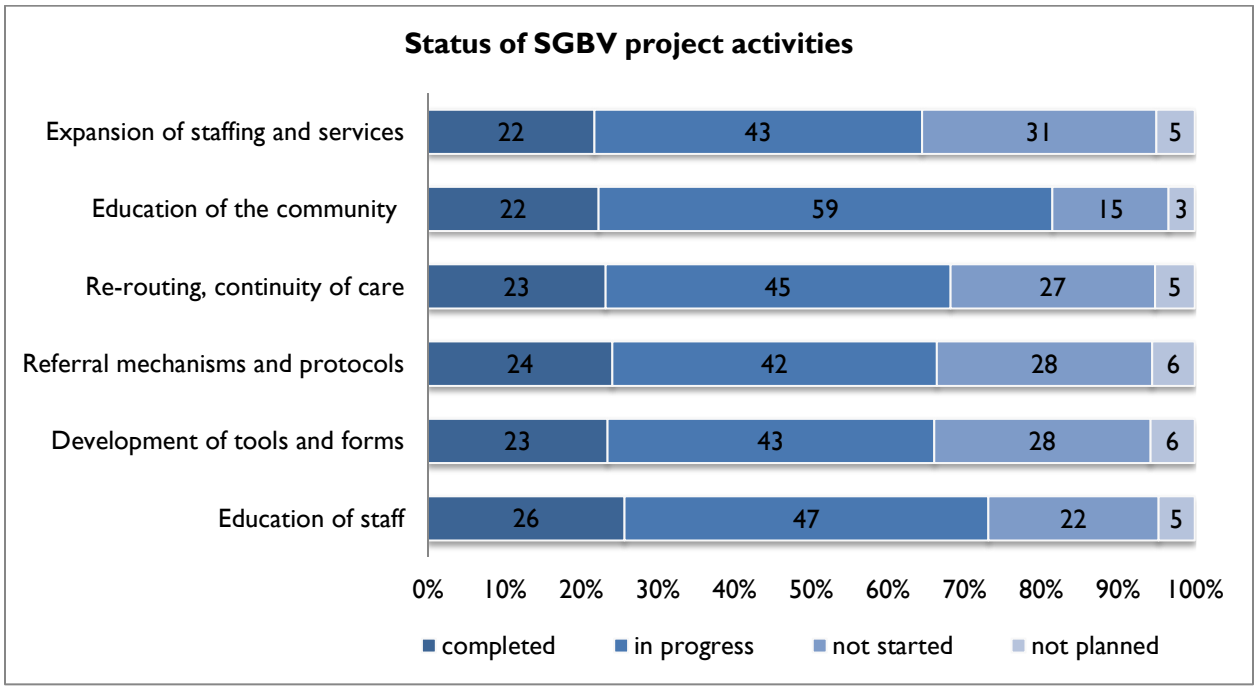

Figure 39: Status of activities within SGBV projects (n=1286)

[31] These are the activities covered in the Integrated Management training curriculum.

Respondents who were not planning to implement an SGBV project in their facilities were asked why. Figure 40 shows that the main reasons for not planning implementation were lack of time to dedicate to the project (24 percent) and a lack of resources (staff, financial, etc.) (23 percent).

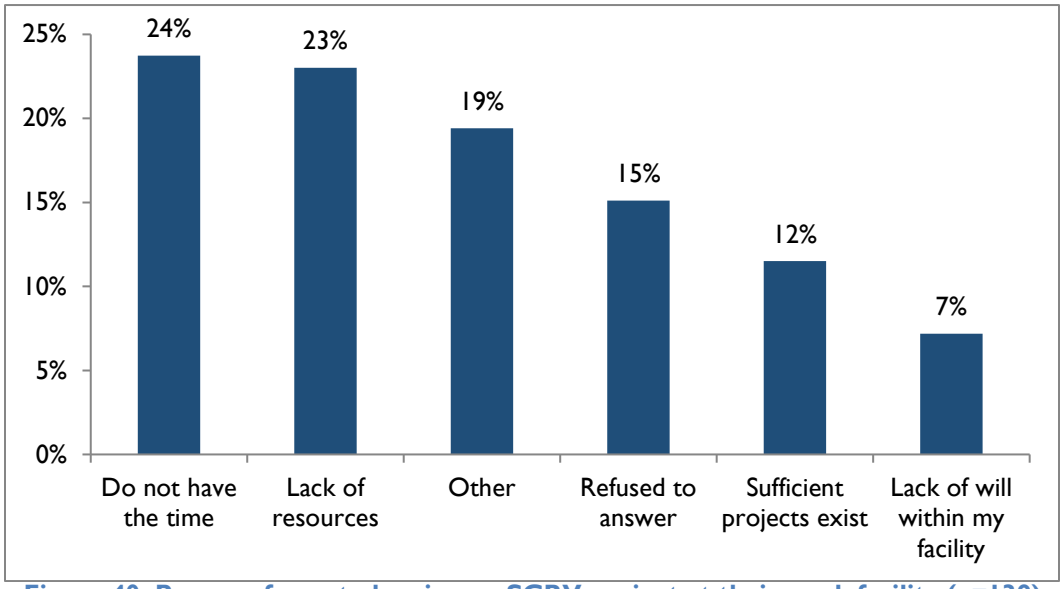

Figure 40: Reasons for not planning an SGBV project at their work facility (n=139)

In summary, findings from the pre- and post-training surveys show that training participants substantially increased their knowledge of TCCs and TCC services during the training. Moreover, we observe smaller, but statistically significant changes in many attitudes toward SGBV, including less victim-blaming, as well as some improvements in reported behaviors in working with survivors of SGBV. Thus, the Treatment 2 training can be regarded as successful in improving the knowledge, attitudes, and to a limited extent, the practices of those service providers who attended the trainings. It is important to note that the study did not include a control or comparison group for Treatment 2, and, as such, we cannot completely rule out the possibility that there are other factors that explain the changes over time. Nonetheless, given that few nationwide phenomena could be expected to elicit such consistent change, we feel confident that this is not a major methodological concern. Of greater concern, however, is the changing of survey modalities, from a self-administered survey to a phone-based survey conducted by an enumerator. It is possible that this change in modality influenced responses. It is also important to note that this group of professionals self-selected into the training, and as such are not representative of the service providers targeted by the training (e.g., teachers, police, and health workers) more broadly. As trainees self-select by choosing to participate or not, it is likely that these are individuals who are motivated to learn about TCCs and provide assistance to survivors of SGBV. Consequently, these results are not generalizable to all service providers in the system of care, and do not necessarily indicate improvements in the system of care as a whole.

CONCLUSIONS

- 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, recordkeeping practices, and resources. Many TCCs face deficiencies in these areas; however, through coordination with NGOs and other stakeholders, TCCs are sometimes able to fill service gaps that they could not address on their own, and improve the quality of care provided survivors.
- We find no impact of the community dialogues or the service providers' training on TCC utilization, measured by survivors presenting to the TCC.
- Predictors of TCC utilization include population size, reported sex crimes, and the murder rate, as a proxy for general crime and SGBV. There is also some indication that TCC capacity influences utilization; however, the effect of various measures of TCC capacity, such as staffing, after-hours operation, facilities, and supplies, is not consistent across the statistical models.
- We also find no impact of the community dialogues on community knowledge and attitudes toward sexual assault. Knowledge of TCCs in treatment and control areas remains low and at similar levels as baseline. It is possible that the intervention influenced the individuals who attended the dialogues; however, such an approach is inadequate to reach the larger population and change community knowledge and attitudes.
- The Treatment 2 training can be regarded as successful in improving the knowledge, attitudes, and to a limited extent, the self-reported practices of those service providers who attended the trainings. It is important to note that this group of professionals self-selected into the training, and as such are not representative of the service providers targeted by the training (e.g., teachers, police, and health workers) more broadly.

RECOMMENDATIONS

Based on the findings and conclusions from this impact evaluation of the ISSSASA activity, the evaluation team recommends that USAID, the NPA, and other stakeholders consider the following areas of intervention to continue developing the system of care for survivors of sexual assault.

- **Support TCC capacity.** TCCs reported various areas of need for support across staffing, facilities, and supplies. In a resource-constrained environment and given the relatively low levels of TCCs use—where perhaps a TCC only serves one survivor every other day or several times a week—justification for added staffing or other resources may be a challenge. On-call staff that are available 24 hours a day seven days a week, for example, as opposed to staff sitting at the TCC around the clock may be a more reasonable use of resources, especially in areas with low TCC use. Continuing to encourage partnerships with NGOs and community organizations, which we find to be providing important complementary services and filling resource voids, is another promising area for intervention. The findings above indicate some changes that would be effective while expending minimal resources. For example, the policy of keeping TCCs' locations somewhat secret undermines utilization and should be reconsidered.

- **Test the effects of a more broad-based, social marketing approach to raising awareness about TCCs and SGBV.** Given continued low awareness of the TCCs within surrounding communities and continued apprehension about reporting SGBV, more intensive outreach efforts should be tested. The broader ISSSASA program includes a television drama series, a school based intervention engaging children in grade 7, a radio public service announcement campaign, and a digital and social media campaign. Efforts to increase awareness and change attitudes should build on best practices in social marketing and be designed to reach and influence a wider audience with sustained and repeated messaging via a "saturation" approach. Such an approach would be amenable to a follow-on impact evaluation using the same survey methodology applied here and could even be focused on communities with the greatest perceived need. The intervention would require a stronger theory of change that would be likely to produce a change detectable in a random sample of women in targeted communities. As one stakeholder noted, "…social change at the community level often occurs gradually and over a more protected period of time and with repeat exposure as opposed to a one-off exposure to an intervention."

  Furthermore, given that the TCCs report limited to no direct community outreach activities at present, the evaluation team recommends that TCC staff engage directly with communities, thereby building connections with schools, clinics, police, community organizations, and community members themselves. These direct relationships have the potential to improve the status of the system of care, build trust, and increase awareness. Data from this evaluation shows that few TCC staff were available to participate in community dialogues or service providers' trainings due to their responsibilities at the TCC or lack of transportation. Human resource limitations remain a challenge at the TCCs; however, centralized staff could help coordinate outreach efforts. Where it is not possible to send TCC staff into communities for outreach, consider technology, social media, or radio as a means for TCC staff to engage with communities.

- **Selectively choose dialogue participants that are potential agents of change.** It was assumed that messages disseminated in community dialogues would spread throughout communities. Findings from this IE show that this assumption did not hold true. If dialogues are maintained, they will either need to be scaled up dramatically to reach a critical mass of women and men or there should be greater selectivity in who participates in the dialogues. Future interventions should consider targeting community members who are potential agents of change

who will proliferate messages from the dialogues. Participants should be provided with the skills and materials to encourage such proliferation.

- **Adopt a train-the-trainer approach to community dialogues.** Community dialogues are an attractive option towards meeting the goals to decrease SGBV incidence and increase support for survivors, as they allow for a more in-depth discussion of SGBV issues, which is likely necessary to change attitudes and reduce stigma. Nonetheless, these dialogues are only able to reach a small number of participants, and we did not find evidence that they were effective in achieving the objectives tested in this evaluation. As such, they should either be used strategically as part of a "saturation" strategy in targeted communities, or they should be scaled-up dramatically. As part of the latter approach, we would recommend adopting a train-the-trainer or promoter-based approach. There is some precedent for this, as Soul City has been working to establish clubs of young women who could lead their own dialogues. Participants should be provided with the skills and materials to encourage information proliferation while ensuring fidelity to the established approach.

- **Formalize SGBV training for police and other professionals in the system of care**. Participants in the Integrated Management training were recruited via open invitations to service providers at targeted institutions. As such, participants self-selected into the program and many had a strong interest in SGBV or were already working on SGBV. In fact, at baseline, 80 percent of service providers already knew of SGBV services and 65 percent had informed a victim about the TCCs in the last 60 days. This could explain why the intervention did not increase referrals from this group. It seems probable that a training could be most beneficial if it were provided to service providers who likely have contact with SGBV survivors but are not knowledgeable about such issues nor the services that exist to address them. These individuals would be less motivated to attend a three-day training, but a shortened one-day training could be offered to a wider audience of service providers with a heavy emphasis on follow-up action.

- Police would be an obvious target for such training; however, USAID/South Africa reports that it is difficult to work with the South Africa Police Service in such capacity due to Leahy Law requirements for training. Training nurses in making referrals would be an attractive alternate target group, as these professionals often interact with survivors. While nurses have many demands on their time, they might be amenable to such a training because the TCCs offer a support service that can make their jobs easier. If this were to occur, we would recommend conducting the same pre- and post-survey. Some of the knowledge and attitude gains might be lower with a less motivated group; however, a well delivered training could lead to greater awareness throughout the service provider community and increase referral sources.

- **Use statistics in this report to inform future programming**: The survey data demonstrate a number of knowledge gaps, important perspectives, and potentially problematic attitudes that could help USAID, the NPA, and the IPs improve their programming. For example, while survey data reveals generally progressive attitudes, it also shows that many individuals think there are limits on a woman's right to refuse sex and there is evidence of victim blaming in certain situations. These statistics should be incorporated into curriculum, discussed, and addressed.

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK[32]

Impact Evaluation Strategy for South Africa GBV Project

Eric Mvukiyehe
November 15, 2012

Background

Over the past five 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 nine provinces. The Mission is now launching a new five-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

[32] While the USAID approved design is based on this SOW, some aspects of the SOW were changed or dropped in the approved design. For example, the evaluation does not answer if capacity strengthening activities improve survivors' psychological and social wellbeing.

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)[33]
- 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

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

- Seek out treatment
- Satisfaction with TCC services
- Staying on through a counseling plan
- Trust in referral systems
- Willingness to report GBV crimes
- Likelihood to stay through the legal processes or to withdrawal case
- Psychological and social wellbeing (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 though 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 these individuals stay 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 is not very well defined, partly as a result of TCCs' emplacement in populated areas that are most at risk of GBV. Another difficultly 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 three 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 four different kinds of project activities.[34] One way to go about drawing this sample is to select four communities in TCC's catchment areas that are equally eligible to receive project activities. Three-fourths 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 1 below provides an illustration of one possible design option.
Table 1. Impact Evaluation Design

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)	

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

[34] 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.

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 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? [ ] Health Worker [ ] NGO Worker [ ] TCC Site Coordinator [ ] Educator [ ] Victim Assistance Officer [ ] Social Worker [ ] Police officer [ ] 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)** [ ] Transportation [ ] Psychological and counseling assistance [ ] Medical assistance [ ] Legal assistance [ ] 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?

[ ] None [ ] Most
[ ] A few [ ] All
[ ] Many [ ] Don't Know

A9. Who can go to the Thuthuzela Care Centre for help? **(PLEASE SELECT ALL THAT APPLY)**

[ ] Women [ ] Boys
[ ] Men [ ] Lesbian, gay, bisexual, and transgender
[ ] Girls [ ] Don't Know

A10. Can a person under age 18 receive help from a Thuthuzela Care Centre?

[ ] Yes [ ] Don't Know
[ ] No

A11. Can a man receive help from the Thuthuzela Care Centre if he has experienced sexual violence?

[ ] Yes [ ] Don't Know
[ ] No

A12. How often do those who go to the Thuthuzela Care Centre have to pay for the services?

[ ] Always [ ] Rarely
[ ] Often [ ] Never
[ ] Sometimes [ ] 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?

[ ] Yes [ ] Don't Know
[ ] No

A14. Is it possible to file a police report at the Thuthuzela Care Centre without having to go to the police station?

[ ] Yes [ ] Don't Know
[ ] No

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?

[ ] Yes [ ] Don't Know
[ ] No

A16. How many of your colleagues at your workplace know about the Thuthuzela Care Centre services?

[ ] None [ ] Most
[ ] A few [ ] All
[ ] Many [ ] Don't Know

A17. How many of your colleagues at your workplace regularly refer victims to the Thuthuzela Care Centre?

[ ] None [ ] Most
[ ] A few [ ] All
[ ] Many [ ] Don't Know

Section B: Recent Practices

*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?*

B1. Had someone report sexual or gender-based violence to you.

[ ] Never [ ] 2-4 Times

[ ] Once [ ] 3-5 Times

B2. Identified a student or client that you suspected to be a victim of sexual or gender-based violence.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B3. Documented information about a case of sexual or gender-based violence.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B4. Informed a victim about her/his rights with respect to sexual or gender-based violence.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B5. Informed a victim of sexual or gender-based violence about resources available at the Thuthuzela Care Centre.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B6. Personally taken someone to the Thuthuzela Care Centre to get help.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B7. Informed a victim of sexual or gender-based violence about other services (please specify):
[ ] Never [ ] 2-4 Times →
[ ] Once [ ] 3-5 Times →

B7a. If you informed a victim about other services please specify what service.
_____

B8. Assessed the level of danger a victim of sexual or gender-based violence was facing.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B9. Helped a victim of sexual or gender-based violence in a dangerous situation establish a safety plan.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B10. Contacted a service provider on behalf of a victim of sexual or gender-based violence.
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

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)**
[ ] TCC [ ] Police
[ ] Hospital [ ] Other

B11a. If you selected other, please specify
_____

B12. Coordinated with another service provider to assist a victim of sexual or gender-based violence
[ ] Never [ ] 2-4 Times
[ ] Once [ ] 3-5 Times

B13. If you have coordinated with another service provider, which type(s) of service provider did you coordinate with? **(PLEASE SELECT ALL THAT APPLY)**
[ ] TCC [ ] Police
[ ] Hospital [ ] Other

B13a. If you selected other, please specify_____

B14. How difficult or easy is it for you to talk with a victim about sexual or gender-based violence?
[ ] Very difficult [ ] Easy
[ ] Difficult [ ] Very easy
[ ] Neither difficult nor easy

Section C: Sexual Assault and the Legal System	
Now please consider a few questions about laws in South Africa.	
C1. Are there any laws in South Africa that address sexual and gender-based violence?	
[ ] Yes	[ ] Don't Know
[ ] No	
C2. What percentage of sexual or gender-based violence cases do you think are actually reported to the police?	
[ ] 0-25%	[ ] 76-100%
[ ] 26-50%	[ ] Don't Know
[ ] 51-75%	
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)?	
[ ] 0-25%	[ ] 76-100%
[ ] 26-50%	[ ] Don't Know
[ ] 51-75%	
C4. What percentage of sexual or gender-based violence victims do you think go to the TCC for treatment or support?	
[ ] 0-25%	[ ] 76-100%
[ ] 26-50%	[ ] Don't Know
[ ] 51-75%	
C5. Have you ever received training related to sexual or gender-based violence?	
[ ] Yes	[ ] Don't Know
[ ] No	

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. For each statement, please state whether you strongly agree, agree, disagree or strongly disagree with each statement.	
D1. The extent of the woman's resistance should be the major factor in determining if a rape has occurred.	
[ ] Strongly agree	[ ] Strongly disagree
[ ] Agree	[ ] Don't know
[ ] Disagree	
D2. A raped woman is usually an innocent victim.	
[ ] Strongly agree	[ ] Strongly disagree
[ ] Agree	[ ] Don't know
[ ] Disagree	

D3. Women often claim rape to protect their reputations.	
[ ] Strongly agree	[ ] Strongly disagree
[ ] Agree	[ ] Don't know
[ ] Disagree	
D4. Women who have had prior sexual relationships should not complain about rape.	
[ ] Strongly agree	[ ] Strongly disagree
[ ] Agree	[ ] Don't know

[ ] Disagree

D5. Women do not provoke rape by their appearance or behaviour.

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

D6. Women who are raped while accepting rides from strangers get what they deserve.

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

D7. Many women invent rape stories if they learn they are pregnant.

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

D8. Many women claim rape if they have consented to sexual relations but have changed their minds afterwards.

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

D9. Accusations of rape by bar ladies, strippers, and prostitutes should be viewed with suspicion.

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

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."

[ ] Strongly agree
[ ] Agree
[ ] Disagree
[ ] Strongly disagree
[ ] Don't know

E2. For women in this neighbourhood who experience such situations, would they file a police report?

[ ] Always
[ ] Often
[ ] Sometimes
[ ] Rarely
[ ] Never

E3. Would it be helpful for this woman to report this situation to the police?

[ ] Very helpful
[ ] Helpful
[ ] Not very helpful
[ ] 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?

[ ] Fear of being blamed
[ ] The police staff would not be helpful
[ ] Fear of the perpetrator
[ ] Lack of information about where to find help
[ ] Other

E4a: If other, please specify

_____

E5. Considering women in this neighbourhood who experience such situations: would they go to the Thuthuzela Care Centre?

[ ] Always
[ ] Often
[ ] Sometimes
[ ] Rarely
[ ] Never

E6. Among the following reasons, what would be the main reason that a woman would not go to a Care Centre in this case?

[ ] Fear of being blamed
[ ] The Centre staff would not be helpful
[ ] Fear of the perpetrator
[ ] Lack of information about where to find help
[ ] Don't Know

E7. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?: **Medical**

[ ] Very helpful
[ ] Helpful
[ ] Not very helpful
[ ] Not at all

E8. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?: **Legal**

[ ] Very helpful
[ ] Helpful
[ ] Not very helpful
[ ] Not at all

E9. Would a Thuthuzela Care Centre be helpful in this situation in any of the following ways?: **Psychological/emotional**

[ ] Very helpful
[ ] Helpful
[ ] Not very helpful
[ ] 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?

[ ] 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
[ ] 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 three 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***
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.	
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? *[Do not prompt, enumerator codes all categories that respondent mentions]*	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 5=Other: _____ 6=dk

	7=rf
13. Have you heard of the Thuthuzela Care Centres? [If yes, skip to 16]	*1=Yes 2=No* *3=Don't know 4=rf*
Read: A Thuthuzela Care Centre is a crisis centre, to help victims of sexual assault. 14. Do you know of any places like this in your community? [If no, Skip to 30}	*1=Yes 2=No* *3=Don't know 4=rf*
Read: As you may know, a Thuthuzela Care Centre is a crisis centre, to help victims of sexual assault. 15. Do you know what services the Thuthuzela Care Centres offer?	*1=Yes 2=No* *3=Don't know 4=rf*
16. Do you know the location of the nearest Thuthuzela Care Centre?	1=Yes 2=No 3=Don't know 4=rf Location:
17. Of the following services, which are offered by the Thuthuzela care Centres? a) Transportation b) Medical assistance c) Psychological and counseling assistance d) Legal assistance	 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
18. Can a man receive help from the Thuthuzela Care Centre if he has experienced sexual assault?	1=Yes 2=No 3=don't know 4=rf
19. Can a person under age 18 receive help from the Thuthuzela Care Centre, even without parental consent?	1=Yes 2=No 3=don't know 4=rf
20. Do those who go to the Thuthuzela Care Centre have to pay for the services?	1=Always 2=Often 3=Sometimes 4=Rarely 5=Never
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?	1=yes 2=no 3=dk 4=rf
22. Is it possible to file a police report at the Thuthuzela Care Centre without having to go to the police station?	1=Yes 2=No 3=Dk 4=rf
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 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	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 e) 1=SA 2=A 3=D 4=SD 0=DK
63. Would you agree or disagree that a married woman can refuse to have sex with her husband in the following situations: a) She doesn't want to b) He is drunk c) She is sick d) He mistreats her	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
64. When a woman is raped, she usually did something careless to put herself in that situation	1=SA 2=A 3=D 4=SD 0=DK
65. In some rape cases, women actually want it to happen	1=SA 2=A 3=D 4=SD 0=DK
66. If a woman doesn't physically fight back, you can't really say it was rape	1=SA 2=A 3=D 4=SD 0=DK
67. In any rape case, one would have to question whether the victim sleeps around a lot or has a bad reputation.	1=SA 2=A 3=D 4=SD 0=DK

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 toward 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 1: 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

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. 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	_____
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. e. Fear of being blamed f. The police staff would not be helpful g. Fear of the perpetrator 84. Lack of information about where to find help	
85. For women in this neighborhood who experience such situations, how likely are they to go to the Thuthuzela Care Centre?	1=Very likely 2=Likely 3=Not very likely 4=Not at all likely
86. What would be the main reason that a woman would not go to the Thuthuzela Care Centre in this case? [*Do not prompt*] 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	_____
87. Would the Thuthuzela Care Centre be helpful in this situation in any of the following ways? a. Medical b. Legal c. Psychological/emotional	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
88. If you were in this situation, which of the following would you go to for help? a. Police: b. Hospital: c. Thuthuzela Care Centre: d. NGO crisis centre: e. Family member: f. Friend: g. Other:	1=Definitely 2=Maybe 3=No 4=dk 5=rf

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.

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."	1=Strongly agree 2=Agree 3=Disagree 4=Strongly disagree 0=Don't know
90. For women in this neighbourhood 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
91. Would the police be helpful in this situation?	1. Very helpful, 2. Helpful, 3. Not very helpful, 4. Not at all helpful
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_____	_____
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_____	
93. For women in this neighbourhood who experience such situations, how likely are they to go to the Thuthuzela Care Centre? *[Prompt]*	1=Very likely 2=Likely 3=Not very likely 4=Not at all likely
94. What would be the main reason that a woman would not go to a Thuthuzela Care Centre in this case? [*Do not prompt*] 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	_____
95. Would the Thuthuzela Care Centre be helpful in this situation in any of the following ways?	a. 1. Very helpful, 2. Helpful,

a. Medical b. Legal c. Psychological/emotional	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
96. If you were in this situation, which of the following would you go to for help? h. Police: i. Hospital: j. Thuthuzela Care Centre: k. NGO crisis centre: l. Family member: m. Friend: 97. Other:	1=Definitely 2=Maybe 3=No 4=dk 5=rf

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

98. What is your age?	
99. What is your race?	*1=Black 2=White 3=Coloured 4=Indian 5=Asian* *6=other:* _____
100. What is the primary language spoken at your home? (Do not, prompt]	1. Afrikaans 2. English 3. Ndebele 4. Pedi 5. Sotho 6. Swati 7. Tshonga 8. Tswana 9. Venda 10. Xhosa 11. Zulu 12. Other: _____
101. What is the highest level of education you have completed? (Do not, prompt]	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 (1st 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. *If yes*: Police station where crime **occurred:**	
9. *If yes*: Police station where survivor **resides**:	
10. *If no*: Address/neighborhood where the crime **occurred**: Police station closest to that address/neighborhood:	
11. *If no*: 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? *[If no, skip to question 6]*	Yes___ No___ Unknown___ Refused response ___
5. If yes, what were the main messages do your remember? *[Do not prompt, mark all that apply.]*	Awareness of sexual assault as a problem___ Where to seek help___ Rights of victims___ Messages to deter perpetrators___ Other___ Unknown___ Refused response___

	Specify (Other):_____
6. What are the main difficulties that you and people you know encounter in accessing TCCs?	
7. Has the TCC been open during the times you have wanted to come to the TCC?	Yes___ No___Unknown___ Refused response ___
8. How did you get to the TCC center?	Public transport___ Private car___ Walked___ Driven by police___ Other___ Specify (Other):_____
9. Have you told teachers or any adult at school about this incident (if in school)?	Yes___ No___ Unknown___ Refused response ___ N/A ___
10. Have you told police about this incident?	Yes___ No___ Unknown___ Refused response ___
11. How would you rate the level of respect shown to you by the police? *[Go to end]*	Disrespectful___ Somewhat disrespectful___ Respectful___ Very respectful___ Refused response___

12. Why did you not go to the police?
[Do not prompt. Mark all that apply]

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___

Specify (other):_____

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?

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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 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***, one 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 three sectors, five sub-sectors are drawn from each). One exception to this rule is when the urban/rural weighting rules suggested otherwise. For example, if three 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 three households should be selected from the urban sector and 12 from the rural sector.
- Sampling procedures for each precinct should always 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 two 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 three attempts are made to reach the sampled individual before resampling a secondary individual.

ANNEX V: COMPLETENESS OF BASELINE 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%

ANNEX VI: REGRESSION TABLES

Logistic regression results table for effect of Treatment 1 on knowledge of TCCs (n=2,950)

Have you heard of the TCC?	Odds ratio	p-value	Std. error
DiD Treatment effect	1.036	0.903	0.302
Treatment	0.960	0.840	0.195
Endline	1.118	0.606	0.243
Age	1.019***	0.008	0.007
Zulu	1.019	0.941	0.253
Xhosa	0.620*	0.097	0.179
Tswana	0.922	0.743	0.229
Afrikaans	1.184	0.666	0.463
Coloured	0.663	0.227	0.226
Lower than secondary education	0.546***	0.000	0.080
Tertiary education or higher	1.219	0.217	0.196
Income < R1,000 per month	1.693***	0.000	0.255
Income > R5,001 per month	1.208	0.199	0.178
Urban precinct	0.840	0.245	0.126
Knows a SGBV survivor	4.811***	0.000	0.581
Perception of SGBV as a problem in the community	1.123*	0.089	0.077
Sex crimes per 1,000	1.293**	0.017	0.139
Woman's right to refuse sex PCA	0.973	0.348	0.028
Tolerance of violence toward women PCA	1.072**	0.023	0.033
Rape victim-blaming PCA	1.052	0.208	0.043
province: Limpopo	7.733***	0.000	4.228
province: North We	5.288***	0.001	2.582
province: Kwa-Zulu	4.499***	0.001	2.098
province: Eastern	17.06***	0.000	8.442
province: Western	5.946***	0.001	3.230
province: Nothern Cape	6.547***	0.000	3.051
province: Free State	7.209***	0.000	3.546
province: Mpumalanga	2.661*	0.076	1.466
Constant	0.0063***	0.000	0.003
Observations	2950		
Pseudo R2	0.176		

Robust p-value in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Regression results table for impact of community dialogues on attitudes toward SGBV (n=2,931)

Attitudes Index (PCA)	Coefficient	p-value	Std. error
DiD Treatment effect	0.276	0.285	0.257
Treatment	-0.285*	0.071	0.157
Endline	0.649***	0.000	0.180
Age	0.0149***	0.008	0.006
Zulu	0.526***	0.003	0.171
Xhosa	0.166	0.515	0.254
Tswana	-0.091	0.722	0.255
Afrikaans	0.564	0.284	0.524
race: white	-0.379	0.384	0.434
race: coloured	-0.296	0.525	0.464
race: indian	0.381	0.228	0.314
race: asian	3.615***	0.000	0.257
Lower than secondary education	-0.864***	0.000	0.144
Tertiary education or higher	-0.824***	0.000	0.173
Income < R1,000 per month	-0.236	0.137	0.158
Income > R5,001 per month	1.107***	0.000	0.148
Sex crimes per 1,000	-0.11	0.245	0.094
Perception of SGBV as a problem in the community	-0.176**	0.014	0.070
Knows a SGBV suvivor	0.577***	0.000	0.106
province: Gauteng	0.0293	0.917	0.280
province: Limpopo	-0.079	0.788	0.292
province: North West	0.435	0.242	0.370
province: Kwa-Zulu	0.145	0.652	0.320
province: Western Cape	-0.498**	0.026	0.221
province: Nothern Cape	-0.335	0.264	0.298
province: Free State	0.343	0.349	0.365
province: Mpumalanga	0.349	0.264	0.311
Urban precinct	0.137	0.288	0.128
Constant	-0.779**	0.031	0.356
Observations	2,931		
R-squared	0.118		

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

ANNEX VII: INITIAL POWER CALCUATIONS

Power Calculations

One of the challenges of this evaluation is the small sample size of geographic units available for randomized sampling. The number of TCC catchment areas is relatively small since there are only 51 TCC currently in operation. For the purposes of the evaluation, a community is defined as a police precinct, following extensive consultation with government officials and CSO's and the determination that this is a natural community unit at which local administrative data is available. Many TCCs have only three to six police stations serving them, so for each TCC, three of the neighboring police precincts will be randomly sampled into the study. Due to these small numbers, the design had to be limited to only two interventions with one control. While it would have been useful to evaluate the impact of other interventions, or have a third treatment group with the two interventions implemented at the same time to learn more about the combined effects, the small sample size of TCCs and communities within each TCC catchment area made these options infeasible.

For the purposes of the power calculation, each group is rounded to 50, so the modeled design calculates MDES assuming ~50 sites per group.

The first project component is a two-level multi-site cluster randomized trial (MSCRT) with cluster level outcomes. In this case, randomization occurs at the second level, which is the community. The outcomes for this component are also measured at the community level.

The second project component is three-level MSCRT with individual-level outcomes. Here, again, randomization occurs at the second level, the community, but in this case, the outcomes are measured at the first level: the level of the individual.

For both designs, blocking shall be used in order to improve the precision and power of the IE. Depending on data availability, several of the following types of variables will be used to construct site blocks: geographic regions, rural versus urban, crime rates and reported incidents of sexual assault, and demographics. These sites or blocks can be viewed as fixed.

Unfortunately, since few comparable studies are available and there is no possibility to conduct a pilot, it is difficult to have a high degree of confidence in the estimates of model parameters and the corresponding effect sizes. The following calculations use relatively conservative estimates for each parameter for this reason.

All power calculations were performed using the Optimal Design software package.

Design 1: Cluster-Level Outcomes

The first design is a two-level MSCRT, or blocked, cluster randomized trial. The first level represents the stage in which communities shall be blocked prior to randomization, and the second level represents the stage where the interventions will be administered to the treatment communities, after which cluster level outcomes will be measured. These outcomes include precinct-level estimates of the total number of GBV reports, utilization of TCC services, etc. obtained from administrative data. The power calculations are based on standard assumptions, which are presented in Table 1.

Table 1: Assumptions for Power Calculations, Design 1

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

This IE employs an effect size approach to power analysis because the number of communities that can be used in the intervention is immutable. First, the desired level of power is set to .80 and significance level to .05 (as is standard in the literature). Next, the effect size that can be detected for the given sample size can be computed. There are fifty communities in each group, and we use two blocking sites to ensure an even number of clusters across each site. No adjustment is made for inclusion of any covariates for the purposes of these calculations. If covariates are included, this will serve to slightly improve the power. The calculations use the default .70 cluster level reliability (since this is the standard for publication).

Table 2 presents the results for MDES estimates under the assumptions listed in Table 1. A graph showing the MDES versus power is presented in Figure 4. The MDES ranges from 0.53 and 0.65, which is comparable to a moderate treatment effect.

Table 2: Summary of MDES under Various Assumptions for Design 1

Power	Alpha	CLR	B	MDES
.80	.05	.7	.1	.65
.80	.05	.7	.2	.63
.80	.05	.7	.3	.60
.80	.10	.7	.1	.58
.80	.10	.7	.2	.56
.80	.10	.7	.3	.53

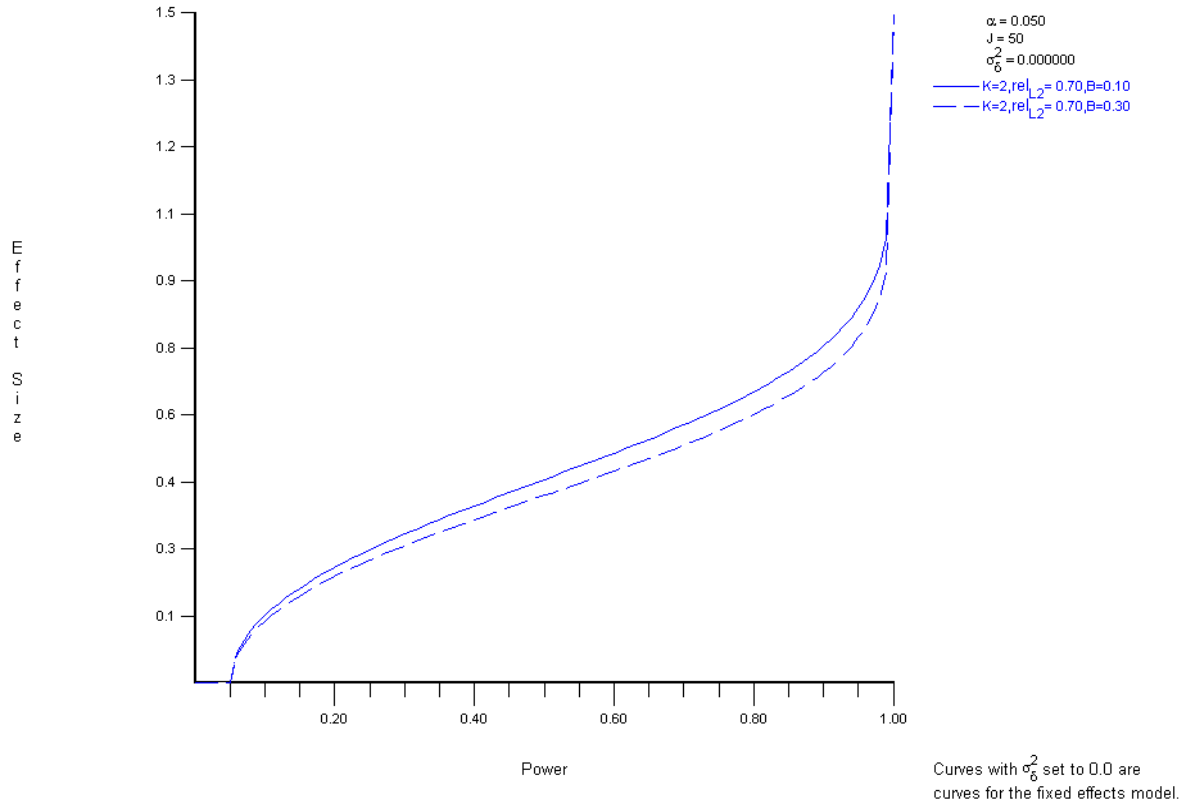


Figure 1: Relationship between MDES and Power, Design 1, cluster level outcomes

Design 2: Individual-Level Outcomes

The second design is a three-level MSCRT, or blocked cluster randomized trial with individual level outcomes. Specifically, the first level is the blocking variable, the second level is the treatment level (clusters - communities), and the third level is the measurement level (individuals). The outcomes will be gathered using surveys to be conducted in each community. The surveys will poll twenty female household heads per community and twenty institutional representatives. Table 3 shows the standard assumptions utilized by the power calculations.
Again baseline data or pilot results are not available, so we opted to use .1 and .2 for the ICC coefficients among individual, more conservative than Optimal Design's default of .05.

The power calculations for the survey instruments do not assume a panel survey or repeated measures, which would increase the power of the study since data collection will not be panel-based. Instead, new respondents will be drawn each round.

Table 3: Assumptions for Power Calculations, Design 2

Target power: 80%
α = 5%
Intra-Class Correlation = .1 to .2
B = .2 and .3
σ^2 = 0 (fixed effects)
K = 2
J = 50
η1 = 20 surveys (institutional)
η2 = 20 surveys (community - household)
δ = standardized MDES, to be estimated

Table 4 displays the estimated MDES under a range of different assumptions, with variation on the amount of variation explained by the blocking variable "B" from 20-30 percent, and ICC among households from .1 to .2. These calculations yield an MDES for individual level outcomes of between .19 and .26, significantly lower than for the first design. This design is able to capture small effects. Figure 5 demonstrates the relationship between MDES and power for the second design.

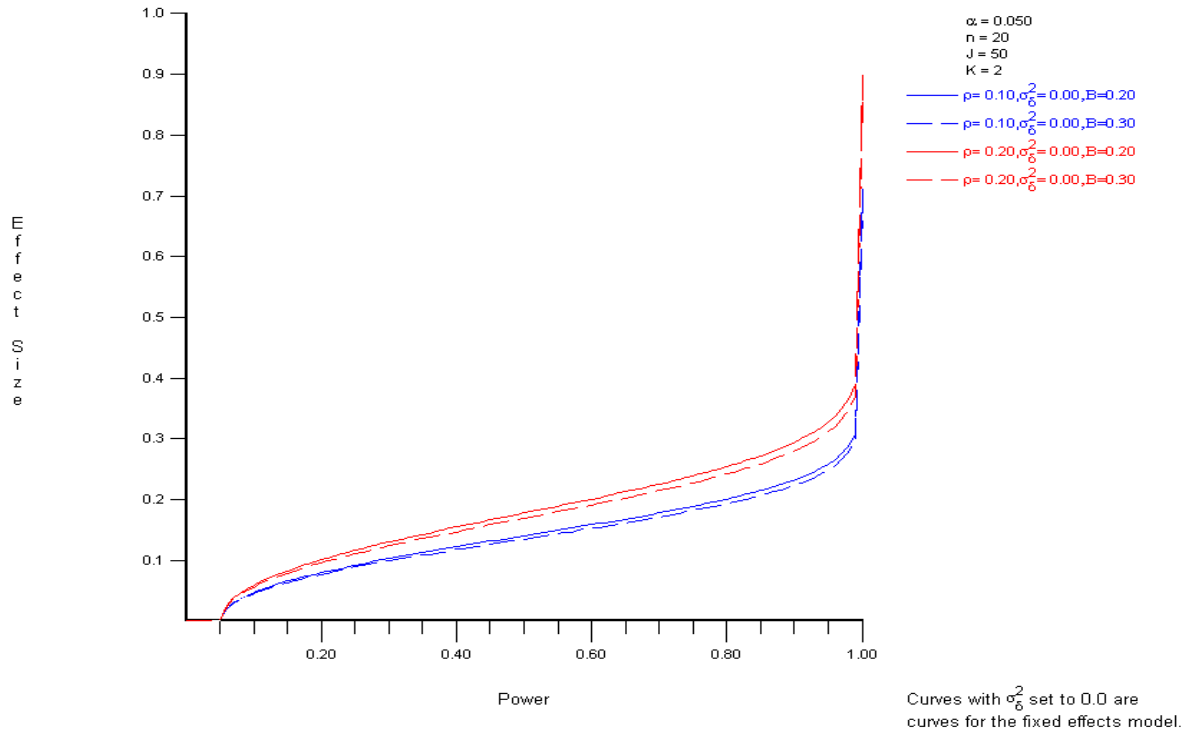


Figure 2: Relationship between MDES and Power – Design 2, individual level outcomes

Table 4: Summary of MDES under Various Assumptions for Design 2

Power	Alpha	N	B	ICC	MDES
.80	.05	20	.20	.20	.26
.80	.05	20	.30	.20	.24
.80	.05	20	.20	.10	.20
.80	.05	20	.30	.10	.19

Assumptions of the Sampling and Randomization Plan

The feasibility of the implementation of the proposed sampling and randomization plan is dependent on the following two assumptions:

1. The implementing partners will be able to complete the implementation within the boundaries of the one police precinct in each TCC catchment area assigned to the relevant treatment group.
2. The evaluation team will receive, in a timely manner, TCC case record data that is or can be disaggregated to police precinct level.

Should one of these assumptions not hold, the evaluation team would need to implement an alternative plan of randomizing at the TCC level. It must be noted that TCC-level randomization would result in a loss of power for the IE. The loss of power would be most significant for design 1 (precinct-level outcomes). The power calculations for TCC-level randomization yield a much higher range for the MDES (.86 to .93, depending on the assumptions), implying only large treatment effects of the intervention would be able to yield statistically significant measured differences within this IE design. For design 2 (individual-level outcomes), the change in MDES is less dramatic, though still notable (.27 to .37 under varying assumptions). These options are presented in further detail in table 5 below.

Table 5: Overview of possible approaches

	Preferred option	**Alternative option**
Problem and research question	TCC utilization is lower than desirable given the extent of gender based violence. How then should utilization be increased? More specifically, what are the independent effects of the following two approaches to increasing TCC utilization: (1) an educational campaign targeted at women in TCC catchment areas designed to inform them about the TCCs and reduce the stigma attached to using TCCs, and (2) a training program designed for police and teachers to help them identify victims of gender based violence and refer them to the TCCs.	
Approaches	Within each of the TCC catchment areas SI will randomly assign police precincts to one of three groups: control, professional referrals, or educational campaign groups. (Typically there are 3-6 precincts per catchment area.) As such, the evaluation will be based on 153 police precincts, including 51 control, 51 professional referrals, and 51 education campaign precincts. The main evaluation will compare TCC utilization at the precinct level before and after the intervention and determine which approach, if either,	SI will randomly assign the 51 TCCs to one of three groups: 17 will be assigned to the control group, 17 to the professional referral group, and 17 to the educational campaign group. Given the size of the catchment areas (often a radius of 25km around the TCC) it will still be desirable to focus the intervention in specific precincts. The main evaluation will compare TCC utilization at the precinct level before and after the intervention and determine which approach, if either, resulted in greater increases in TCC utilization.

	resulted in greater increases in TCC utilization.	
Strengths/ weaknesses	This approach will provide a higher number of observations to test the impact of the two approaches. The design will be able to detect a moderate increase in TCC utilization. Nonetheless this approach is only possible if the following conditions are met. (1) TCCs must collect and provide intake information at the precinct level, (2) the implementing partners must be able to conduct activities in all 51 TCC catchment areas and limit their activities to assigned precincts.	This approach will be easier and more cost effective for implementation of the intervention. Nonetheless, because of the small sample size, the main impact evaluation will be poorly powered, and will only be able to detect a large increase in TCC utilization. This will be a high bar to overcome and it is unlikely that the IE will be able to make a confident determination. Even under this approach, it will still be desirable for the TCCs to collect and provide intake information at the precinct level. The study will still be able to confidently test aspects of the education campaign through the household survey.

ANNEX VIII: COMMUNITY SURVEY DATA COLLECTION TIMELINE

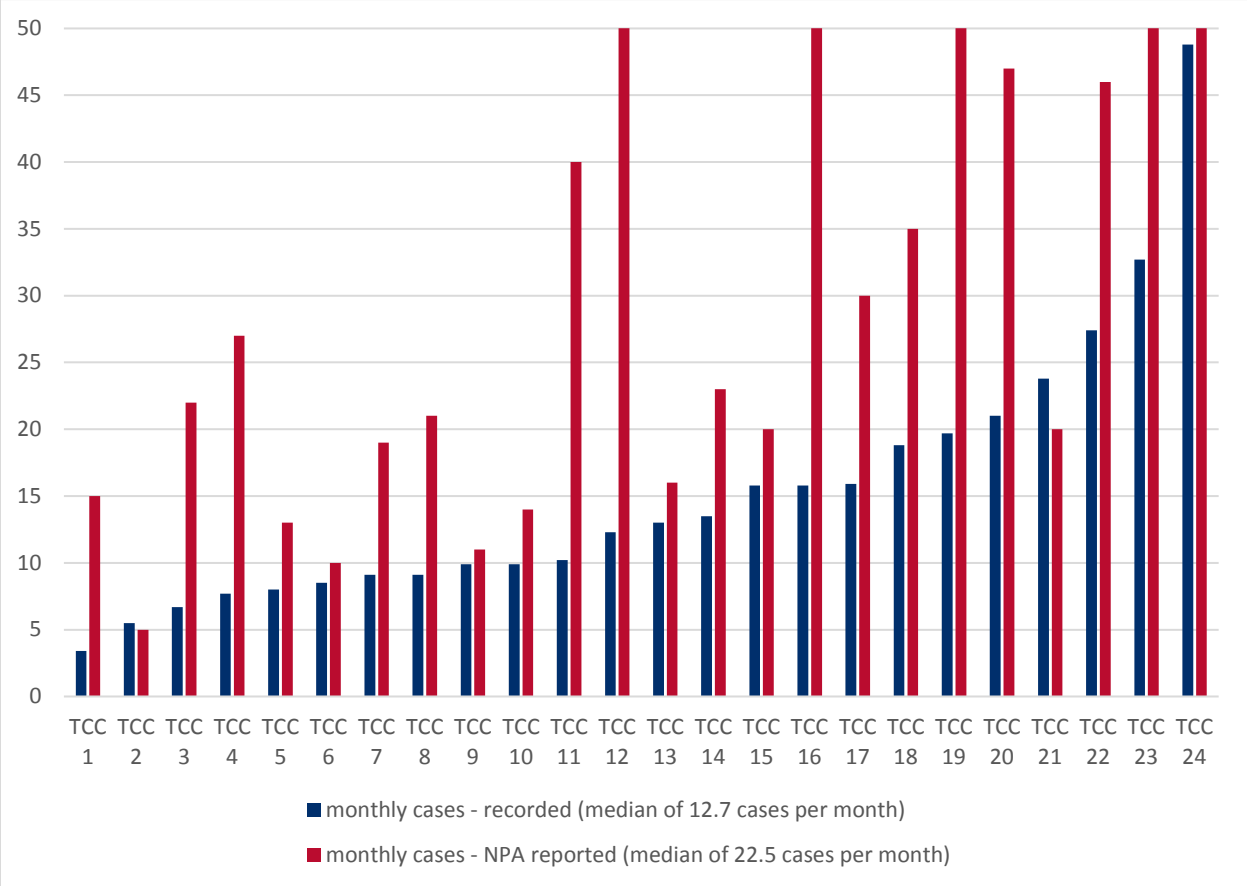
IRI HOUSEHOLD DATA COLLECTION				
Province	**TCC**	**Police Precinct**	**Baseline Date**	**Endline Date**
Gauteng	Laudium	Diepsloot	14-Aug-14	3-Feb-15
Gauteng	Laudium	Olievenhoutbosch	15-Aug-14	3-Feb-15
Gauteng	Tembisa	Rabie Ridge	19-Aug-15	4-Feb-15
Gauteng	Tembisa	Thembisa	20-Aug-15	4-Feb-15
Gauteng	Natalspruit	Thokoza	21-Aug-14	9-Feb-15
Gauteng	Natalspruit	Vosloorus	22-Aug-14	9-Feb-15
Gauteng	Mamelodi	Mamelodi	12-Aug-14	2-Feb-15
Gauteng	Mamelodi	Silverton	23-Aug-14	2-Feb-15
Gauteng	Baragwanath	Meadowlands	25-Aug-14	10-Feb-15
Gauteng	Baragwanath	Orlando	26-Aug-14	10-Feb-15
Gauteng	Lenasia	Lenasia	27-Aug-15	6-Feb-16
Gauteng	Lenasia	Ennerdale	27-Aug-14	6-Feb-15
Gauteng	Kopanong	Vanderbljipark	28-Aug-14	5-Feb-15
Gauteng	Kopanong	Sebokeng	28-Aug-14	5-Feb-15
Limpopo	Mankweng	Mankweng	6-Sep-14	1-Mar-15
Limpopo	Mokopane	Mahwelereng	3-Sep-14	26-Feb-15
Limpopo	Mokopane	Tinmyne	3-Sep-14	27-Feb-15
Limpopo	Seshego	Mashashane	5-Sep-14	28-Feb-15
Limpopo	Seshego	Seshego	5-Sep-14	1-Mar-15
Limpopo	Nkhensane	Giyani	9-Sep-14	2-Mar-15
Limpopo	Musina	Musina	10-Sep-14	3-Mar-15
Limpopo	Musina	Masisi	11-Sep-14	4-Mar-15
Limpopo	Thohoyandou	Thohoyandou	12-Sep-14	3-Mar-15
Limpopo	Thohoyandou	Magatle	13-Sep-14	28-Feb-15
Mpumalanga	Tonga	Komatipoort	19-Nov-14	10-Mar-15
Mpumalanga	Tonga	Tonga	20-Nov-14	10-Mar-15
Mpumalanga	Temba	Pienaar	21-Nov-14	11-Mar-15
Mpumalanga	Temba	Kabokweni	22-Nov-15	11-Mar-15
Mpumalanga	Ermelo	Breyton	23-Nov-15	12-Mar-15
Mpumalanga	Ermelo	Ermelo	25-Nov-14	12-Mar-15
Mpumalanga	Evander	Leslie Leandra	26-Nov-14	13-Mar-15
Mpumalanga	Evander	Embalenhle	26-Nov-14	13-Mar-15
Mpumalanga	Witbank	Delmas	27-Nov-14	9-Mar-15
Mpumalanga	Witbank	Witbank	28-Nov-14	9-Mar-15
KwaZulu-Natal	Umlazi	Umlazi	16-Jan-14	15-Jun-15
KwaZulu-Natal	Umlazi	Bhekithemba	16-Jan-15	15-Jun-15
KwaZulu-Natal	Phoenix	Inanda	17-Jan-15	16-Jun-15

KwaZulu-Natal	Phoenix	Phoenix	18-Jan-14	16-Jun-15
KwaZulu-Natal	RK Khan	Marianhill	19-Jan-14	17-Jun-15
KwaZulu-Natal	RK Khan	Hillcrest	19-Jan-15	17-Jun-15
KwaZulu-Natal	Port Shepstone	Port Shepstone	20-Jan-15	20-Jun-15
KwaZulu-Natal	Port Shepstone	Hibberdene	20-Jan-15	20-Jun-15
KwaZulu-Natal	Stanger	Umhlali	21-Jan-15	19-Jun-15
KwaZulu-Natal	Stanger	Sundumbili	22-Jan-15	19-Jun-15
KwaZulu-Natal	Ngwelezane	Esikhawini	23-Jan-15	18-Jun-15
KwaZulu-Natal	Ngwelezane	Empangeni	24-Jan-15	18-Jun-15
KwaZulu-Natal	Edendale	Taylors Halt	24-Jan-15	21-Jun-15
KwaZulu-Natal	Edendale	Mountain Rise	25-Jan-15	21-Jun-15
Eastern Cape	Taylor Bequest	Afsondering	23-Feb-15	15-Jul-15
Eastern Cape	Tayler Bequest	Avondale	24-Feb-15	15-Jul-15
Eastern Cape	Bizana	Bizana	25-Feb-15	16-Jul-15
Eastern Cape	Bizana	Mpisi	26-Feb-15	16-Jul-15
Eastern Cape	Lusikisiki	Hlababomvu	26-Feb-15	17-Jul-15
Eastern Cape	Lusikisiki	Lusikisiki	27-Feb-15	17-Jul-15
Eastern Cape	Libode	Libode	27-Feb-15	19-Jul-15
Eastern Cape	Libode	Ngqeleni	28-Feb-15	19-Jul-15
Eastern Cape	Umthatha	Umthatha	1-Mar-15	20-Jun-15
Eastern Cape	Umthatha	Tsolo	1-Mar-15	18-Jul-15
Eastern Cape	Butterworth	Centane	2-Mar-15	21-Jun-15
Eastern Cape	Butterworth	Idutywa	2-Mar-15	20-Jun-15
Eastern Cape	Mdantsane	Mdantsane	3-Mar-15	22-Jun-15
Eastern Cape	Mdantsane	East London	3-Mar-15	22-Jun-15
Eastern Cape	Port Elizabeth	Motherwell	4-Mar-15	23-Jun-15
Eastern Cape	Port Elizabeth	Bethelsdorp	4-Mar-15	23-Jun-15
Western Cape	George	George	5-Mar-15	6-Sep-15
Western Cape	George	Conville	5-Mar-15	6-Sep-15
Western Cape	Worcester	Worcester	6-Mar-15	7-Sep-15
Western Cape	Worcester	De Doorns	6-Mar-15	7-Sep-15
Western Cape	Khayelitsha	Harare	8-Mar-15	8-Sep-15
Western Cape	Khayelitsha	Lingelethu-West	8-Mar-15	8-Sep-15
Western Cape	Bellville	Kraaifontein *	8-May-15	N/A
Western Cape	Bellville	Delft *	10-May-15	N/A
Western Cape	Mannenberg	Gugulethu *	11-May-15	N/A
Western Cape	Mannenberg	Mitchells Plain *	9-May-15	N/A
North West	Rustenburg	Phokeng	12-May-15	1-Sep-15
North West	Rustenburg	Boitekong	12-May-15	1-Sep-15
North West	Mafikeng	Mafikeng	13-May-15	4-Sep-15
North West	Mafikeng	Madibogo	14-May-15	4-Sep-15

North West	Potchefstroom	Ventersdorp	14-May-15	3-Sep-15
North West	Potchefstroom	Klerkskraal	15-May-15	3-Sep-15
North West	Klerksdorp	Klerksdorp	15-May-15	2-Sep-15
North West	Klerksdorp	Kanana	16-May-15	2-Sep-15
North West	Taung	Taung	30-Apr-15	5-Sep-15
Free State	Sasolburg	Deneysville	16-Apr-15	22-Sep-15
Free State	Sasolburg	Sasolburg	17-Apr-15	21-Sep-15
Free State	Bethlehem	Bethlehem	18-Apr-15	23-Sep-15
Free State	Bethlehem	Reitz	18-Apr-15	22-Sep-15
Free State	Welkom	Odendaalsrus	19-Apr-15	24-Sep-15
Free State	Welkom	Thabong	19-Apr-15	23-Sep-15
Free State	Bloemfontein	Bloemspruit	21-Apr-15	25-Sep-15
Free State	Bloemfontein	Park Road	21-Apr-15	24-Sep-15
Northern Cape	Kimberley	Kagisho	23-Apr-15	1-Oct-15
Northern Cape	Kimberley	Kimberley	23-Apr-15	1-Oct-15
Northen Cape	De Aar	Britstown	24-Apr-15	2-Oct-15
Northern Cape	De Aar	Sunrise	24-Apr-15	2-Oct-15
Northern Cape	Springbok	Springbok	26-Apr-15	4-Oct-15
Northern Cape	Steinkopf	Steinkopf	26-Apr-15	4-Oct-15
Northern Cape	Kuruman	Bothithong	29-Apr-15	5-Oct-15
Northern Cape	Kuruman	Mothibistad	30-Apr-15	5-Oct-15
Northern Cape	Taung	Pampierstat	1-May-15	6-Oct-15

ANNEX IX: COMPARISON OF MONTHLY CASES RECORDED THROUGH PRIMARY DATA COLLECTION AND MONTHLY CASES REPORTED BY THE NPA (OCT. 2015-SEPT. 2016)

As shown in the figure below, NPA utilization data is considerably higher in many cases than the primary data collected by the evaluation team directly from the TCCs. There are at least two potential explanations for these differences. First, the NPA data is from October 2015 to September 2016, whereas the evaluation data is from a selection of months between the fall of 2014 and the summer of 2015. Because these data span different time periods, we would not expect the numbers to completely match up. Implementers contend that utilization increased from 2015 to 2016. Furthermore, NPA data shows a seasonal drop in reporting during the second quarter, when most of our data collection occurred. Second, there is a possibility that one or both of the data sources are inaccurate. In the primary data collected by the evaluation, there is a possibility of under-reporting. This would contradict TCC statements from the 24 TCCs for which we present primary data that the information provided is close to complete. There is also a possibility of over-reporting by the NPA, which would contradict NPA statements. For example, it is possible that the NPA data includes multiple visits from the same individual, while the evaluation data only includes the first visit of each presenting survivor. Does this affect the evaluation findings? It would certainly be better to have complete utilization data from the TCCs in which we feel confident and from which we can make descriptive inferences with more confidence. Nonetheless, as noted in the report, if there is a problem of underreporting, it should affect control and treatment precincts equally. As such, we feel that even provided the possibility of underreporting, the evaluation still offers an effective test of program impact.



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