The Victims' Charter

Assessing the Effectiveness of Implementation by Departments of Health and Correctional Services.

NATIONAL REPORT 2012

Commission for Gender Equality
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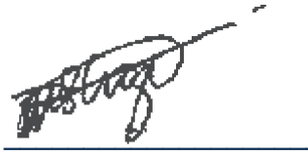
FOREWORD

The high levels of crime in South Africa, particularly sexual assaults against women and children, has made it imperative that the Crime and Justice Cluster is effective not only in delivering justice, but also in ensuring that the rights of victims of crime are safeguarded and reinforced. The Victims Charter (VC) seeks not only to reinforce the rights of the victims of crime in a rights-based approach to justice, but also seeks to place the victims of crime at the centre of both the system of the administration of justice in South Africa and service delivery processes. The national Departments of Health and Correctional Services have not only pledged to implement the Victims Charter; they have also committed to serving the victims of crime in line with the standards of service outlined in the Victims Charter.

Despite official statements of intention and lists of departmental strategic objectives attempting to realise the aims of the Victims Charter, this report identifies a range of constraints and challenges that seem to undermine officially stated commitments to the Victims Charter. The two departments covered in this study have established facilities in administrative regions across the nine provinces with the purpose of implementing the Victims Charter. While it was found that many of these facilities operate under enormous operational constraints due to financial and staff shortages, this has not undermined the dedication and commitment of thousands of professionals to providing vital care to victims of crime throughout the country.

The CGE hopes that this report will contribute towards a broader dialogue within the Crime and Justice Cluster to develop appropriate responses and effective interventions to strengthen internal systems and practices within the facilities tasked with serving the needs of victims of crime across South Africa.

The CGE is grateful to both the national Department of Health and Correctional Services, especially their regional facilities (i.e. hospitals, Thuthuzela Care Centres and Parole boards), for the cooperation offered to the CGE team of researchers by their professional staff during the period of the study.



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ACRONYMS

ARVs:	Antiretrovirals
CFM:	Clinical Forensic Medicine
DCS:	Department of Correctional Services
DOH:	Department of Health
DoJ & CD:	Department of Justice and Constitutional Development
DSD:	Department of Social Development
FAMSA:	Family and Marriage Association of South Africa
FOVOC:	Foundation for Victims of Crime
M&E:	Monitoring and Evaluation
MoU	Memorandum of Understanding
NICRO:	National Institute for Crime and the Reintegration of Offenders
NIP:	National Implementation Plan
NPA:	National Prosecution Authority
OPD:	Outpatient Department
PACT	Private Agencies Collaborating Together
PEP:	Post Exposure Prophylaxis
PEPFAR:	Presidential Emergency Plan for Aids Relief
SAPS:	South African Police Services
TCC:	Thuthuzela Care Centre
VAO:	Victims Assistance Officer
VC	Victims Charter
VEP:	Victim Empowerment Programme
VOC:	Victims of Crime
VOM:	Victim Offender Mediation
VRW:	Victims Rights Week

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SECTION 1:

Background and Overview

SECTION A: Background and Overview

1.1. Introduction

This report is the third in a series by the Commission for Gender Equality (CGE) on the implementation of the Victims Charter (VC) in South Africa.[1] The current report focuses on the work of the national Departments of Correctional Services (DCS) and Health (DOH), including their provincial counterparts.

Victims of crimes usually need a range of services to address their plight, and various state institutions are obliged to provide these services in line with the VC, a document that outlines the rights and services to be afforded to the victims by selected state institutions.[2] For instance, the South African Police Service (SAPS) is usually the first service point for victims to report a crime. In the case of sexual assault, victims might approach a health facility (e.g. hospital) before approaching other state institutions within the justice and crime prevention cluster for services such as reporting a crime (i.e. police services) counselling and psychosocial services (health facilities or Thuthuzela Care Centres (TCCs)) or for shelter (provided by the Department of Social Development (DSD)). The Department of Justice provides prosecutorial services while the Department of Correctional Services (DCS) is responsible for the incarceration of perpetrators. The VC provides for victims of crime to be adequately informed, not only about their rights and the services they are entitled to, but also about progress in the court cases and the fate of the perpetrators.

Six state institutions (i.e. Correctional Services, Health, SAPS, National Prosecuting Authority (NPA) Social Development and Justice & Constitutional Development (DoJ & CD) are responsible for providing an integrated set of services for the victims of crime, in line with the VC and the National Implementation Plan (NIP) for the Service Charter for Victims of Crime (2007).

1.2. Objectives of the study

The purpose of the study was to monitor and assess the implementation of the VC by the Departments of Health and Correctional Services. The study sought to determine the extent to which the two departments are rendering services to victims of crime in a manner that is consistent with the VC and related guiding policies. For the purpose of this study, the emphasis is placed on victims of sexual and domestic violence, where the services provided by the two departments are crucial. Specifically the objectives of this study are to:

- Assess whether the implementation of the VC by the DOH and DCS is consistent with the guiding policy documents
- Establish whether the services, conditions and infrastructure in the hospital facilities/TCCs and correctional facilities meet the minimum standards as prescribed
- Identify gaps and challenges with a view to making recommendations for the effective implementation of the VC.

[1] The first report (2009) assessed the work of the Department of Justice and Constitutional Development (DOJ&CD) and the South African Police Services (SAPS). The second report (2011) focused on the Department of Social Development (DSD) and the National Prosecuting Authority (NPA).
[2] Department of Justice and Constitutional Development (2007), National Implementation Plan: Service Charter for Victims of Crime.

In line with CGE's constitutional mandate, the findings of this study will be reported to Parliament. The policy document on Minimum Standards of Services for victims of crime outlines what is expected from service providers in terms of services to be rendered to victims of crime.

1.3. Methodology and Approach

Three methods were used to conduct the study: review of relevant documents and publications, in-depth interviews with relevant state officials, and observations of state facilities in the provinces where services are rendered to victims of crime.

1.3.1. Review of key documents

This entailed reviewing a limited number of relevant documents and publications relating to the treatment of, and services for, the victims of crime. Relevant departmental policy and programme documents as well as reports, including the National Implementation Plan (NIP) (2006-2011) and the Strategic Plans and Annual Reports (2011/12) of the two departments were analysed. Other relevant publications, such as the Victims of Crime Surveys (VOCS) conducted by Statistics South Africa in 2011 and 2012 were used to provide additional insights and contextual data on sexual crime.

1.3.2. Observations of facilities

In 2009 the Interdepartmental Committee, through the Department of Justice, developed a checklist for identifying what each department should provide in terms of onsite services and facilities for victims of crime. This checklist was used in the two previous studies. For the current study it was used to observe the health facilities (i.e. public hospitals or clinics) and one-stop centres, as well as correctional facilities (i.e. parole board centres).

1.3.3. Key informant interviews

For the purpose of this study, focus was placed on selected provincial public health facilities (i.e. public hospitals) and one-stop centres, where services for victims of crime are rendered by the DOH. Also, selected correctional facilities (i.e. parole boards) in the provinces operated by the DCS were identified for observation. Senior state officials were interviewed. In particular, senior health workers at selected public health facilities and one-stop centres in the provinces were interviewed. Similarly, senior state officials at Correctional Services facilities in the provinces were interviewed. A schedule of open-ended questions was used to guide these informant interviews. Included among the key issues explored in this study were the following:

- Knowledge and understanding of the VC, the victim empowerment programme, (VEP) and victim empowerment policy guidelines
- Institutional capacity issues (e.g. skills development, resources, etc.)
- Services rendered to victims of crime
- Monitoring and evaluation.

[3] RSA (2007), Minimum Standards on Services for Victims of Crime for implementing the Service Charter for Victims of Crime in South Africa.
[4] This checklist draws heavily from one developed by the North West Regional Justice Department (August 2008) and also from the Complainants' Management Form developed by the Mpumalanga Regional Justice Department.

1.3.4. Limitations of the study

The study was subject to two crucial limitations that need to be acknowledged, for they have the potential to impact negatively on the robustness of the findings. Firstly, the CGE did not have a researcher to conduct research in the Western Cape Province. Therefore this report does not have findings relating to this province.

Secondly, due to limited research capacity and financial resources it was not possible for the research team to undertake a comprehensive study focusing on all the key aspects of the implementation of the VC. As a result, the study was confined to two national departments (Health and Correctional Services) and selected facilities in eight of the nine provinces.

Finally, the findings related to the Mpumalanga province were not included in the report because the information obtained was insufficient.

1.4. Review of Key Documents

The following documents are important in guiding state institutions in the implementation of the VC :

- The National Implementation Plan (NIP) and the Service Charter for Victims of Crime
- National policy guidelines for victim empowerment
- Minimum standards for service delivery in victim empowerment
- Policy framework and strategy for shelters for victims of domestic violence in South Africa
- Guidelines for services to victims of sexual offences
- The Service Charter for Victims of Crime in South Africa, 2004 and Minimum Standards for Victims of Crime

The Minimum Standards on Services for Victims of Crime (hereafter the Minimum Standards) and the Service Charter for Victims of Crime (hereafter the 'Victims Charter'), serve as tools for protecting and promoting the rights of victims of crime in line with South Africa's obligations under various international and regional human rights instruments. The two documents provide a framework that consolidates all key laws and policies on the rights of victims and the services to be provided to them in fulfilment of the following objectives:

- Eliminate secondary victimisation in the criminal justice process
- Ensure that victims remain central to the criminal justice process
- Clarify the service standards that can be expected by and are to be accorded to victims whenever they come into contact with the criminal justice and associated systems
- Make provision for victims' recourse when standards are not met.

The Minimum Standards document provides information on what is expected from service providers. It also outlines the rights of victims and states what standards and quality of services victims of crime could expect. The Minimum Standards incorporate a complaints mechanism to address failure to adhere to the Standards. The Victims' Charter spells out

[5] For more information refer to each individual document.

seven rights which victims are entitled to:

- The right to be treated with fairness and respect for dignity and privacy
- The right to offer information
- The right to receive information
- The right to protection
- The right to assistance
- The right to compensation
- The right to restitution.

Underpinning all these key policy and legislative frameworks is the country's constitution , particularly the Bill of Rights which guarantees all citizens a variety of basic human rights as well as the right to dignity, security, equality before the law, fair treatment and access to basic services provided by the state.

[6] Department of Social Development (2010), Guidelines for Services to Victims of Sexual Offences, (February), p. 5
[7] Department of Social Development (2009), Strategy for Shelters of Victims of Crime and Violence in South Africa, (31 March), p.17-18
[8] RSA, The Constitution of the Republic of South Africa, Act 108 of 1996.
[9] RSA, Constitution of the Republic of South Africa (Chapter 2, Bill of Rights).

SECTION 2: The Findings

SECTION B: THE FINDINGS

This section will report on and discuss the findings of the study on the implementation of the VC by the Departments of Health and Correctional Services in the eight provinces covered by the study. The section is structured as follows: the findings will be presented separately for each of the two departments. For each department, the findings will be presented for the national office, followed by the provincial findings. Conclusions and recommendations will be presented for each department at the end of the report.

2.1. Department of Health

2.1.1. National Findings – Policy Frameworks and National Perspective on Implementation

1. Departmental Policy Frameworks

According to the department's director-general, the department committed itself to ensuring that victims of crime are given the best treatment in health facilities by using a multidisciplinary integrated approach in dealing with crime. The Batho Pele Principles and the Patients' Rights Charter would be used as guiding documents to ensure that victims of crime receive the appropriate healthcare services. The department further committed itself to ensuring that designated health facilities for clinical forensic medicine (CFM) are established, and are adequately resourced to allow easy access to comprehensive health service delivery for victims of crime.

Three of the department's key strategic objectives provide insights into its commitment to the VC. These are:

- To promote the equal enjoyment of all the rights and freedom guaranteed in the Constitution
- To set service standards for victims of crime, and ensure that victims remain central in the criminal justice system in order to eliminate secondary victimisation.
- To provide for the consolidation of the present legal framework in South Africa relating to the rights of, and services provided to, victims of crime.

In addition to these strategic objectives, the department has also developed a number of policies, directives and related policy instruments to underpin its commitment to the implementation of the VC. Among them are the following.

- The National Management Guidelines for Sexual Assault, October 2003 and the National Sexual Assault Policy, Department of Health, January 2005.
- National Health Act, 2003: Regulations Regarding the Rendering of Clinical Forensic Medicine Services, 2 March 2012.
- National Directives and Instructions on conducting a forensic examination on survivors of sexual-offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 200, DOH, 6 March 2009.

[10] RSA (2007), National Implementation Plan: Message of Support, Director-General, p.80.
[11] Ibid.

- The Patients' Rights Charter
- Realising rights for victims of crime in the Health Sector as determined by the Minimum Standards.
- Instructions on conducting forensic examinations of survivors of sexual- offences cases in terms of Criminal Law (i.e. the Sexual Offences and Related Matters Amendment Act of 2007).
- Regulations and schedules regarding the rendering of clinical forensic medical services for victims of crime, especially sexual assault and domestic violence

While these policy frameworks and directives are clearly intended to ensure the effective provision of a full range of comprehensive services to the victims of crime, the actual situation at health facilities in many provinces reflects a far less rosy picture.

2. Implementation of the Victims Charter: National Perspective

2.1 Institutional Capacity

2.1.1 Knowledge and Understanding of the Victims Charter

The Department has a national coordinator in the Forensic Pathology Service Unit, who coordinates and monitors the implementation of the VC across all nine provinces. The coordinator was interviewed and displayed an understanding of the key policy and implementation issues relating to the VC, as will become clear in this discussion.

However, the coordinator indicated that there is a widespread lack of knowledge and understanding of the VC among health workers in the provinces. For instance, the coordinator stated, "If I ask some of the health workers whether they know what the seven rights of the victims are, some of them are surprised; they don't know what I 'm talking about." While this is a generalisation, some of the findings from the provinces appear to confirm this observation.

2.1.2 Internal Skills Development/Capacity Building

Based on the interview with the national coordinator, the department provided the necessary training for forensic health workers across the country, focusing on skills relevant for implementation of the VC and the rights of the victims. The coordinator added that the training placed sensitivity on avoiding re-victimisation of victims at health facilities across the country. The training provided varies, and includes post-exposure prophylaxis (PEP) for victims of sexual violence; clinical forensic medicine and skills for doctors and nurses on how to handle victims of sexual assault. In addition, the national coordinator referred to training health workers on the management of sexual assault and the collection of vital information from victims of crime. However, as will be apparent in this report, the findings from the provinces do not seem to bear this out, with some of the health workers at numerous health facilities across the country seeming to lack the necessary skills, knowledge and understanding of the VC and the obligations of the department to provide minimum standards of services for victims of crime.

[12] For in-depth information, refer to the specific documents as listed.
[13] RSA, (2009) Government Notices (31953) National Department of Health, Notices (223) National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offences, 6 March 2003.
[14] Interview, national coordinator for Victims Charter, DOH.
[15] Interview, national Coordinator for the Victims Charter and Clinical Forensic Medicine.

2.1.3. Monitoring & Evaluation

It would appear that there is no standard and consistent practice of monitoring and evaluating the implementation of the VC at health facilities across the country. This is in contravention of the NIP's requirements. According to the national coordinator, budgetary constraints are responsible for this. However it would appear that many health facilities have rudimentary systems, such as suggestion or complaints boxes, which are routinely ignored. This appears to reflect the experience at many health facilities in the provinces, as will be discussed in this report.

2.2. Services Rendered to Victims

According to the national coordinator, a range of services, such as counselling, pre- and post-HIV/AIDS test counselling, provision of PEP and antiretrovirals (ARVs) and other services are available at designated healthcare facilities across all nine provinces. So are clinical forensic services, which are crucial in terms of collecting forensic evidence from the victims to ensure that the necessary medical intervention is provided where required. These services are supposed to be available at all healthcare facilities across the country on a 24-hour basis.

2.3. Key Challenges/Constraints

A number of constraints and challenges were identified, based on information obtained during the fieldwork phase of this study. Key among these constraints is the lack of financial resources/budgetary allocation. During interviews with officials from the national office and the provinces, it became clear that there are no specific budget allocations for the VC as a programme; it would appear that implementing the VC is the responsibility of the Forensic Pathology Services Directorate, which also handles other functions, such as medico-legal services, mortuaries, and clinical forensic medicine, meaning that the limited resources have to be spread across all these different services. Obviously the limited resources compromised the effectiveness and quality of services delivered to victims of crime around the country.

In addition to a limited budget for implementing the VC, it was found that Thuthuzela Care Centres (TCCs) tend to suffer from general lack of basic resources such as office equipment (e.g. computers, printers, audio-visual equipment, photocopiers), limited office space including consulting rooms. In comparison, the medical-legal or crisis centres located within or close to public hospitals tend to be much better resourced. The second constraint is the accreditation of clinical forensic medicine (CFM) as a professional skill. The nurses and doctors who routinely carry out clinical forensic examinations of the victims indicated during interviews that their training is not accredited by the South African Nursing Council. This contradicts the NIP calls for the provision of accredited CFM training.

Thirdly, it was found that due to staff shortages,, particularly skilled healthcare experts, at many designated healthcare facilities in the provinces, the NIP's call for 24-hour services for victims is not being met uniformly across the all these facilities. This means that victims needing urgent medical assistance might not find it at all at many health facilities across the country, despite the stated policy intention of the department.

[16] RSA (2007,) DOJ &CD, National Implementation plan for the Victim Service Charter, pg. 85.
[17] Interview with the national coordinator: NDOH.
[18] RSA, (2007), DOJ & CD National Implementation Plan, pg. 83

The fourth constraint is the lack of training for community health workers on the VC, due to lack of funds, which increases the risks that the rights of victims of crime might be violated. The fifth key constraint is the limited number of designated health facilities dealing with sexual assault and domestic violence cases.

Finally, it would appear that incompatible administrative and service delivery boundaries or areas of jurisdiction of different institutions are creating difficulties in the effective and efficient provision of integrated services to victims of crime. For instance, the areas of jurisdiction of the SAPS, the NPA, Departments of Correctional Services and Health differ significantly, which often prevents the delivery of efficient and effective services to victims as and when needed.

2.1.2. Provincial Findings

1. GAUTENG PROVINCE

1.1. Institutional Capacity Issues

The study in Gauteng province was based on interviews conducted with healthcare workers at one TCC and three crisis centres in the province. The following centres were selected: Kopanong TCC, Hillbrow Medico-Legal Centre, Stretford Medico–Legal Clinic, Tshepo Crisis Centre and Tshwane Medico-Legal Centre. In addition to interviews, observations of the facilities of these centres were carried out.

1.1.1. Knowledge and Understanding of the VC

The study found that the VC was understood by the informants as aiming to ensure that the victims of crime received the comprehensive treatment they are entitled to, ensuring enjoyment of their rights as outlined in the VC. The informants appeared to emphasise confidentiality and privacy in the treatment of the victims of crime at TCCs. At facility level the doctors and nurses in all the centres selected for this study appeared to have the necessary knowledge and understanding of the VC and the seven rights outlined in it.

1.1.2. Skills Development – Successes and Failures

The DOH's national policy guidelines for the victims of sexual offences emphasises the need for accredited extensive training programmes and also for special skills such as the forensic medical skills necessary for examining and obtaining forensic evidence from victims. Practitioners are expected to understand the physical and psychological consequences of rape/sexual abuse and provide the necessary treatment appropriate at the different levels of healthcare. Training should include gender discrimination, gender sensitivity, sensitivity to victims of crime, basic counselling and trauma counselling skills, and skills for collecting forensic evidence. Emphasis is also placed on proper programme orientation for doctors, nurses and general practitioners who use sexual assault kits.

The study found that there is no gender-specific training for staff at facility level. However the courses provided are gender-related. It was found that the Department of Justice has provided accredited clinical forensic medico-legal training to professional nurses in all the five centres. In-house service training on HIV and basic counselling has also been provided

[19] See http://www.justice.gov.za/policy/guide_sexoff/sex-guide02.html
[20] RSA, National Policy Guideline for the Victims of Crime), p. 1. (http://www.justice.gov.za/policy/guide_sexoff/sex-guide02.html
[21] RSA (2007), DoJ&CD, National Implementation Plan: Service Charter for Victims of 2006/7-2010/11.

to all the centres. In different centres some of the health workers attended training on trauma counselling, sexual assault care training and a course on medico-legal skills.

This indicates that skills development and capacity building has taken place in these centres in line with the requirements of the VC. However, interviews with healthcare workers revealed that the majority of medical doctors at these facilities are not undergoing any training related to those requirements.

1.1.3. Availability of Relevant Resources

The government departments implementing the VC should ensure that adequate resources are available in order to render services to victims of crime in line with its requirements. For example, resources are necessary for victim-friendly services, including transport for victims, providing language/translation services, clothes for victims of sexual offences, etc. A victim-friendly service also means taking into account the diverse needs among victims (e.g. the elderly, mothers with children, and people with disabilities.

Based on observations of the five centres, it was found that they all had buildings for rendering clinical medico-legal services. It was also found that in two centres the buildings were in a poor state of disrepair and had limited space.

With regard to financial resources, it was not clear what financial resources or budgetary allocations each centre had been allocated. Nonetheless four of the five centres selected for the study were dissatisfied with their financial/budgetary resources. Only one centre was satisfied with the resources allocated to it. At district level, some resource allocation towards victim support, including funds for PEP, debriefing sessions for staff, and office refurbishment. However, no figures were disclosed by informants.

While there was general dissatisfaction about lack of office equipment such as computers, faxes, and stationery by all the centres, most of them expressed satisfaction with staff levels. Although clinical medico-legal services, particularly sexual assault, are critical at the level of the facilities, interviews indicated there are limited resources funding for this purpose, and that available staff with expertise appointed and paid at district level. Similarly, officials pointed to lack of funding for counsellors. It would appear, though, that all the centres were able to provide 24-hour service for victims of crime.

1.1.4. Monitoring and Evaluation

The NIP states that a number of mechanisms, such as complaints handling mechanisms, surveys, unannounced visits to the facilities, reviews of cases, and interviews with victims of crime should be used as instruments to monitor and evaluate the services rendered to victims of crime. Many of the informants pointed to the existence of a feedback form developed by the Department of Justice, with minimum standards and indicators to measure not only implementation, but also to assess the impact and sustainability of the services. The VC also makes provision for regular monthly and quarterly reporting of progress on implementation. Informants indicated that provincial monthly and quarterly meetings are held to monitor service delivery with the coordinators from the five districts as well as provincial directors to discuss progress. All five centres indicated that they use suggestion boxes for victims to express their views about services rendered. Many of the informants

[22] RSA (2007), DoJ&CD, National Implementation Plan: Service Charter for Victims of 2006/7-2010/11.
[23] RSA (2007), DoJ&CD, National Implementation Plan: Service Charter for Victims of 2006/7-2010/11.
[24] Ibid.

claimed that the suggestions received show that the victims are satisfied with the services rendered, although no proof was provided to substantiate these claims. It is clear though that no effective, systematic and independent mechanism exists for monitoring and evaluating the performance of these centres in terms of services rendered to victims of crime.

1.2. Services Rendered to Victims

Services to be provided to the victims are guided by a range of legislative and policy frameworks outlined at the beginning of this report. Interviews with health workers revealed that at provincial level, clinical forensic medical services are available, particularly for victims of sexual assault, domestic violence, and abused children. Other services include coping skills for rape victims, psycho-social services, and education for victims about their rights. At facility level, officials referred to the provision of medical and counselling services, including counselling on HIV and provision of PEP for victims of sexual assault. Some of the healthcare workers went into lengthy details explaining the procedures to be followed when examining and treating victims.

Other services rendered to victims at all the facilities selected for this study include legal advisory services, collecting forensic evidence and preparing victims for court in instances where court cases are opened. For rape victims, clothes, comforter packs and a bath are made available after forensic evidence has been provided. It would appear that some of the centres have received donations of clothes from civic organisations.

1.3. Key Challenges/Constraints

Based on interviews with healthcare workers from the five centres, a number of challenges or constraints were identified. At provincial level, it was clear that the differing and sometimes conflicting administrative boundaries of various state institutions in the province stand in the way of rendering effective, comprehensive and integrated services to victims of crime in line with the VC. For instance, the provincial medico-legal director articulated this issue succinctly:

> *"I would have believed that one of the first things [that] we should have done [with the] coming of democracy was to get rid of boundaries in government departments. This sometimes impacts negatively on service delivery. For example, Orange Farm and Lenasia South fall within the Joburg metro health district. So victims who have been sexually assaulted in that area will [either] go to Strafford clinic or Lenasia South centres, but those victims will have to go to court in Vereeniging because the NPA's boundaries fall within the jurisdiction of Vereeniging, which becomes a problem, especially when the centre has to follow up on those victims."*

The informant added that the administrative/service boundaries of the DCS do not coincide with those of the DSD or even those of the NPA, and each and all of these boundaries often differ from those of the province. The result of this is significant confusion and costly expenses for victims who have to go to different service points to receive vital services.

At the level of the facilities, problems such as inadequate referral clinics, incorrect information/details provided to health workers by the victims, shortage of crime or rape kits, lack of common understanding of medico-legal services among healthcare workers, lack of resources for the TCCs and victims, have created conditions in which the effective rendering and accessibility of quality services to victims of crime is being severely compromised.

2. FREE STATE PROVINCE

1.1. Institutional Capacity Issues

This section aims to indicate whether or not the capacity of institutions implementing the VC is consistent with the requirements of the VC and the NIP.

The DOH established Victim Empowerment Programmes (VECs) within its health facilities in compliance with the provisions of the VC. Several facilities in the Free State province were selected for the purpose of this study. These included the Tshepong TCC (based at a national district hospital), the Botshabelo Victim Empowerment Centre (based at the Botshabelo district hospital), Dr. J. Moroka Victim Empowerment Centre (based at the Dr. J. Moroka hospital) and the Metsimaholo Thuthuzela Care Centre (at the Metsimaholo district hospital).

1.1.1. Knowledge and Understanding of the VC

Interviews were conducted with healthcare workers at the selected centres, as well as field observations carried out to assess progress in implementing the NIP and in compliance with the provisions of the VC.

Healthcare professionals are considered to be in a unique position to render critical services, as they are usually the first to receive the victims of domestic violence in either routine or the emergency services. The literature also indicates that their unique position enables them to identify forms of abuse, and can therefore play a critical role in identifying appropriate interventions.

The forensic nursing staff interviewed for this study demonstrated extensive knowledge of the VC, as well as the VEP. The respondents indicated that the VC was the document that guided them on what needs to be done by health facilities when rendering services to the victims/survivors of crime. They added that the document clearly stipulated the rights of victims. One respondent considered the VC as a vehicle for ensuring a fair treatment of the victims of crime. Another respondent highlighted the rights to a range of services outlined in the Charter, including its objective of preventing secondary victimisation.

In line with their apparent knowledge of the provisions of the VC, some of the respondents went on to outline some of the services offered by their health facilities. For instance, some of them explained that services were contained in a package of the department's VEP. These included counselling services, medical services, information and relevant skills to deal with their situations as victims and survivors of violence.

In terms of the role of the department's VEP Unit in the implementation of the Charter, many of the participants were knowledgeable, pointing to its function of examining and providing treatment to the victims and using evidence kits to collect evidence for the police.

1.1.2. Internal Skills Development/Capacity Building

All the forensic nursing staff from the four facilities who were interviewed for this study received training on various subjects which are broadly within the area of the VC. For

[25] Interview, provincial medico-legal director, 07 November 2012
[26] Interview, Healthcare worker
[27] Krug et al. 2002, quoted by Peter, L. P. Psycho legal Assessment in South Africa: Domestic Violence, (ed. Kalaski, S). South Africa: Oxford University Press Southern Africa, Cape Town, 2007,p. 155.

instance, all the forensic nursing staff interviewed for this study received skills training on counselling victims, particularly trauma and HIV/AIDS counselling, and have used these skills in assisting victims of crime. Some of the informants identified language barriers as a constraint to rendering these services to victims (it would appear that some of the nursing staff are unable to speak the main local African/Sotho language of the majority of the population in the province).

Some of the informants referred to occasional skills-training workshops convened by their hospitals and the regional coordinator. The acting head of the National District Hospital argued that most of the training within her facility was commissioned by the NPA, as the NPA was responsible for the centre. Some the workshops entailed awareness training on respecting the rights of victims of crime, including collecting and handling forensic evidence from victims. In some cases the nursing staff was exposed to awareness sessions on legislative amendments, especially where such amendments affected their functional areas (e.g. Amendments to the Sexual Offences Act and Children's Act).

Clearly there is reason to believe that health workers at the facilities selected for this study have been exposed to some of the basic skills-development initiatives to enable them to render services to victims of crime in line with minimum standards outlined in the VC.

1.1.3. Availability of Relevant Resources

The respondents argued that their resource needs were addressed through submissions to the provincial coordinators office, where normal procurement processes are usually handled. While the TCCs did not have dedicated budgets for their work, they were nonetheless well catered for through the offices of the provincial coordinator, who made sure that the necessary resources were provided to the centres. The TCCs based at hospitals also utilised the superior resources of the hospitals. In addition, observations conducted at the VEP centres within the facilities under study showed that the VEP was well resourced to deliver services related to the VC.

The facilities were in line with the provisions of the NIP, except that they did not have secluded facilities for breastfeeding. There were common approaches, processes and procedures for handling the victims on arrival. In terms of the structure of the centres, it was found that there were some health facilities which only had a TCC, such as the Metsimaholo District Hospital in Sasolburg and the National District Hospital. These facilities had similar institutional capacity to those managed by the health facilities, such as the Botshabelo District Hospital and the Dr. J. Moroka Hospital in Thaba-Nchu.

1.1.4. Monitoring and Evaluation

It would appear that for monitoring and evaluating the effectiveness of services rendered, the centres are using two types of tools. The first is a form used to record the details of every victim that accessed the services rendered by the centres, ranging from cases of domestic violence and negligence of children to patients needing psychological services and HIV testing. The forms are submitted to their hospital information office and the provincial coordinator on a monthly, quarterly and annual basis.

Some of the informants provided a copy of the tools available to the research team, including some statistics gathered from the form. The statistics appear to reveal that sexual assault

[25] Interview, provincial medico-legal director, 07 November 2012
[26] Interview, Healthcare worker
[27] Krug et al. 2002, quoted by Peter, L. P. Psycho legal Assessment in South Africa: Domestic Violence, (ed. Kalaski, S). South Africa: Oxford University Press Southern Africa, Cape Town, 2007,p. 155.

cases declined during the winter months and the explanation was that during those months, there was not a lot of movement and that people visited the entertainment areas less, due to the cold weather. The cases escalated from the month of October on throughout summer. The respondents indicated that the trend was similar every year. Such insights from this or any other monitoring tool are potentially useful in terms of planning policy and operational responses by the centres. However it would appear that the tool is largely used to gather statistics rather than gauge outcomes and the extent of impact of services rendered on the lives of the victims.

The second tool is a suggestion box. Three of the four centres indicated that an evaluation form is made available for victims to complete in order to establish their levels of satisfaction on services rendered. Completed forms are placed in suggestion boxes in the care of information officers. However it appears as if there is no systematic way in which such information is processed and the findings used to inform policy and operational responses at facility level.

1.2. Services Rendered to Victims

Based on informant interviews, the services regularly rendered to victims include counselling services, medical examinations, medical treatments, HIV/AIDS testing, including providing PEP where necessary. Some respondents said that regular home visits were carried out by social workers within the centres to determine the state of the victims. Such information is useful for forensic nurses to determine where urgent interventions are necessary. Other services mentioned by the informants included the provision of basic information to victims about how to report crime or minimise prospects for re-victimisation.

Some of the respondents pointed to the fact that the forensic nursing staff not only render services to victims, but also become exposed to some of the trauma experienced by the victims, although there is an absence of opportunities for debriefing and formal psychological support services for the forensic nursing staff themselves.

1.3. Key Challenges/Constraints

The discussion of the information obtained from the interviews highlighted one major constraint for the centres in general. This was a shortage of staff, particularly forensic nursing staff. There is a limited number of forensic nursing staff within the centres and they tend to have high workloads related to VEP responsibilities. The forensic nursing staff has to also attend court cases regularly to give evidence on behalf of victims. Those interviewed for this study insisted that such court appearances consumed significant amounts of their time.

3. NORTHERN CAPE PROVINCE

1.1. Institutional Capacity Issues

The DOH, as one of the key stakeholder departments in the VC and VEP, has certain responsibilities that it has to fulfil to ensure that victims receive the necessary assistance at public health facilities. The national policy guidelines for victim empowerment stipulate that the DOH “must provide professional and accessible medical and psychological services to victims of crime and violence who approach healthcare facilities for assistance.” The

guidelines also spell out a number of services that the Department is responsible for. They are:

- Emergency and ongoing medico-legal services, ARV treatment, contraceptives and mental health/psychological services (if available) and referral to other relevant service providers;
- Implementation of the Patients' Rights Charter
- Provision of services to women in terms of Gender Policy Guidelines for the Public Health Sector, 2002
- Provision of services by medical personnel to victims of sexual assault according to Sexual Assault Policy Guidelines
- Sensitivity training of frontline health sector workers (e.g. ambulance personnel) in victim empowerment
- Training of health professionals to provide victim empowerment and trauma support in collaboration with the DSD.

In accordance with its VC commitments and responsibilities, the DOH prioritised some of the following areas in the 2007– 2011 Victims Charter National Implementation Plan:

- To develop policies, guidelines, strategies and regulations
- To capacitate and train staff in dedicated units on an ongoing basis
- To make victims of crime and violence aware of the existing complaint system through producing an information leaflet by 2007
- To develop and implement a monitoring and evaluation tool for CFM.

It would be reasonable to expect these commitments to the VC to be reflected in the DOH's annual strategic plans and priorities. However, the Department's Strategic Plan for 2010/2011, 2012/13 and the Annual Report for 2011/12 do not make any mention of the VC at all. The strategic objectives, targets and indicators do not include the Charter.

Interviews were conducted with the provincial coordinator for CFM as well as three healthcare professionals at Kuruman Hospital and Upington Hospital. Also, onsite observations were conducted at these healthcare facilities.

1.1.1. Knowledge and Understanding of the VC

In terms of knowledge and understanding of the Charter among the informants, the DoH's provincial coordinator for CFM is an active member of the provincial Victim Empowerment Forum, the Victims Charter Inter-departmental Committee and the Gender Justice Forum, and therefore displayed a detailed understanding of what the VC and VEP are about. However, both doctors that were interviewed and a CEO of one hospital, did not know much about the VC. This could be indicative of a broader institutional problem of disjuncture between stated official departmental objectives and commitment to train its staff on the VC on the one hand, and poor execution on the ground on the other.

It should, however, be indicated that despite this lack of knowledge, the doctors were nonetheless knowledgeable about standard procedures for dealing with and assisting the victims of crime. They were able to articulate and describe procedures that are consistent with and prescribed in terms of minimum standards contained in the VC. One doctor describes a typical procedure: "The first thing that happens is that the victim usually opens

a case and the investigating officer takes the victim to hospital. Then the doctor who is on call for forensics will be called to attend to the victim. Then we examine the patient to see if there any signs of forced vaginal or anal penetration and other signs of trauma. Then we fill in the J88 forms for evidence. Then we put them on PEP treatment and also treatment for STIs and HIV."

Nonetheless it is still crucial for training to be provided on the VC and the VEP for all key healthcare workers, particularly doctors and nurses, to ensure effective provision of services to victims of crime.

1.1.2. Internal Skills Development/Capacity Building

According to the DoH's Overview of the 5-year National Implementation Plan 2007-2011 on the Victims' Rights Charter, some of the progress and achievements by the department include the following:

- The training of 975 doctors and nurses for designated public health establishments
- 10 000 pamphlets, booklets and posters on the VC were printed and distributed to all provinces
- The national policy on the management of victims of sexual assault was developed and reviewed in 2011
- Regulations regarding CFM services were promulgated in 2010 and reviewed in 2011
- Provincial annual support and/or visits to all provinces to monitor the CFM services were conducted
- Crime Victims' Rights Week was commemorated in seven provinces between 2008 and 2011

Despite the undertaking of the DoH to train nurses in forensic work, this area appears to be overwhelmed with challenges of implementation, ranging from difficulties in appointing forensic nurses and a lack of training for most nurses in forensic medical services. In cases where nurses had received the necessary training, due to the general shortages of nurses, interviews revealed that forensic nursing staff are often put to work in areas of responsibility where they are unable to utilise those skills. Both the Kuruman Hospital and Gordonia Hospital in Upington have no dedicated trained forensic nurses and rely on casualty doctors to attend to victims of crime.

When interviewed about issues relating to the DOH, the provincial coordinator for CFMs said:

> *"We train a number of forensic nurses but because of a shortage of nurses in the hospitals that these nurses work at they find themselves forced to get involved in other work such as emergencies, HIV & AIDS and chronic cases… We still have a challenge with regards to the appointment of forensic nurses. Last year we had interviewed a number of nurses but only one accepted our offer and the rest rejected it on the basis of salary. They do not get OSD [occupational specific dispensation] so they would rather go… where they get OSD. Forensic nurse training is not recognised as a speciality by the SA Nursing Council so even if we wanted to appoint people they would still not come because of OSD."*

In the case of Gordonia Hospital, there was a trained forensic nurse who was based at Bopanang Centre but she passed away in 2011 and no replacement has been appointed.

[25] Ibid.
. Interview, Dr. Van Voore, Gordonia Hospital, Upington, 10/10/ 2012

As a result, forensic services are rendered at the hospital by casualty doctors, who often lack the requisite skills training. One of the respondents from Gordonia Hospital confirmed this, stating that, “No doctor, nobody was trained to do it; no professional nurse in the institution was trained to do forensic work.” The Kuruman Hospital also does not have forensic nurses and relies on doctors from the casualty ward.

1.1.3. Availability of Relevant Resources

From the data gathered, it appeared that the biggest challenge with regard to resources is financial resources. In particular, CFM does not have a dedicated budget of its own from the DOH’s overall provincial budget. The provincial coordinator confirmed this, stating that, “There is no specific budget for Clinical Forensic Services but HIV & AIDS assists. Last year they gave about R3 million for the appointment of extra nurses but nurses couldn’t be appointed so they took away the money and only gave us R400 000.” This budgetary constraint also exists at hospital level, as evidenced by the situation in Gordonia Hospital which does not have a budget for paying doctors that are doing forensics.

Also Gordonia Hospital’s forensic examinations room is currently being used for attending to general patients, rather than for dealing with the needs of the victims. This was confirmed by the CEO of the hospital, “Our current infrastructure doesn’t talk to that. We have a separate room where the doctors do the forensic procedure but it is not conducive for that because it was never made for that particular purpose. That is why I think that Bopanang Centre is the ideal place for victims to go instead of the hospital because the levels of secondary trauma are higher here.”

In contrast, Kuruman Hospital used the Thuthuzela Centre located within its premises. Observations revealed that the TCC had all the necessary equipment in place except for a working angle lamp that had not yet been fitted. Additional challenges, according to the provincial coordinator, include the unavailability of dedicated transport for forensic nurses to respond to 24-hour calls in Siyanda district. Additionally, the TCCs that are based inside hospitals have no maintenance plans due to the unclear division of roles between the DOH and the NPA.

1.1.4. Monitoring and Evaluation

According to the Patients Rights’ Charter every clinic should have “a schedule of monthly visits stating date and time of supervisory support visits and that there is a written record kept of results of visits”. The national DOH claims to have conducted provincial annual support visits to all provinces to monitor the CFM services. In their list of achievements, the provincial DOH listed support visits to all five districts.

With regard to the complaints procedure, the Minimum Standards state that

> *“If you are not satisfied with the service rendered by a healthcare worker in the public health sector, you should first complain to the person who attended to you. However if your complaint is not to your satisfaction you may refer your complaint to the head or manager of the public health facility where you have been examined or treated. If you receive no response or are dissatisfied with the way in which your complaint has been attended to by the head or manager of the public health facility, you can refer your complaint to the relevant Provincial Health Department. If you are dissatisfied with way in which the Provincial Health Department has dealt with your complaint, you can request*

the relevant professional board or council, such as the Health Professionals Council of South Africa, to investigate the matter".

When asked what procedure exists for laying a complaint if a victim was not satisfied with the services rendered, the provincial coordinator said, "We have a Quality Assurance Unit but they can also report to hospital management and if they are still not satisfied then they can complain to the HOD. If it is something directly to do with the victim, like if the victim did not get medication, did not get comfort packs or did not get counselling. Those basic needs of the victim and those services specified in the Sexual Assault Policy then I can intervene."

It is not clear, however, if all the centres utilised these two forms of monitoring and evaluation to ensure that effective and quality services are rendered to victims of crime in line with the minimum standards outlined in the VC. Also the effectiveness of these two methods determines the impact and outcomes of the work of the centres in meeting the requirement of the VC and VEP could not be assessed.

1.2. Services Rendered to Victims

With regard to the right to receive information it appears that the DOH has done well, as indicated by the number of VC pamphlets, booklets and posters that were printed and distributed across provinces. This was noticed during the observations carried out at the TCCs. It was only at the hospitals that use casualty wards instead of designated facilities for victims of crime that such information was not in abundance.

The challenges that are highlighted elsewhere in this report tended to have a negative impact on the quality of services rendered to the victims of crime. For example, the lack of trained forensic nurses at both Kuruman and Upington means that victims of crime have to compete with casualty patients for the attention of doctors. This challenge is clearly articulated by one of the informants, who said,

"Doctors in casualty do forensic work, that is an emergency area, but remember now when there are about 50-60 cases of emergencies and here is a forensic case, these are competing because either way you will have people complaining of long waiting hours before getting a doctor. Forensics is a specialised field that needs special attention on its own for every hospital to have."

This sentiment was strongly echoed by the doctor responsible for forensics. Similarly, the issue of the lack of budget for forensic work is proving to be a serious challenge for Gordonia Hospital in Upington.

A major contributing factor to this is the DOH's overtime system, where doctors are only allowed up to 30% overtime. The problem, as stated by the officials at Gordonia Hospital is that the doctors reach the 30% overtime threshold through normal hospital duties, and by the time they have to do forensic work they have already exceeded that limit. This then means that if the doctors continue to do the forensic work they will not be paid for it because the system does not allow for this. Invariably, this lack of budgetary resources and the overtime threshold have affected the delivery of services to victims negatively, as it means that doctors cannot be paid for forensic work even though there are many forensic cases that hospitals such as Gordonia receive on a regular basis.

It was discovered that Gordonia Hospital is currently the only hospital in the entire Siyanda district that is rendering forensic services to victims of crime. With the challenges that the hospital is facing, this creates a crisis with regard to the rendering of forensic services to victims of crime. In fact, the situation in the Siyanda district has deteriorated to such an extent that the Siyanda District Victim Empowerment Forum laid a formal complaint with the Human Rights Commission to investigate the matter.

When questioned about the average time that it takes for a victim to receive the necessary help at Gordonia, the response was that it can take between two hours and sometimes up to the next day. This means that rape victims do not receive PEP treatment within the prescribed 48 hours, thereby exposing them to HIV/AIDS infections and unwanted pregnancies. In addition, the fact that there is no separate waiting facility for victims means that they have to use the same area as everyone else including the casualty ward, thus increasing risks for secondary victimisation.

The following list reveals the challenges that were presented by the DOH in one of the national VEP conferences in 2012. What is contained there seems to be totally consistent with what has been found by the study and discussed elsewhere in the report.

1.3. Key Challenges/Constraints

The following challenges or constraints were identified, based on interviews and other information obtained during fieldwork.

- *Lack of a dedicated budget allocation for CFMs*
- *Lack of commitment and support for the VEP*
- *Lack of an effective monitoring and evaluation tool to measure progress in the VEP programme*
- *Lack of coordination between the DSD and NPA in supporting the DOH with regard to the work of TCCs and one-stop centres.*

4. KWAZULU-NATAL PROVINCE

1.1. Institutional Capacity Issues

Five centres were selected for the purpose of assessing the work of the DOH in implementing the VC in KwaZulu Natal. The centres were: Ngwelezane TCC, RK Khan Hospital, Addington Hospital, Pinetown Crisis Centre, Prince Mshiyeni TCC.

Six informants were selected for in-depth interviews: four healthcare workers, a provincial coordinator for the VC in the DOH, and a respondent from an NGO contracted to render healthcare services to victims of sexual assault. Of the TCCs identified for this study, one was selected from a semi-rural community and the others from urban areas.

1.1.1. Knowledge and Understanding of the VC

Informants were probed on their knowledge and understanding of the VC and the rights of victims of crimes as outlined in the Charter. Knowledge and understanding of the department's obligations and commitments to serving the interests of the victims in line with

the NIP is also important. All the respondents showed a high level of understanding of the Charter. For example, the provincial coordinator even located the implementation of the VC within the context of the country's national and international commitments.

In line with the obligation to treat victims with fairness, respect, dignity and privacy, the respondents applauded the creation of TCCs because these institutions were seen as offering victims of sexual assault opportunities to realise these rights. Before the advent of TCCs, victims of sexual assault were treated at Out Patient Department (OPD) of hospitals where lack of privacy prevented them from receiving the intensive care and medical attention they needed.

The respondents' descriptions of services currently being offered to victims of crime presupposed relatively well informed and knowledgeable professionals in terms of the requirements of the VC. Informants reported that while the majority of the victims come to the TCC for medical assistance such as examinations and treatment, such visits are utilised to advise the victims on other crucial matters such as how to open cases. Officials also insisted that forensic evidence is routinely collected and medical files compiled on victims for purposes of court proceedings, prosecutors or magistrates. One informant emphasised the importance of collecting forensic evidence, "If I didn't study forensic medicine coupled with statistics after my doctorate degree I would not be in a position to perform my job the way I do now. In almost 90% of the cases where I provided evidence in court, the perpetrators are convicted."

1.1.2. Internal Skills Development/Capacity Building

All the informants referred to the issue of lack of training, particularly in terms of forensic medical services, which are vital for victims of sexual assault. However it would appear that the TCCs are also facing severe budgetary/financial constraints. It was found that due to limited resources, the DOH did not contribute to the training of forensic doctors and nurses whose skills are vital for services currently rendered by the TCCs. Many of these professionals made private financial arrangements for their own training in forensic medical expertise. The provincial coordinator acknowledged this limitation and revealed that negotiations with the Nelson Mandela Medical School are currently underway to provide training for TCC medical staff.

1.1.3. Availability of Relevant Resources

Resources in the form of financial resources, adequate and skilled professionals, working equipment and other vital infrastructure, are important for ensuring that the DOH fulfils its commitments to meeting minimum standards of services to be rendered to victims of crime.

In terms of human resources (i.e. professionals working in the various centres) it was found that each centre had the necessary medical professionals, nursing staff and doctors to carry out the various functions. However, the issue that was raised was the inadequate numbers of professionals to handle the workload involved. Problems of inadequate medical personnel at these healthcare centres become obvious and amplified at important times, such as when medical doctors have to attend court cases and present evidence, leaving no alternative professionals to assist victims, or at night when a limited number of doctors are on call for more than one healthcare centre.

Nonetheless the informants insisted that one of the successes has been that patients are not sent from pillar to post anymore, as all services, such as counselling, examination, legal advice, opening of the case and medication, are available under one roof through the TCCs. For TCCs based within the premises of healthcare facilities such as hospitals, medication for their patients can be ordered directly from the hospital dispensary, thus reducing the time it takes for patients to obtain medications after consultation. It was also pointed out by the informants that the advent of TCCs has improved the quality of medical services available to victims of crime given that the victims have immediate access to specialised services.

During interviews with healthcare workers it also emerged that some of them were becoming increasingly exposed and vulnerable to the trauma suffered by the victims, particularly the children that have to be assisted at the centres. For instance, one informant stated, "seeing rape cases particularly children from the age of one year is traumatic, this has a negative impact on our personal lives and our capacity to deliver; we have raised this with our superiors in all forums that we need de-briefing…" It would appear that many of the centres currently do not have resources or provisions for assisting their medical personnel to deal with their exposure to such trauma.

1.1.4. Monitoring and Evaluation

The DOH committed itself to developing a monitoring tool to conduct annual audits/ assessments of the effectiveness of the implementation of the VC and to identify necessary measures or intervention to improve services. However, none of the respondents had knowledge of such a monitoring tool. Also, there was no evidence to suggest that any evaluations or audits had ever been undertaken by the department. The only form of monitoring known to all respondents was the submission of monthly statistics on the number of patients that had been assisted by the TCC. There was no evidence to suggest that the statistics gathered are being utilised in any way for the purposes of improving services or standards of service delivery by the centres.

1.2. Services Rendered to Victims

The department is mandated to offer a range of services to victims of sexual assault such as conducting forensic assessment; taking evidential samples; doing professional investigation; counselling; dispensing ARVs and developing a referral system for special centres for victims of crime. These commitments were made in the NIP.

Interviews with medical staff from the TCC were categorical that some of these services were being provided. However due to insufficient personnel and skills, some of these services are provided by onsite NGOs such as Childline, particularly counselling and obtaining forensic evidence from children. An informant from an NGO confirmed this, stating that an MOU had been signed with the DSD to provide shelter, trace victims and counselling for HIV/AIDS.

It is clear that NGOs are providing the services that should be provided by some of the departments, including the DOH, whose services are being rendered through the TCCs. Based on information obtained through interviews it would appear that funding support for the NGOs carryout out this work on behalf of departments is severely limited if not non-existent. One of the NGOs lamented the fact that despite an MOU with the DSD and the Ethekwini Metro, there is lack of commitment from these government institutions to match the funds spent by the NGO for services rendered.

1.3. Key Challenges/Constraints

The key constraints identified for this department were lack of financial resources, including lack of funding to assist in the training of forensic medical personnel as well as funding the work currently being undertaken by NGOs within the premises of healthcare facilities and TCCs.

Another important constraint is the absence of an effective system of monitoring the performance of the facilities in terms of progress made to meet the standard of services outlined in the VC. The current basic system of monthly reporting on the numbers of victims assisted by the TCCs and other facilities where vital healthcare services are rendered to victims of crime is insufficient to determine the effectiveness of the implementation of the VC through the DOH.

5. NORTH WEST PROVINCE

1.1. Institutional Capacity Issues

Five institutions rendering healthcare services to victims of crime in the North West Province were selected for the purpose of this study: Bophelong Provincial Hospital (BPH), Job Shimankana Tabane Provincial Hospital (JSTPH), Taung Hospital (TH), Khuseleka One-Stop Centre (KOSC) and Korsh Crisis Centre (KCC) in Klerksdorp.

1.1.1. Knowledge and Understanding of the Victims Charter

While most respondents felt that there is a need for further training in terms of operational matters, they displayed a clear knowledge and understanding of the general purpose of their work. One respondent indicated that “our main purpose is to render services to victims of crime and mostly sexual assaults”. However it was noted during interviews and onsite observations of these facilities that the informants did not have clear and detailed knowledge of the minimum standards of services to be provided to the victims of crime in line with the VC. The majority of the informants could only describe the procedure to be followed when assisting victims of crime when they arrived at the centre seeking assistance.

1.1.2. Internal Skills Development/Capacity Building

In terms of assessing the skills related to services to be rendered to victims of crime and abuse, forensic medical expertise is crucially important. Combined with this is the importance of understanding current policies and programmes relating to services to be delivered to victims of crime. All the health facilities that were selected for this study in the North West had trained counsellors. Interviews with informants from the five centres also revealed that there was a general shortage of trained Victims Assistant Officers (VAOs), and that this was a problem across all hospitals and TCCs.

There was also a general shortage of doctors and forensic nurses dedicated mainly to delivering forensic services to victims of crime. For instance, forensic nurses attend to some cases, while in other cases a doctor on duty in casualty wards have to be called to assist. This usually results in significant delays and a long waiting period for victims. It was discovered that only two of the five centres had two professional nurses – one qualified clinical forensic nurse based at the Bophelong Provincial Hospital, and the other one, based at the Taung Hospital, was still undergoing training in clinical forensic nursing.

There was clearly an urgent need for dedicated doctors to enable the health facilities in the North West Province to render services to victims of crime and sexual assault. It would appear that there is a need for more clinical forensic nurses in many healthcare facilities across the province as this will assist in easing the workload for existing doctors and nurses. According to one of the informants, Doctor Sein at the JSTPH in Rustenburg, there is a need for doctors who deal mainly with cases of a medical-legal nature to be given intensive training on forensic medicine, to increase their knowledge and understanding of the importance and potential impact on court cases of the forensic evidence they collect from victims. The informant emphasised the need for doctors who provide forensic medical assistance to victims to meet more often to share information, exchange best practices, and therefore improve their knowledge of this area of expertise.

1.1.2. Availability of Relevant Resources

The informants from three of the five the centres selected for the study in North West Province expressed the need for more resources to improve the quality of services to victims. These were the Bophelong Provincial Hospital, Korsh Crisis Centre and Taung Hospital (although at Taung Hospital victims have to move from the TCC to the OPD to be examined by a doctor). The JSTPH had a serious shortage of resources, such as a private examination room, beds and other related resources. The shortage of such facilities not only compromises the quality of services provided by the healthcare workers, but also prevents the victims from enjoying their rights to be treated with respect for dignity and privacy.

In the Korsh Crisis Centre, it was reported that incorrect supplies were being purchased, while the correct resources were not used. Problems of insufficient sanitary packs, food and clothes for ensuring comfort and privacy for victims were also reported during interviews and onsite observations.

Informants were unable to provide information on their institutional budgetary allocations, mainly because procurement processes were driven at provincial level where purchases of supplies took place.

1.1.3. Monitoring and Evaluation

Monitoring and evaluation is critical to organisational self-assessment of progress, effectiveness and impact of service delivery. During interviews with informants and onsite observations, it became clear that all the healthcare centres selected for this study used a basic system of compiling and submitting monthly reports to the regional and national offices. In addition, the Korsh Crisis Centre holds weekly reviews every Tuesday to assess impact and progress on services rendered to victims.

1.2. Services Rendered to Victims

During the interviews conducted with healthcare workers, the level of professional commitment and dedication was unmistakable. However the level and quality of services rendered by the workers depended on the level of available resources at each healthcare centre. The speed with which victims of crime are attended to also depended on the number and availability of doctors and forensic nurses. In most instances, clients are received in private consultation rooms, where the nursing staff or doctors attend to them immediately. However, in the case of the JTSPH, victims are attended to by a doctor at the OPD or ward.

Based on interviews with all the informants it would appear that most of the centres followed a similar procedure whereby the victim would be received by the nurse on duty or site coordinator. In the case of first-time visitors, a file would be opened and a detailed explanation of the entire procedure given before the victim is examined by a nurse or doctor. This is the stage when forensic skills are crucial, because forensic evidence is collected that will be used in judicial processes should court proceedings result from the report.

Victims are also given comforter/sanitary packs (containing panties, washing rack, toothpaste, toothbrush, soap, Vaseline) and allowed to take baths/showers after being examined. In some of the health facilities victims receive clothes. Some health centres also provide clinical psychological services when needed. In the case of Taung Hospital, this is currently difficult as the psychologist is based in Klerksdorp. Taung Hospital also has no private consultation rooms, which makes it difficult for nurses and doctors to handle cases of sexual abuse where privacy is of the utmost importance.

Once services have been rendered, victims are usually given dates to return for follow-up consultations and medical care; if victims live far away from the health facility, they are usually referred to clinics or healthcare facilities nearer to where they live. However, an absence of a Victims Assistant Officer (VAO) in many facilities means that follow-up visits cannot be dealt with effectively.

1.3. Key Challenges/Constraints

Key constraints were identified among the healthcare facilities selected for the study in the North West Province. These included a lack of financial resources, shortage of trained CFM workers, limited knowledge of and lack of adequate training on the VC. It was also indicated that the health facilities did not have an effective system for monitoring service delivery performance and the impact on the lives of victims of crime.

6. EASTERN CAPE PROVINCE

1.1. Institutional Capacity Issues

Five healthcare facilities, which incorporated TCCs, were selected in the Eastern Cape for in-depth interviews with healthcare workers and onsite observations. These were: Cecilia Makiwane Hospital, Dora Ngiza Hospital, Mthata Hospital, Butterworth Hospital and St. Barnabas Hospital. Cecilia Makiwane and Dora Ngiza hospitals are located in urban areas while the other three are in rural areas.

1.1.1. Knowledge and Understanding of the Victims Charter

Based on interviews conducted with healthcare workers in the facilities selected in the Eastern Cape, it could be concluded that they had a clear understanding of the VC. One informant from the Mthata hospital clarified one crucial aspect of the work of healthcare workers, “We examine the patients and are able to collect evidence ultimately to be used in court.” Informants understood the importance of the DOH as the first receiving point for victims of sexual assault to receive the necessary medical attention. The information collected at this stage is crucial in assisting in future court processes. Despite the apparent knowledge and understanding of the VC among those interviewed, there are still obstacles in the way of

healthcare workers effectively discharging their responsibilities. These challenges will be discussed later in this report.

An informant from an NGO called Rape Crisis Centre, was also interviewed and displayed extensive knowledge and understanding of the key issues relating to the work of the health facilities connected to the VC. The NGO works closely with and renders vital services to rape survivors.

1.1.2. Internal Skills Development/Capacity Building

The study found that regular training workshops and seminars are convened by the DOH for doctors, nurses and social workers. The informants also pointed out that the NPA assists with training on subjects such as sexual assault and the management of victims of crime. The NPA emphasises developing the skills of healthcare workers to collect forensic evidence specimens and to be prepared to testify in court.

The health facilities selected did have skilled, trained forensic nursing staff, although the nurses interviewed pointed out that forensic nursing is not accredited by the South African Nursing Counsel as a profession. The nurses insisted that many of their colleagues with the necessary training in forensic medical skills were leaving the public service because of this. It was also found that the hospitals based in the more rural areas were more likely to experience a shortage of doctors and forensic nursing staff, mainly because of salary-related problems.

1.1.3. Availability of Relevant Resources

According to most of the informants, their hospitals do not have dedicated budget allocations for activities related to the VC. For instance, the provincial coordinator confirmed this, “We are operating on zero budget.” This is in contrast with the Rape Crisis Centre, which indicated that it had set aside budgetary resources for assisting victims of crime. However the NGO receives funding from donors (e.g. Terre De Homes, the Lottery Board, Anglo Gold, a German Foundation and the Nelson Mandela Local Council) specifically earmarked for this purpose.

Problems were identified in terms of hospital equipment at the health centres. Many of the healthcare centres were struggling with lack of facilities and equipment; for instance, some of them reported that due to a shortage of computers, victims of crime are often advised to go to police stations where their details are often not captured accurately by the SAPS. Some of the centres (e.g. Mthata)) were still under construction, which meant that services were currently being rendered in makeshift facilities. Some of the TCCs reported that there was a shortage of doctors, and there had been incidents where general nursing staff, without the necessary training and qualifications, were allowed to perform tasks and functions related to forensic medical services for victims of sexual assault. This not only undermines the effectiveness and quality of services rendered to victims of crime, but also poses grave risks of contamination of forensic evidence needed for future court cases to prosecute perpetrators of crimes.

Interviews with informants in some of the hospitals revealed that some of the rural hospitals which had a shortage of doctors and other vital personnel were unable to operate for 24 hours. That meant that victims of sexual assault arriving at night seeking medical assistance

were usually turned away. The lack of budgetary resources also meant that for VC activities social workers could not undertake home visits for the victims due to lack of vehicles.

Despite these challenges, the informants felt that the healthcare centres, including the TCCs, were providing vital services to victims of crime. In the majority of cases the victims are able to received high quality healthcare services, including attention to their needs in privacy.

1.1.4. Monitoring and Evaluation

Informants referred to suggestion boxes currently used by healthcare facilities to monitor performance and progress in delivering services. In addition, reference was made to meetings with the NPA to report on challenges and achievements related to implementing the VC. In some hospitals, such as St. Barnabas, apparently volunteers were employed to conduct assessments. It was also reported by some of the informants that the DOH has a provincial oversight committee for the Eastern Cape/Border region that sits every two months to consider complaints. It is not clear what the status of the structure is in terms of assessing the performance of the healthcare facilities with regard to the VC.

1.2. Services Rendered to Victims

The informants interviewed for this study were largely satisfied with the services currently being delivered to the victims of crime, and felt that the department was generally fulfilling its primary functions.

Nonetheless it was indicated that many of the TCCs, particularly in rural areas, were unable to offer 24-hour services to victims of crime in line with departmental policy and commitments. Only two centres, based in urban areas, offer 24 hours services to victims of crime. One respondent was quite clear on this, arguing that “In the EC we have 8 centres, and only 2 offer 24 hour services. Cecilia Makiwane Hospital started only recently in 2012 to be a 24-hour service, and also Dora Nginza Hospital.”

Usually victims of sexual assault arriving at the healthcare centres are referred to the OPD where they are examined and counselled. Victims are also provided with comforter packs which are usually available in at all TCCs. However during onsite observations at Butterworth Hospital it was discovered that there were no comforter packs as the hospital had run out of supplies.

1.3. Key Challenges/Constraints

The first major constraint in this study was the lack of dedicated budgetary resources for VC-related programmes and activities. It would appear that hospitals have to find resources from some of their programmes to cover the costs of implementing the Charter. Secondly, a major constraint was the shortage of doctors dedicated to the TCCs, and nurses with training and qualifications in forensic medical skills in the province. The negative impact of this on the services rendered to victims of crime cannot be overestimated. Thirdly, the obvious absence of an effective monitoring and evaluation system means that the department does not have a reliable tool for assessing the performance of its health facilities in terms of meeting the VC standards of service. Finally, the capacity of many healthcare centres to provide critical health services over 24 hours as required in terms of policy was identified as

one of the key weaknesses for the DOH. Out of the eight TCCs in the province, only two are currently able to remain open for 24 hours.

7. MPUMALANGA PROVINCE

1.1. Institutional Capacity Issues

The Themba Thuthuzela Care Centre in Mpumalanga Province was selected for the purpose of assessing progress in the implementation of the VC through the DOH. An interview was also conducted with a representative of an NGO called Foundation of Victims of Crime (FOVOC) which is currently offering victim empowerment services in two districts of Mpumalanga - Enlanzeni and Gert Sibande. In addition to an in-depth interview conducted at the Centre, onsite observations were also carried out. The provincial coordinator for the VC was also interviewed on progress in implementing the VC in the province.

1.1.1. Knowledge and Understanding of the Victims Charter

From the information received, the provincial coordinator had good knowledge and understanding of the VC and the rights contained in it. However the CFM nurse seemed less knowledgeable in terms of detailed understanding. There was awareness among the informants that the Charter was about promoting the rights of victims of crime to be treated with dignity by the service providers at designated facilities of the DOH. A representative of the NGO known as FOVOC working with victims of crime at the facility was also interviewed. The NGO is currently also rendering victim empowerment services in two districts of Ehlanzeni and Gert Sibande in Mpumalanga. The representative of the NGO was also fully conversant with the aims and objectives of the VC, referring to it as a set of government's commitment to improving service delivery for survivors of rape, sexual assault and domestic violence.

1.1.2. Internal Skills Development/Capacity Building

Not enough information was obtained to determine the extent to which skills development and capacity building was being provided to centre staff. However, the informant who was interviewed for this study was a skilled forensic nurse in possession of a forensic nursing diploma and a certificate in the same field of expertise. The FOVOC informant that was interviewed for this study indicated that its staff had received the necessary training from Private Agencies Collaborating Together (PACT) South Africa to deal with and assist victims of all age groups, including children. Training had apparently also been offered on the VC and the VEP.

1.1.3. Availability of Relevant Resources

At the time when the interviews were conducted, the VC provincial coordinator indicated that a budget of R1 600 000 had been allocated for the financial year under review, but that it was allocated for specialised services. It is not clear if the Charter is considered part of specialised services covered by this amount. The coordinator revealed that there were 24 designated CFM centres in the province, with 52 trained clinical forensic nurses. However, it was not clear whether or not the budget was adequate to cover the operational costs of all these centres. Moreover, the TCC was unable to confirm this amount and instead indicated that the TCC relied on resources, particularly equipment, from Themba Hospital.

Based on observations carried out at the premises of the TCC, it was noted that the centre had standard facilities, including waiting rooms and public and disabled parking spaces. With regard to consulting and examination rooms, these provided reasonably adequate levels of privacy for the victims to receive the attention needed from healthcare workers. Resources such as showers and sanitary towels were also available. In terms of a relevant staff complement, the Themba TTC has a site coordinator, CFM nurse, social worker and VAO provided by the NPA. Information leaflets were also available, including one on a complaints procedure. There were therefore sufficient resources to ensure that victims received the minimum levels of services required.

FOVOC had a budget of R5 million for the current financial year, based on funding from donor agencies such as the Independent Development Trust, the Presidential Emergency Plan for Aids Relief (PEPFAR), Kinderfonds Mamas and the European Union. These donor funds are critical in providing a range of costs such as administrative costs, care facilities and other operational costs.

Based on this discussion, it would appear that the Themba TCC is facing limited resources and funding constraints in order to deliver on the DOH's commitments to the VC. This would suggest that access to the hospital's resources would play a crucial role in enabling the TCC to deliver basic services to the victims of crime.

1.1.4. Monitoring and Evaluation

The informants indicated that the DOH had a system of quarterly meetings and support visits to all designated centres as a way of monitoring progress in the implementation of the VC in general, and rendering basic minimum standards of service to victims of crime. It was also revealed that public complaints were dealt with through quality assurance committees that operate across all the CFM centres in the province. In addition the TCC has a suggestion box for receiving feedback from victims. It is not clear how effective these mechanisms are in terms of assessing the TCC's ability to meet the minimum standards of services as outlined in the VC.

In the case of FOVOC, the informant from the NGO revealed that an internal mechanism was in place to monitor and evaluate the work of the FOVOC. However it was also revealed that an independent service provider, an NGO called Health Development Africa (HAD), was appointed in May 2012 to carry out a thorough evaluation of the services rendered to victims of crime.

1.2. Services Rendered to Victims

Based on the onsite observations that were conducted at the Themba TCC, there was reason to believe that the centre made efforts to provide the minimum service standards prescribed for rendering services to victims of crime. For instance, it remains open for 24 hours, thus ensuring that vital healthcare services are available and accessible at all hours for those who need them. However, medical doctors are not available at all times, especially at night. In fact, it was discovered that there are no doctors specifically assigned to the TCC, implying that while the centre remains open at all times, the shortage of doctors at all times prevents vital healthcare service from being provided.

FOVOC indicated that it assists victims by rendering services such as trauma debriefing, pre- and post-AIDS test counselling, and providing PEP. The NGO also carries out home visits to victims, prepares court preparations and court support, and provides shelter for abused woman and their children. FOVOC also indicates that the victims are informed in terms of their rights. To minimise the risks of secondary victimisation for victims, victim-friendly facilities have been established in 13 police stations, 8 public hospitals and 4 regional courts, in addition to a shelter for abused women and children within the province.

As indicated above, staff working within FOVOC has been trained to offer counselling and deal with groups of all ages, including children who have been exposed to abuse.

1.3. Key Challenges/Constraints

A key constraint for the Thamba TCC was identified as a lack of financial resources, in particular a budgetary allocation for VC-related activities. This has ramifications for other resources needed to sustain its operations. For instance, based on information obtained through interviews and onsite observations, it was clear that VC activities are resourced through reliance on other programmes (eg. specialised programmes) and on the resources of Themba Hospital whose facilities are available for the TCC. It was also indicated the while the TCC is able to remain open for 24 hours, the shortage of doctors undermines its ability to render critical medical services to victims at all times.

8. LIMPOPO PROVINCE

1.1. Institutional Capacity Issues

To examine the work of the health department in the implementation of the VC in Limpopo, five hospitals and three TCCs were selected for this study. Onsite observations and in-depth interviews were conducted with healthcare officials (clinical forensic nursing staff and doctors) at these facilities, including an interview with the department's provincial coordinator for clinical forensic services in the province. The following hospitals were selected: Kgapane Hospital, Lebowakgomo Hospital, Groblersdal Hospital, Polokwane Hospital and St Rita's Hospital. The TCCs selected were Tshilidzini, Mokopane and Mankweng.

1.1.1. Knowledge and Understanding of the Victims Charter

Interviews conducted with healthcare workers revealed a level of understanding of the VC among some of the forensic nurses, while others were clearly less knowledgeable. Some of the nurses were hearing about the Charter for the first time during the interviews. Those who were knowledgeable were aware that it sought to guide them on how to treat victims of crime seeking medical assistance. The provincial coordinator described the VC as an undertaking by the department and other stakeholders to deliver minimum standards of services to victims of crime. The coordinator also pointed to numerous pieces of national legislation that compel the department to provide services to victims of crime.

1.1.2. Internal Skills Development/Capacity Building

Based on the interviews with the health workers, there are insufficient opportunities relating to skills development and capacity-building for them. All the forensic nurses that were interviewed agreed that they had undergone skills training sessions, particularly on

how to provide counselling to victims of sexual crimes, particularly children and people with disabilities. Some of the training was on pharmacology which equipped them to provide medical treatment to victims of crime. This type of training is clearly in line with the requirements of the VC, even though the informants felt that the training was insufficient to prepare them adequately for their tasks.

All the forensic nursing staff also lamented the fact that their forensic medical training was not recognised by the South African Nursing Council as a profession, meaning that they could not be given occupational-specific benefits, including commensurate remuneration.

One of the major issues raised by the informants from all the medical facilities, including the TCCs, was insufficient forensic medical expertise or medical personnel trained in this area of expertise. There was a dominant perception among the informants from the hospitals that the DOH did not take this area of expertise seriously, which contributed to high turnover rates among forensic nursing staff in many of the healthcare facilities in the province. However similar perceptions did not appear to be prevalent among informants from the TCCs. It also appeared as if some of the TCCs did not suffer from shortage of personnel with forensic medical skills to the same extent as the hospitals. Curiously though, the Mankweng TCC indicated that it had three full-time forensic nurses, seconded from the DOH.

1.1.3. Availability of Relevant Resources

During observations of the facilities at the healthcare centres and TCCs, it was noted that much equipment and many facilities were in a general state of disrepair. There was general lack of proper maintenance of facilities, especially in the hospitals, which often affected their functioning severely. Some hospitals like St Rita's hospital did not have special consultation rooms for the private treatment of victims of sexual assault and instead used general casualty wards which offered no privacy. Neither did the hospital have shower rooms or even social workers to assist to the victims.

In contrast, the Polokwane hospital appeared to have all the necessary facilities and equipment, although informants pointed to issues of poor management and poor use of hospital facilities. Lebowakgomo Hospital also appeared to have problems relating to poor use of resources, including limited space for treating patients. Similar problems of lack of space affected Kgapane Hospital, with men and women sharing facilities such as toilets and bathrooms. In terms of resources for TCCs, it was noted that they generally had the necessary facilities, including bathrooms, toilets, rooms for counselling, and waiting rooms. The TCCs also appeared to have adequate clothes for victims.

Where budget allocations for hospitals are concerned, it would appear that individual hospitals are not given individual budget allocations but receive their cost allocations through casualty/emergency divisions. Nonetheless informants generally believed the funding was inadequate to cover all their expenses. However it was not possible to determine what the informants would regard as adequate because no details were available to determine the extent of funding shortages. Some of the informants argued that the implementation of the VC was funded through resources from the casualty wards of their hospitals, and no specific budget allocation had been made to implement it.. It was pointed out that the NPA provides additional resources, in particular clothes and comforter kits containing supplies such as soap, toothbrushes, undergarments and facecloths.

The TCCs insisted that their resources were provided by the NPA. An interview with the provincial coordinator revealed that no specific budgetary allocation has been made to provincial health departments to fund services for victims of crime. However according to the coordinator it was expected that provincial health departments would make resources available to fund services for victims of crime. It appears also that the regional coordinator expected that specific units or directorates within the provincial health department, such as the Gender Desk, HAST (HIV directorate) and the training directorate, would make resources available for VC-related costs.

1.1.4. Monitoring and Evaluation

Informants insisted that systems were in place to ensure monitoring and evaluation of the progress of both the hospitals and TCCs in implementing the Charter. However in most cases this referred to using existing complaints handling or administrative disciplinary procedures, suggestion boxes or variations thereof, whereby victims are asked to write their suggestions and express their levels of satisfaction with services and treatment received. Clearly this is not an effective and reliable tool for a thorough review and assessment of the effectiveness of service delivery and implementation of the VC, yet many facilities appear to rely on this method of assessing their performance. The informant from Polokwane Hospital did, however acknowledge that there were no monitoring and evaluation systems currently in place.

Similarly some of the TCCs were also utilising suggestion boxes, while others, such as the Tshilidzini Care Centres, were also using victim surveys completed by the victims of crime. While some informants insisted that such surveys were used to effect changes to improve the quality of services rendered to victims of crime, it is not clear what the frequency and scope of these tools are and the extent to which they are being utilised by the other centres to improve the quality of services delivered. The Mankweng TCC referred to meetings with the NPA to assess progress and performance.

1.2. Services Rendered to Victims

The interviews with informants from the TCCs and hospitals made it clear that a lot still needs to be done to meet the minimum standards of services as prescribed in the VC. Yet informants insisted that their centres followed the procedures as described in the regulations contained in the National Health Act of 2003 for rendering services to victims of crime, except in cases where their forensic units were not functioning well. Most informants described the standard administrative and other procedures for assisting victims arriving at their healthcare facilities, particularly in terms of the provision of information, conducting initial consultations, capturing case details, victim pre-test counselling for HIV/AIDS), examinations, conducting pregnancy tests, provision of PEP and collecting forensic evidence. All informants insisted that treatment kits are also provided to victims of sexual crime. One of the vital services performed by forensic nursing staff is that they assist in preparing case evidence for court, and are usually expected to appear before court as witnesses testifying for the victims during court trials.

The provincial coordinator argued that more centres are being established jointly with the NPA and dedicated to implementing the VC in the province. For instance, it was pointed out that five TCCs had been established, although only three were fully operational. One centre had been established by the DSD. In addition, 20 hospitals had been gazetted as

designated clinical forensic hospitals, with 20 additional forensic nurses trained to serve as forensic expert witnesses during court cases involving victims of crime.

1.3. Key Challenges/Constraints

The discussion above revealed a number of challenges facing the hospitals and TCCs in terms of delivering services to victims of crime. For instance, the perennial issue of lack of resources, particularly financial resources, was identified by all the facilities. It is clear that these facilities were operating within the context of limited financial/budgetary resources, which impacted significantly on the availability of other resources such as infrastructure, equipment and routine maintenance.

The issues of poor use of resources and poor management of the physical resources (i.e. effective use of physical facilities at hospitals) was identified by a few informants, suggesting that some of the constraints have less to do with the availability of resources than with effectively using such resources.

It would appear that training has been provided to personnel at these facilities, although the relevance of the training for the VC is an important aspect that could serve as a constraint in the future. Linked to this is the widespread perception that there is a shortage of healthcare personnel with the necessary expertise, particularly in forensic medical services. This is a critical skill for the purposes of assisting victims of crime.

It is also clear the provincial DOH has not provided the sort of financial support for the VC expected of it. However it is not clear what systems and programmes are in place to ensure effective support and consistent participation by the provincial health department in planning and budgetary processes for the Charter.

2.1.3. Conclusions

This study sought to assess the progress and effectiveness of the DOH in its implementation of the VC through a network of healthcare facilities, including TCCs around the country. It was found that a strong foundation of policies and legislative framework is in place to guide the work of healthcare officials and professionals across the country in terms of implementing the VC and meeting the prescribed minimum standards of service for victims of crime.

In implementing the VC in line with guiding policy documents, it can be concluded that the DOH has put in place the necessary structures and processes to guide its officials and healthcare professionals. In addition to the hospitals, the establishment of the TCCs across the country has proved to be crucial in providing exclusive and dedicated services to the victims of crime. However, implementing the Charter in the various healthcare facilities is often impeded by severe shortages of appropriately skilled and trained healthcare workers, as well as by shortages of financial and physical resources. A severe shortage of resources is a widespread problem, not only among hospitals, but also among TCCs, which appear more vulnerable to such resource constraints.

In looking at whether the services, conditions and infrastructure at these facilities meet the minimum standards, the evidence found was not convincing. The findings of the study show varying and different levels of facilities and quality of services at different hospitals and

TCCs around the country. In particular, it was discovered that many of these facilities are rendering services amid overwhelming conditions of lack of resources, insufficient personnel and shortage of vital expertise and services. It can also be concluded that depending on the geographic location of these healthcare facilities, those located in the more rural parts of the country were more vulnerable to severe financial and other resource constraints compared to those located in the more urban areas of the country.

With regard to the gaps and challenges, it can be concluded that the biggest challenge and constraint facing the DOH in its implementation of the VC is insufficient budgetary resources for its healthcare facilities. This shortage of finance has repercussions affecting a whole range of other vital areas, such as recruitment and training of skilled (especially forensic) professionals dedicated towards handling victims of crime; purchasing of supplies and routine maintenance of office equipment for hospitals and related healthcare facilities; as well as adequate space for treatment and caring for victims. The lack of resources has also had an impact in the absence of effective internal monitoring and evaluation systems to enable the department at national level, as well as the individual facilities, to determine the extent to which the delivery of services to victims of crime is in line with prescribed policy frameworks and minimum standards of services.

2.1.4. Recommendations

In line with the findings of this report on the DOH the following policy recommendations are suggested.

- The current model of funding TCCs appears to be both obscure and ineffective. It appears to have rendered the TCCs vulnerable to a financial crisis. It is recommended that the NPA, DOH and other relevant role players should commission a thorough independent review of the resources and funding model currently being used for funding the TCCs. This process should lead to a long- term funding strategy for them to reduce their reliance on the use of and access to the financial and other resources of hospitals, where this is the case.
- It is recommended that the DOH institutes a system of regular and on-the-job training and skills development for healthcare workers who are regularly involved in the provision of vital services to victims of crime. The training should be aimed not only at healthcare workers in the TCCs but also in the hospitals. In particular, the need is for skills such as forensic medical services (including collecting, storing and presenting forensic evidence), psycho-social counselling services, and awareness of the standards of services for victims of crime outlined in the VC.
- It is important that the DOH puts in place an effective and comprehensive system of reviewing the state of its healthcare facilities throughout the country to determine if these are consistent with the standards prescribed in both the VC and in line with current policies and legislations. Commitment to the highest standards and quality of health services should be accompanied by regular reviews of internal systems, processes and programmes that aim to maintain these services and, where necessary, implement effective interventions based on the outcomes of these reviews.
- Linked to the above recommendation, it recommended that the DOH, together with the NPA, puts in place an effective, reliable and preferably independent system of regular reviews, monitoring and evaluation of the performance of its healthcare facilities, including the TCCs. Such a system should have a wide scope, focusing on the effectiveness and relevance of internal and external operations, systems, policies and practices of

healthcare facilities throughout the country. It should also focus on the experiences and levels of satisfaction of the victims of crime.

2.2. Department of Correctional Services (DCS)

2.2.1. National Findings – Policy Frameworks and National Perspective on Implementation

1. Departmental Policy Frameworks

The work of the DCS is governed by two legislative frameworks: the Correctional Services Act (Act no 111 of 1998) and the Correctional Services Amendment Act (no. 25 of 2008). The department has identified the parole system as a strategic structure for fulfilling its functions and responsibilities in the implementation of the VC. The parole system is provided for in terms of Chapter VI ('Community Corrections') and Chapter VII ('Release and Placement under Correctional Supervision and on Day Parole and Parole') of the Correctional Services Act (Act no 111 of 1998).

The DCS has committed itself to turning the punitive system into a correctional service which includes families, communities, civil society and other partners in government. The department seeks to give victims of crime more recognition by offering them services in line with the VC in general and the VEP in particular. Furthermore, the department has developed policies on victims/complainants' involvement in parole boards, as well as a policy on restorative justice. Restorative justice denotes putting right "the harms caused by the offence (individual, relational, social) to heal victims, offences and communities that have been injured by the crime". The department has sought to align these policies with the Charter, particularly its provisions regarding the treatment of victims and how the DCS intends to meet them.

The parole system is identified as a tool for community corrections as contemplated in Chapter VI and VII of the Correctional Services Act. Therefore the composition of the parole board is intended to reflect this. Parole boards comprise a judge as the chairperson, a director or deputy director of public prosecutions, a member of the DCS, a person with special knowledge of the correctional system, and two representatives of the community. The roles and functions of the parole boards are clearly articulated in paragraph 75(1) of the Correctional Services Act.

The parole system is further expanded in section 5.5 of Chapter 5 of the White Paper on Corrections in South Africa, on Correctional Management. It draws attention to the fact that the policy on parole governs the release of incarcerated offenders under community correctional supervision, and therefore promotes the principles of restoration of relations between the offender and the victim, while assisting the victim to forgive the offender. It also seeks to restore the offender to his family and to the community at large and therefore facilitate re-integration back into the community upon his release from a correctional facility. These principles are contained and elaborated on in the DCS Policy on Restorative Justice, 2007.

A number of key policy frameworks have already been outlined in the section dealing with the findings of the DOH. However, one of the key policy commitments by the DCS aims to secure victims' or complainants' involvement in parole boards. This is in fulfilment of the

minimum standard of the right of victims to be treated with fairness and respect for dignity and privacy. In terms of this policy provision is made for a victim to be present at a parole hearing. The chairperson of the parole board is obliged, prior to the hearing, to inform the victim about the procedures during the hearing and also what is expected of the victim, in a language that is understandable. The victim will be protected from being victimised or traumatised again during the hearing. In terms of the right to be offered information, the chairperson will be obliged to inform the victim about the time, date and venue of the parole hearing. Also, the victim will be allowed to give inputs, either verbally at the hearing or in a written submission to the parole board.

The CS also commits itself to providing every victim with the necessary information relating to the offender's sentencing, including when the offender is being considered for parole. If it is deemed necessary during the parole hearing, the victim will be provided with support, including counseling, on request. Victims are also entitled to be given any other relevant information, including changes to the dates and venues of the parole hearings, as well as outcomes of parole processes and conditions relating to paroles granted to offenders.

Victims have the right to protection, which means that the DCS has to ensure that the victim is informed in cases that pose a threat to the safety of the victim, such as if and when an accused escapes from custody or is transferred to another facility. The need to protect the victim may extend to cases of rape and sexual offences where the parole board may include imposing parole conditions to prevent the offender from making unwanted contact with the victim.

Finally, it is the responsibility and duty of all state institutions and agencies involved in the case to provide relevant information to victims on the available complaints mechanisms. If the victim's complaint involves correctional officials, the victim can submit a complaint in writing to the National Commissioner of Correctional Services or the inspectorate judge.

2. Implementation of the Victims Charter: National Perspective

2.1 Institutional Capacity

2.1.1 Knowledge and Understanding of the Victims Charter

The DCS has a national coordinator for the VC, located within the Pre-release and Resettlement Directorate, which focuses on restorative justice and parole placements. Three people report to her.

The coordinator displayed knowledge of the VC, describing it as "a tool that Government… has developed and adopted to fast-track the programme of victim empowerment…, stipulates clearly the requirements that the different government departments, particularly those in the criminal justice cluster, should adhere to in ensuring that victims are at the centre of the criminal justice system". She went to add that "the Victims Charter would guide you to the specific rights that you need to ensure that you protect the victims who have experienced crime".

In terms of realising the seven rights as articulated in the VC, the DCS has identified the parole system as a focus area for ensuring that the rights of victims are protected and relevant information offered. Parole takes place when the offender is due to be released

from a correctional facility; hence the victim has a right to know the date and time of this release. On the other hand, the DCS should also give the parole board sensitive information about the offender which might place the victim's life in danger if that particular offender has to be released; this is why victims are given a platform to participate in the parole hearings in order to exercise their rights to be heard and their rights to be offered information about the release of the offender. Therefore the DCS upholds the right to be heard and the right to offer information.

The national coordinator went on to explain the role of the DCS in the implementation of the Charter, particularly in developing policy frameworks, interventions and programmes. She mentioned a programme developed by the DCS for tracking victims of crime to attend parole hearings. This is a potentially crucial programme, given that the findings from many parole boards indicate the difficulty of locating victims to attend parole hearings. The tracking programme involves an MOU with an organisation called the Foundation of Victims of Crime (FOVOC) to assist the department and parole boards in tracing the victims for purposes of attending parole hearings. Findings from parole boards in various provinces seem to confirm the fact that many victims are usually not available when parole hearings are convened for offenders.

The knowledge and understanding of the national coordinator in terms of the VC and related policy framework is therefore crucial in that this position is responsible for guiding DCS officers across the country in implementing the Charter.

2.1.2 Availability of Relevant Resources

At provincial and regional level, the implementation of the VC is the responsibility of parole boards. The parole boards are responsible for the placement of offenders and the participation of victims in the parole hearings across all nine provinces. Adequate resources are therefore important for this work to be carried out effectively and efficiently. However, the national coordinator was unable to provide information on the resource allocations to parole boards, the apparent explanation being that those parole boards are independent of the national coordinator. This is a curious explanation, given that parole boards are part of the DCS, and are assigned the responsibility of spearheading the role of the DCS in implementing the VC. What is clear, though, based on information obtained from the interview with the DCS national coordinator, is that there is no specific budget allocation for implementing the VC through parole boards across the country. During the interview with the coordinator, the point was made that a lack of a dedicated budget for implementing the VC has grave implications for realising the department's restorative justice programme.

2.1.3. Internal Skills development /Capacity Building

As already indicated, the implementation of the VC occurs at regional/provincial level through parole boards, while the DCS sets national policies. The development of capacity for staff is therefore the responsibility of the regional parole boards. Nevertheless, it would appear that the DCS places significant emphasis on promoting restorative justice, at the centre of which is the mediation process that takes place between the victim and the offender. Yet there was no indication of the level of resources and skills development currently being dedicated to this process.

The coordinator indicated that the department places emphasis on empowering the victim through the provision of information about their rights, including the right to participate in promoting restorative justice at community level. Therefore capacity building and skills

development in this context entails enabling victims to claim their rights and make effective demands of the parole system to realise the rights and privileges of victims, including the right to get answers from the offenders.

The DCS also drives a programme called Victim Rights Week (VRW) to educate and develop the capacity of justice cluster departments and partner NGOs to implement the VC. The department states that the VRW has become the Charter's most important programme. The department also runs programmes to raise awareness among communities, particularly in rural areas, about the VC.

2.1.4 Services Rendered to Victims

Specific services for victims of crime are provided by parole boards rather than the national office of the DCS, and more details will be provided under the findings from the provinces. For instance, parole boards are also responsible for providing the necessary services (e.g. counselling) and facilities (e.g. waiting rooms) during the parole hearings and during victim–offender mediation. Parole boards are also responsible for maintaining communication with victims, ensuring that they know their rights and are aware of developments relating to the offenders/perpetrators.

2.1.5. Monitoring and Evaluation

Although monitoring and evaluation is the competency of the national office of the DCS, the department was unable to provide information on whether this function is currently being carried out. It would appear, though, that the department has put in place a complaints mechanism for offenders within the correctional centres. Based on the interview conducted with the national coordinator and other officials from DCS centres across the country, it is clear that there is no national policy framework or system to ensure effective monitoring and evaluation of the implementation of the VC. This should determine if the department is achieving its key strategic objectives.

2.2. Key Challenges/Constraints

A number of key challenges with the potential to undermine the ability and capacity of the department to discharge its responsibilities in terms of the implementation of the VC are outlined below.

A potentially important issue that emerged during the interviews with some of the officials is that, despite the focus on the victims of crime, greater attention continues to fall on taking care of the offenders. The issue of shortage of funds for the transportation of victims to attend parole hearings was raised by many officials from various provinces. The point being made here is that the department and its parole boards are failing to provide the necessary resources to ensure participation of victims in parole board proceedings.

The second constraint is the apparent lack of dedicated personnel or structure within the DCS to focus attention on promoting restorative justice in general and the VC in particular. The fact that many parole boards lack the necessary budgetary resources and have to rely on the work of an NGO to trace victims of crime for the purposes of parole hearings is seen as an indicator of lack of capacity to discharge its responsibilities to the victims of crime.

Finally, there is still limited knowledge and understanding among communities regarding the roles and functions of the parole boards and the benefits for the victims of crime. In particular, many victims have lost faith in the system after finding out that they do not have the authority to influence the decisions of the parole boards on the granting of parole to offenders.

2.2.2. Provincial Findings

1. GAUTENG PROVINCE

1.1. Institutional Capacity Issues

Three Correctional Service facilities were identified and selected for this study. They are Gauteng, Hillbrow and Modderbee parole boards.

1.1.1. Knowledge and Understanding of the Victims Charter

Based on interviews with officials from these parole boards, it was concluded that they displayed some understanding of the VC and some of its key provisions. The officials were able to identify and talk about the seven rights of victims outlined in the Charter, including the right to attend parole hearings when the offender applies for parole and the responsibility of parole boards to ensure that these rights are observed, respected and realised.

1.1.2. Internal Skills Development/Capacity Building

Based on information obtained from informants, no specific training for parole boards on gender sensitivity has been provided to board members. For instance, a chairperson of one of the parole boards indicated that failure to provide training on gender issues and the VC is potentially risky, as it undermines their effectiveness in promoting the rights of the victims. However, it would appear that staff members of some parole boards have received some training on the VC by the Department of Justice and Constitutional Development.

Informants who underwent the training indicated that this included facilitation skills for parole hearings. In addition, manuals on victim participation in parole board processes were provided. It is clear though that not all members of parole boards' staff have received training. Some of the chairpersons were concerned about the lack of consistency in the provisions of skills training for staff members, especially in the case of, for example, social workers who are intricately involved in assisting and rendering services to victims of crime.

1.1.1. Availability of Relevant Resources

Based on interviews conducted with officials, as well as observations at parole board centres, it was found that the centres selected for this study had the staff and basic facilities necessary to render basic services to victims of crime. It was observed that all the centres had waiting rooms for victims, and adequate space for victims and offenders to sit in separate rooms to avoid the possible intimidation of victims by offenders. According to the parole board chairpersons, the sitting arrangements allowed for victims and offenders to sit separately and away from each other, thus ensuring the security of the victim. Other facilities included separate male and female toilets, and toilets for the disabled. So the minimum standards of basic services existed in all the parole board centres that were visited. It was

noticed, however, that the facilities at all the centres observed did not cater for the privacy of breast-feeding mothers.

In terms of financial resources, the chairpersons of all three parole boards selected referred to lack of adequate financial resources for effective implementation of the VC. One of these chairpersons alluded to the fact that some victims are unable to attend parole hearings because of shortage of funds to cover their transport costs. While the parole boards had access to the services of social workers from the DCS, one of the chairpersons expressed concern that there were not enough social workers available, which forced the parole boards to rely on the voluntary services of community social workers.

Some of the officials interviewed for this study pointed to the need for counselling and psychological support services for parole board staff members who are regularly exposed to the trauma suffered by the victims. This issue of the language of communication victims was also raised, with some parole board officials indicating that English is the main language of communication because of lack of resources to utilise the services of translators and interpreters.

1.1.2. Monitoring and Evaluation

It was found that the DCS does not have a standard system for performing systematic monitoring and evaluation of the work of its parole centres. It was also found that all three parole boards did not have any systems of reporting on their implementation of the Victims Charter. Two of the three boards kept a register of statistics of the victims assisted by the centres. Nonetheless it would appear that there is no form of systematic monitoring and evaluation of the work and quality of services rendered by the parole boards. Some boards indicated that they rely on feedback from victims, yet it was not clear what system was in place to secure the feedback and process them.

1.2. Services Rendered to Victims

Based on information obtained from parole board officials, the services provided by the three parole boards revolved mainly around educating victims about their rights, contacting victims to inform them about offender parole applications as well as conducting victim-offender mediations.

1.3. Key Challenges/Constraints

A number of factors were identified as constraints that affected the work of the parole boards that were selected in Gauteng. These include insufficient funds, lack of staff dedicated to implementing the VC and conflicting administrative/service delivery boundaries of the different state institutions involved in implementing the VC, which often leads to fragmented and uncoordinated services by the different institutions serving the same victims.

The officials also expressed disquiet about the fact that the current parole system leads to contact between parole boards and victims taking place very late in the process, when many victims had already moved on with their lives and forgotten about the cases or were are unwilling to re-engage with the justice system to avoid re-living the trauma. These and other factors often create conditions that undermine the ability of parole boards to advance the objectives of restorative justice in general and the VC in particular.

2. FREE STATE PROVINCE

1.1. Institutional Capacity Issues

This section aims to indicate whether or not the capacity of institutions implementing the VC is consistent with the requirements of the VC and the National Implementation Plan.

Four parole boards were selected in the Free State province for this study. They are Kroonstad, Groenpunt, Grootvlei and Goet Moed..

1.1.1. Knowledge and Understanding of the Victims Charter

The chairpersons of the four parole boards around the Free State management areas appeared to have the requisite knowledge and understanding of the Charter. They explained their roles and articulated its provisions.. They also explained and outlined the rights of victims to appear before parole boards during hearings to make inputs. All the respondents felt these inputs are useful in assisting parole board members to make informed decisions and interventions to promote the rights of the victims. The regional coordinator indicated that the DCS had put in place a Compliance Policy to be implemented within different regions of the DCS.

The respondents were also able to refer to and explain the different procedures and processes relating to the VC, especially with regard to the role of parole boards and the treatment of victims during hearings. However, one chairperson indicated that her parole board had never had a victim participating during its hearings but no explanation was provided for this lack of participation.. The interviews with chairpersons showed that more emphasis was placed on the need to make the victims aware of their rights in terms of parole processes. The preferences of the victims about open or private participation were also taken into account during parole proceedings. During observations of the four facilities in the Free State, it was clear that security was a priority both for the victims and visitors.

1.1.2. Internal Skills Development/Capacity Building

Internal skills development seemed to be one area that had major shortcomings. Three of the four correctional facilities selected for this study had had no substantive training on any of the key areas relating to the functions of DCS correctional facilities in implementing the VC or rendering services to victims of crime. Only one of the correctional facilities, Grootvlei, had received training; the staff had undergone two training sessions on restorative justice and victim-offender mediation.

For the correctional facilities that had not received any form of training and skills development, one chairperson indicated that the only form of training provided for members was job orientation. There had never been any formal training or skills development relating to the VC. She emphasised the fact that the parole board had two community members, as per the regulations, who were expected to make crucial decisions on the futures of the parolees and their reintegration into their communities. She argued therefore that lack of training for members was a potential risk to the beneficiaries of the services rendered by the parole board. One of three chairpersons of parole boards that had had no formal skills training on the VC revealed that she participated in the development of the Restorative Justice

Manual, which all the management areas in the province were supposed to participate in. Nonetheless, the dominant sentiment among the officials seemed to be that of lack of training, which in turn seems to contradict the detailed knowledge and understanding of the VC and the rights of the victims found among parole board Chairpersons, as discussed in the previous sub-section.

The interviews appeared to suggest that due to lack of capacity and skills, the DCS facilities/ parole board in the province are forced to rely on the services of other role players, such as NGOs (e.g. NICRO) and the DSD, especially in terms of psycho-social support services. Some of the officials argued that only two correctional facilities had psychologists who had to serve all the management areas in the province.

1.1.3. Availability of Relevant Resources

Availability of relevant resources, particularly financial resources, seemed to be another key shortcoming for all four correctional facilities selected for this study. All the chairpersons indicated that they did not have budget allocations. They also stated that lack of resources affected the ability to provide transport for victims. All the chairpersons were aware that the Minister had approved a budget for this purpose, but claimed that the funds had not been allocated to the correctional facilities.

The lack of funds for transport has forced the victims to cover their own costs in this regard so they could attend parole board hearings. A few correctional facilities had made informal arrangements to fetch victims from their homes and return them after parole hearings – however, it appeared that such arrangements were largely ad hoc and therefore unsustainable.

While the chairpersons of the four parole boards insisted that there was lack of financial resources for their activities, the provincial coordinator revealed that a budget of R117 500 had been allocated to cover seven correctional facilities for the 2012/13 financial year. This budget was meant for a number of victim support programmes such as Victim Offender Mediation (VOM), and victim awareness campaigns within rural areas. The regional coordinator confirmed the lack of funds for transporting victims, indicating that the funds will be allocated in the new financial year. However, no explanation was offered as to why the funds for victim transport were not allocated in the 2012/13 financial year.

Apart from the issue of funding, correctional facilities are expected to have basic amenities and other operational equipment to carry out their services. The officials from the four parole boards did not identify any constraints in this regard. Observations carried out by the research team found that the four correctional facilities had two different waiting rooms for victims and offenders. The Groenpunt parole board had posters on the walls and pamphlets in the waiting rooms containing information about the VC, restorative justice, procedures for reporting sexual assaults, and other relevant information on the rights of victims. The other three facilities did not have similar displays of information for victims. Also, it was observed that the facilities did not have areas that offered some privacy, especially for breast-feeding mothers.

The parole board offices in the four correctional facilities were not visible, but the frontline personnel were efficient in directing visitors. It is important to highlight that the facilities at three Correctional Services facilities had different entrances for the victims and offenders; only Kroonstad had one entrance, with obvious security risks for the victims.

The regional coordinator revealed that audio recording systems would be provided for parole boards in all the DCS management areas in the province before the end of the current financial year. This is intended to improve the capacity of the facilities to meet the minimum standards of the VC.

1.1.4. Monitoring and Evaluation

Based on the interviews with officials from the four correctional facilities, it would appear that there was no standardised monitoring and evaluation system or procedures to determine the effectiveness of these facilities to meet the needs of victims of crime. The Groenpunt parole board claimed to have some tools to monitor offenders and determine the satisfaction levels among the victims. However, evidence to this effect was not provided. Other interviewees referred to submissions of monthly, quarterly and annual reports to the regional office as tools for monitoring and evaluation. However, it was clear that there was no standard, effective and consistently applied system or procedure for monitoring the work of these facilities in line with the VC minimum standards of service.

1.2 Services Rendered to Victims

Officials from the four parole boards insisted that there were major problems in terms of the capacity of their Correctional Services centre to render effective services to victims of crime. As indicated previously, these centres relied largely on the services of other institutions such as the DSD (for psycho-social services) and NGOs such as NICRO for other services and support for victims.

Nonetheless some basic services, such as dissemination of information regarding participation of communities within the processes of parole boards were being carried out internally. Some of the parole board members claimed to use radio stations to communicate with local communities on the importance of participating in hearings.

1.3 Key Constraints/Challenges

Four key constraints were identified relating to the implementation of the VC in DCS facilities in the Free State province. Firstly, the issue of shortage of skills needed to implement the VC was mentioned by all the informants. Out of the three facilities selected, only one had made provision for ongoing staff skills development. The second issue was inadequate financial resources, caused by a failure to allocate a budget specifically for implementing the VC. This was acknowledged by all the informants as a key impediment to the prospects of meeting the minimum standards of service prescribed. Thirdly, the lack of adequate financial resources created a secondary but important problem, whereby the parole boards were unable to provide for the costs of transporting victims to hearings as required by the VC. Finally, there was no effective monitoring and evaluation system to determine the extent to which the facilities complied with and met the minimum standards of service.

3. NORTHERN CAPE PROVINCE

1.1. Institutional Capacity Issues

The national policy guidelines for victim empowerment state that the DCS is "responsible for protecting the interests of victims in relation to convicted offenders, the rehabilitation of offenders and for preventing victimisation of offenders within the correctional service system". Other services by the department include:

- Direct psycho-social services to inmates
- Reducing victimisation of inmates in correctional centres, and support systems to reduce the impact when it happens
- Effective rehabilitation and reintegration of inmates into society (with the focus on taking responsibility for crime committed and to reduce recidivism)
- Ensuring victims' participation in parole board hearings
- Notifying victims of the impending release of inmates
- Developing victim-offender mediation programmes.

In line with these responsibilities, the DCS prioritised the following areas in the 2007- 2011 Victims Charter National Implementation Plan:

- Establish communication channels to ensure that victims are informed when perpetrators are due for parole hearings
- Establish or improve waiting rooms for victims who are attending parole hearings and/ or victim-offender mediation sessions
- Train relevant DCS staff on restorative justice, victim empowerment and victim-offender mediation so that they can give the necessary information to victims
- Make pamphlets available on DCS parole hearings, victim-offender mediation, marketing of the VC and relevant DCS policies
- Monitor and evaluate the implementation of the minimum standards of the VC.

However, these objectives and priorities are not reflected in the current five-year Strategic Plan of the DCS (2012/13-2016/17). This is a document that is supposed to guide the department in its implementation of programmes for a five-year period, yet it is silent on issues of the VC. That means that the DCS does not have a clear strategic plan to guide its implementation of the VC, which suggests that implementation would be done on an ad hoc basis.

1.1.1. Knowledge and Understanding of the Victims Charter

Informant interviews were conducted with two Correctional Services officials – the chairperson of the Kimberley parole board, and the regional coordinator for the Free State and Northern Cape Victim Empowerment Forum. The two are members of the VEP Forums, which gives them in-depth knowledge of the VC and awareness of all the victims' rights contained in it. Such knowledge and understanding is important for proper implementation. The regional coordinator described the role of the DCS in the implementation of the VC as being "responsible to ensure that our sentences of imprisonment are served in accordance with the law. The releases are also considered by the DCS carefully; the parole boards are responsible to invite all the victims that are involved to ensure that we comply with the civil rights of the Victims Charter." Explaining her role as regional coordinator, she said, "As

part of my responsibility, I coordinate all the victims' involvement activities and programmes within the Free State and the Northern Cape region. I also have to attend the provincial and national forum meetings."

The Kimberley the chairperson explained further the issue of victim participation in parole hearings, saying, "We have a policy that we have adopted for victim participation in parole boards so we are encouraging victims to be part of the parole sessions. Whenever we have to see an offender we inform the victim that the offender who was a perpetrator in this crime will be appearing before us. We will explain how it works, and if a victim is interested then we make those arrangements and it is also up to them to decide not to be part of the process."

1.1.2. Internal Skills Development/Capacity Building

While no further details were furnished, the Kimberley chairperson indicated that regular and ongoing training was being given to the members on issues relating to the functioning of the parole board. In terms of the VC, inter-departmental training initiatives were apparently being implemented on matters relating to the VEP and restorative justice.

1.1.3. Availability of Relevant Resources

According to the informants, the DCS does not have a specific budget for VC activities and programmes. This appears to be consistent with the fact that the strategic plans of the DCS do not make provision for the implementation of VC activities in the financial year under review, as indicated earlier. For instance, the regional coordinator confirmed that "we do not have a budget for the Victims Charter, for the VEP services; we do have budget for correctional programmes." For the 2011/2012 financial year the Northern Cape and Free State region received a total budget of R117 500. This was considered inadequate for the seven management areas of the region. Obviously, the absence of a dedicated budget for the VC implies a lack of resources for activities related to it, including transport for victims to attend parole hearings.

1.1.4. Monitoring and Evaluation

In terms of monitoring and evaluation mechanisms, the Kimberley parole board appears to be using the standard monthly, quarterly and annual reporting mechanism submitted to the national office, including the Victim Empowerment Forum. In obtaining feedback from victims on their levels of satisfaction on services rendered, the chairperson of the parole board said, "Immediately after the parole session we have another session with the victim to find out how they feel about the whole process." As in many other correctional facilities in other provinces, it is clear that no effective system of monitoring and evaluation is in place to assess the performance of these facilities in meeting the requirements of the Charter.

1.2. Services Rendered to Victims

Among its responsibilities, the DCS is tasked with ensuring that victims are involved in the parole process. By its own admission, the department is still experiencing some challenges in terms of discharging this responsibility effectively. Evidence for this is the low number of victims that the department has managed to get to participate in parole hearings. Two key challenges were highlighted by the Kimberly chairperson with regard to securing victim

participation in parole boards. The first is that the new Tswelopele correctional facility in Kimberley is a national prison, which means that prisoners come from all over the country. This creates difficulties in terms of tracing the victims from other provinces. The second challenge is that even with victims within the Northern Cape there are still difficulties in tracing them and getting them to participate, as most of them choose not to participate. The informant was convinced that "there is a lot of reluctance so maybe we need to create more awareness on victim participation in parole boards".

With regard to the services available to perpetrators who become victims through being abused in prison by other inmates, it emerged that it is difficult to render services to them, as most of cases of abuse within the cells go unreported. However, with only few cases reported, the secretary of the parole board said, "As soon as the inmate alerts us to sexual abuse or whatever then they are immediately removed from that cell and transferred to another for their safety. Then they will go through the process of making the case and possibly go through counselling as well." The board indicated that despite this challenge they do go to prisons for awareness-raising programmes regarding the parole board and also to inform the inmates about their rights and the channels to go through when those rights are abused.

The DCS has been successfully implementing and taking the lead in the coordination of the VRW through the VEP Forum in the province. The VRW is characterised by high levels of cooperation from other government departments within the justice cluster and civil society organisations that are involved in VEP and VC.

1.3. Key Challenges/Constraints

Three key challenges or constraints emerged from the discussions of the findings from the work of the DCS in the Northern Cape Province. Firstly, the issue of lack of skills development among parole board members is clearly a potential limitation in terms of effective implementation of the VC. This was particularly the case with the shortage of forensic medical personnel at the DCS facilities. The second issue is the lack of financial resources, particularly dedicated budgetary allocations for the activities related to the VC and VEP programmes. Thirdly, lack of a system for effective monitoring of the impact and outcomes of programmes related to the implementation of the VC and VEP programmes. Combined, these factors undermine the prospects of realising the objective of restorative justice through the work of DCS facilities in the province.

4. KWAZULU-ATAL PROVINCE

A total of five correctional service centres were selected for the purpose of the study in KwaZulu-Natal: Westville Centre in Durban, Kokstad Centre, Glencore Centre, Ncome Centre and Pietermaritzburg Centre. The chairpersons of these parole boards were the key informants. The interviews were supplemented with on-site observations of the centres and parole hearings. Each of the board hearings consisted of the chairperson, deputy chair, secretary and two community members. At the Glencore Centre the parole board also had a representative from the SAPS.

1.1. Institutional Capacity Issues

In terms of institutional capacity, we assessed whether the centres had adequate and competent personnel to discharge their responsibilities to serve the victims of crime in line with the objectives, requirements and minimum standards outlined in the VC. We further looked at the presence of adequate infrastructure which allows access to information and the existence of policies and procedures.

In terms of policies and procedures aimed at providing the victims with the opportunity to participate in the hearings, the department had only managed to produce an information brochure. Application forms were also designed for victims who want to participate in parole hearings, although all the informants indicated that there was a general lack of interest in participating. This was attributed to general failure by the DCS facilities to provide adequate information to victims on their cases, court judgements, sentencing of offenders and related activities. But in all five centres it was reported that written submissions were received from victims, particularly in cases where the offenders asked for the victims to be contacted.

In general, though, it would appear that the correctional service facilities are struggling, due to inadequate institutional capacity, to adhere to the minimum standard of service to ensure that the rights of victims are observed and realised.

1.1.1. Knowledge and Understanding of the VC

This section is intended to explore the extent to which the informants were aware of their obligations to the victims and whether they had a thorough knowledge of the VC. This would have been achieved through regular training and relevant skills development of the officials, especially on the VC and its minimum standards. Three out of the five respondents were confident of their knowledge and understanding of the VC, while the other two were not confident with the level of training provided by the DCS on issues relating to the Charter. Those who were dissatisfied cited insufficient time allocated to training. Two centres reported that the last training session took place for two days in August 2011.

1.1.2. Internal Skills Development/Capacity Building

As indicated in the sub-section above, there was a general perception among the informants that training and skills development related to the VC was limited and inadequate.

1.1.3. Availability of Relevant Resources

This section discusses the available resources and operational infrastructure/facilities to ensure effective delivery of services to victims of crime.

The first key resources limitation identified by informants was lack of staff. According to the responses from all five informants, there was no budget allocation for the implementation of restorative justice programmes in the centres. The result of this lack of resources is that parole boards in general have been unable to trace many victims of crime to fulfil their right to participate in parole hearings. Therefore the capacity to trace victims of crime was identified as the second major difficulty, because of insufficient staff and limited resources. One of the informants acknowledged that it is the responsibility of the DCS to provide the victims with relevant information about their cases, including sentencing offenders, and

to ensure that victims participate in parole hearings. In addition, some of the informants also reported that the correctional facilities had no resources to assist victims in terms of transport to attend parole hearings.

It would appear also that the limitation of resources might also be undermining the effective participation of community members in parole hearings. For instance, in some of the parole boards, the two community members are employed on the basis of an hourly rate, meaning that their salaries are determined strictly by the total number of hours spent in board hearings. In addition, limited resources combined with a large number of cases have led to the task of locating the victims of crime to be carried out on a voluntary basis. In some cases victims become untraceable after changing their contact details without informing the correctional service facilities concerned. This was particularly the case for the Westville parole board.

During observation of the centres, it was found that they had properly equipped boardrooms with large posters containing information on various issues of interest for anyone who needed the assistance of the parole board or any institution within the justice cluster. This is crucial in order to fulfil the right of victims to access to information. It was noted from observation that all the centres also had informative pamphlets on the walls of their waiting areas, although these were written largely in English. There were very few instances when such information was available in local African languages. None of the centres had Braille pamphlets. The proceedings of parole hearings were subject to interpretation into local African languages, although lack of resources meant that this function could only be performed if any of the board members were able to translate or interpret from English to a local African language.

With the exception of the Pietermaritzburg correctional facility, none of the other centres visited was fitted with audio-visual equipment (e.g. CCTV cameras) to make it possible for victims to make submissions/presentations to parole hearings without physically being in the same room as the other participants, including the offender, as provided for in the VC. It was found that all the correctional facilities visited for the purpose of this study had strict security infrastructure, not only to ensure security and protection for the victims accessing the services offered at the centre, but also to prevent unauthorised access.

1.1.4. Monitoring and Evaluation

Based on interviews with informants from all the five correctional service facilities selected for the study in KwaZulu-Natal, it became clear that all of them are using two rudimentary systems of monitoring performance. Firstly, the centres used monthly reports containing statistics relating to the number of victims who attended parole hearings or made written submissions. These monthly reports are submitted to the regional and national offices. Secondly, all the correctional facilities reported meetings with stakeholders to discuss progress in their implementation plans. It was not clear how often these meetings are held and their effectiveness as monitoring tools.

It was also not clear whether or not regular evaluation reports are ever produced from these monitoring tools, their frequency, and whether the findings are ever used in a systematic manner to assess progress on the implementation of the VC and meeting its minimum standards.

1.2. Services Rendered to Victims

At the time of conducting the study the DCS facilities in KwaZulu-Natal selected for this study did not render any support services such as psycho-social or counselling services aimed at assisting the victims during the parole hearings. In addition, all the five Correctional Services facilities did not have the necessary funds to cover the costs of transport for the victims of crime intending to attend parole hearings.

In terms of maintaining regular contact between Correctional Service facilities and the victims of crime regarding developments in their cases, the department had entered into a signed MOU with an NGO called Foundation of Victims of Crime (FOVOC) for the latter to be in charge of the facilitation the victim-offender mediation process. The agreement directed FOVOC to fulfil a number of tasks:

- Trace, identify and prepare victims for parole and reconciliation upon request
- Accompany the victims to correctional centres for reconciliation and support in making presentations to the Parole Board
- Identify and prepare an inmate upon request
- Assist victims with the applications to appear at parole sittings and providing facilitation for reconciliation between the victim and the offender.

Clearly, the appointment of a service provider to carry out these tasks comes very late since the commencement of the NIP in 2007. In fact interviews with informants from the selected Correctional Service centres revealed that implementation of the agreement had not yet commenced and that at the time this study was being conducted, the KwaZulu-Natal provincial DCS was only just beginning to introducing FOVOC to all the parole board staff throughout the province. With regards to facilitating mediation between the accused and the victim, informants reported that DCS personnel can only deal with accused and not the victims, due to human resource capacity constraints. It would appear that requests for such services are usually referred to the departments of Social Development and Housing.

1.3. Key Challenges/Constraints

The discussion of the findings in this section identified the lack of financial/budgetary resources as a key overall constraint. The issue was discussed in terms of how it impacted negatively on other areas such as human resources (i.e. adequate staff); skills development and training for staff; provision of services to victims of crime (eg. counselling, psycho-social support services; transportation, etc) and capacity to maintain regular contact between DCS facilities and victims in terms of progress in their cases. It was also found that arrangements for a service provider to handle the interaction between the victims of crime and the DCS facilities in the province were concluded very late in the life cycle of the NIP, meaning that valuable time was lost in terms of enabling victims to enjoy their right to participate in parole board processes.

5. NORTH WEST PROVINCE

1.1. Institutional Capacity Issues

Two Correctional Services centres were selected for the purpose of this study in the North West Province: The Rustenburg Parole Board (Losperfontein) and the Klerksdorp parole board.

1.1.1. Knowledge and Understanding of the VC

Based on interviews conducted with the chairpersons of the two parole boards, it could be determined that they had a working knowledge and understanding of the Victim's Charter. They were both able to articulate without any difficulty the role of the parole board in ensuring that victims enjoy their rights as outlined in the VC, including the right to be informed and to make representation at parole hearings when the offender is due for parole.

Both chairpersons have also been members of, and have consistently participated, in forums such as the VEP and case-flow management structures in the province. In principle, knowledge and understanding of the VC is important in laying the foundation for delivering services to victims of crime in line with the requirements of the Charter.

1.1.2. Internal Skills Development/Capacity Building

While most victims of crime are women, it is still important that the services rendered to women be understood by healthcare workers in terms of their gender implications for both women and men. It is critical that the participation of victims in parole processes be gender sensitive. This implies that gender awareness and gender related skills development is one of the key areas for healthcare workers to be prepared on.

Though members of both parole boards were never exposed to any formal gender awareness and skills training, both chairpersons participate in various forums where gender issues are consistently addressed. Both had also attended various workshops facilitated by the North West Provincial Victim Empowerment Forum where issues of gender sensitivity were addressed. The secretary of the Klerksdorp parole board has had sufficient exposure to gender equality and women empowerment awareness issues due to her previous position as a gender focal person at the DCS. The chairperson of the Klerksdorp parole board pointed out, "We have a gender policy which we consistently consider when making plans and decisions in the parole board and the entire office."

1.1.3. Availability of Relevant Resources

Lack of resources at the Rustenburg parole board was identified as a factor during onsite observations and through the interview with the chairperson. For instance, the parole board does not have well equipped offices (i.e. there was no office equipment such as telephones, computers, printers, etc). This made the performance of simple and routine office tasks difficult. However the situation in Klerksdorp was comparatively much better, although the board had secured office space at premises located in town rather than at the premises of the correctional facility itself.

While informants indicated that DCS correctional facilities had no resource allocations to assist victims with transport costs, the Klerksdorp parole board was providing support

for victims' transport, including food, in an effort to improve victim participation in the activities of the board. It was not clear though how additional resources were found for this purpose and how sustainable this was over time, given the general understanding by many informants from many of the correctional facilities across the provinces that the DCS had not provided the necessary budgetary allocations for transporting victims of crime who sought to participate in parole hearings.

1.1.4. Monitoring and Evaluation

According to the informants interviewed for the study, monitoring is led by the social reintegration coordinator based in Pretoria. The informants indicated that the DCS does not have a formal standard monitoring and evaluation system to measure the progress, effectiveness and impact of its correctional services facilities in rendering services to victims.

In addition, both parole board chairpersons indicated that they submit regular monthly reports to the regional office that contain statistics on numbers of victims assisted by their boards. These are used as an elementary monitoring tool to assess the performance of its correctional facilities. However the effectiveness of such reports as monitoring instruments is usually questionable. It is clear that the department does not have an effective system in place to assess or monitor the level of service satisfaction of the victims.

1.2. Services Rendered to Victims

Only the Klerksdorp parole board had had victims participating in some of their hearings. The board had provided information about this participation in parole board sittings from April 2012 to December 2012. In terms of this information a total of 48 victims (14 males and 34 females) had taken part in its hearings.

Although there are still difficulties regarding the quality of services rendered to victims at correctional facilities, basic services are still being rendered, even if in the context of limited resources and other constraints. Some of the correctional facilities have gone out of their way to make resources available for victims, even in the absence of budgetary allocations by the DCS national office. For instance, the Klerksdorp parole board provides victims with food and transport during parole hearings to ensure that they participate. As indicated above, the parole boards do also provide proper briefings for victims about the hearing processes, including counselling services where necessary. One informant at the Klerksdorp facility added, "Victims receive proper briefing about the process of the parole board, and it is also an advantage that [I am] an experienced social worker. [I] give proper counselling and [I am] also able to contain victims when they break down during the session."

1.3. Key Challenges/Constraints

In the case of the two parole boards selected for this study, and as is the case with many such boards in other provinces, the key constraint is limited financial resources, which has far-reaching consequences for their operations. Lack of office equipment was also identified as a factor in the case of Rustenburg. However this is a common challenge for all parole boards as it is usually a consequence of lack of adequate financial resources. The issue of an effective monitoring and performance evaluation tool is a weakness for both the two boards. However, given the experiences of other boards in other provinces, as indicated in this report, it would appear that this is a broader structural weakness for the DCS.

6. EASTERN CAPE PROVINCE

1.1. Institutional Capacity Issues

This section focuses on key findings about the implementation of the Charter in DCS centres in the Eastern Cape Province. Five parole boards were selected for the study in the province: Cradock, Willowvale, St. Albans, Mthata and East London Correctional Services.

1.1.3. Knowledge and Understanding of the VC

The interviews with the chairpersons of all the parole boards were able to demonstrate understanding of their institutions' mandate. They were able to clearly articulate the standard processes and procedures to be followed when handling the victims of crime at their correctional facilities. Also, onsite observations of a number of parole hearings at these facilities gave further evidence of knowledge and understanding of the VC among the parole board members. These facilities had been able to create environments suitable for handling and assisting the victims of crime. For instance, all these facilities had separate waiting rooms for victims and offenders, and the seating arrangements ensure that there was minimal discomfort and no chance of intimidation and victimisation of the victim by the offender.

1.1.4. Internal Skills Development/Capacity Building

The study found that there were qualified social workers, psychologists, teachers, spiritual leaders and case intervention officials among the DCS correctional facilities covered in the Eastern Cape. However internal training workshops had also been convened for staff members in the past. The department also works with other organisations, such as the Masimanyane Women Support Centre, National Institute of Crime and Reintegration of Offenders (NICRO) and Family and Marriage Association of South Africa (FAMSA) to run awareness-raising and skills-development programmes for staff members. For instance, NICRO has received accreditation to provide training for DCS officials; it has also helped to design and develop manuals on restorative justice, as well as focusing attention on crime prevention and rendering services to the courts and various communities in the province to ensure an environment conducive to the reintegration of offenders.

It was also discovered that NICRO has a memorandum of understanding (MOU) with the Department of Justice, in terms of which prosecutors refer offenders to NICRO's social workers. NICRO is also involved in the Victim Offender Mediation (VOM) programme. It is assumed therefore that the interaction between DCS officials and role players such NICRO has long-term benefits, including the transfer of knowledge and skills for staff at DCS correctional facilities in the province.

1.1.5. Availability of Relevant Resources

All the informants alluded to the fact that there was no budget allocated for the implementation of VC programmes and activities by DCS facilities. One informant amplified the point, "There are no resources budgeted; how do you get a Cape Town victim to the Eastern Cape?" Nonetheless, informants indicated that their facilities ensured the provision of transport for victims of crime to attend parole board sittings.

The team observed that all parole boards had separate waiting rooms for the victims and their families. This is important in terms of ensuring security for the victims. Many of the rooms had posters displayed on the walls containing relevant information for victims, including the minimum standards of service they are entitled to. However it was found that many of the parole boards in the province are 'roving parole boards'. This means that one board would hold hearings in different locations or at different DCS correctional facilities in the provinces, which could imply either lack of staff or a cost savings measure. In some of the correctional centres where the roving parole boards held sittings, it was found that there was a lack of basic facilities, including a separate waiting room for victims and their families.

The researcher also noticed that during parole hearings, all the board members had been provided with background information on the sentencing remarks and other previous convictions for every offender. This is important, not only for ensuring that the board members are able to make informed decisions, but it suggests that the parole boards had adequate and competent administrative support staff to discharge their responsibilities effectively. However it was found that these parole boards used more of their resources communicating with the offenders than with the victims. This is not in line with the standards of service as outlined in the VC.

1.1.6. Monitoring and Evaluation

Informants from all the parole boards revealed that the monitoring and evaluation system in place involved community members monitoring the work of the parole boards. The boards are part of a programme called the crime awareness campaign, where they form a cluster with other key stakeholders including other government departments. Clearly, as is the case with the experiences of many other parole boards from other provinces, there is no effective monitoring and evaluation system that enables the boards' performance to be assessed in terms of achieving DCS objectives, victim satisfaction with services rendered, and progress in meeting the minimum standards outlined in the Charter.

1.2. Services Rendered to Victims

As indicated above, DCS has not made budgetary allocations for transporting victims to attend parole hearings. Yet some of the facilities do make arrangements in this regard. In the more rural areas, some of the parole boards have made efforts to trace the victims and do home visits. However this is usually only possible where victims had provided traceable contact details. Informants have argued that in most instances the victims are either explicitly unwilling to participate in parole hearings or have moved on with their lives and are not willing to re-visit and re-kindle the trauma of the incident. Either way, the parole boards are obliged to respect the decisions and preferences of the victims.

The chairpersons of the boards were nonetheless unanimous in insisting that it was difficult to trace many of the victims of crime. This has meant that in most of the sittings the victims of crime are not present.

The DCS has responded to this widespread problem by signing an MOU with an NGO called the Foundation of Victims of Crime (FOVOC) to assist in tracing the victims of crime for purposes of ensuring participation in parole hearings. However it is not yet clear how successful and effective this arrangement is.

Based on interviews with the chairpersons it was clear that no counselling services are provided on a consistent basis to the victims of crime as required in terms of the VC. The study further revealed that some officials within the DCS connive with the families of the offender.

1.3. Key Challenges/Constraints

The key constraint identified here was the lack of resources, particularly budget allocations for transporting victims of crime to attend parole hearings. However, the issue of tracing victims to ensure their participation appears to be an intractable problem for the Eastern Cape DCS facilities. So is the lack of an effective monitoring system to assess the performance of the DCS facilities in terms of meeting the minimum standards outlined in the VC. The lack of counselling services is a major weakness that was identified, as it fails to meet one of the required standards outlined in the Charter.

7. LIMPOPO PROVINCE

1.1. Institutional Capacity Issues

The CGE selected two correctional services facilities for this study in Limpopo province. These were the Polokwane parole board and the Makhado parole board – a sub-board of the Thohoyandou parole board. In-depth interviews were conducted with the chairpersons of these two facilities and onsite observations carried out. An interview was also conducted with a senior official from an NGO called the Thohoyandou Victim Empowerment Programme.

1.1.1. Knowledge and Understanding of the VC

The parole board were fairly conversant with the issues relating to the VC. At the Thohoyandou parole board the informants were able to articulate the board's mandate in line with specific sections of the Criminal Procedure Act and the Correctional Services Act as guiding their work in ensuring that the victims of crime take part in parole hearings. Also, the Thohoyandou Victims Empowerment Programme, an NGO working with victims of crime in Thohoyandou, explained their role in the VC in terms of how it informs the victim of what they are entitled to expect from service providers. The informant from the NGO understood the VC and victim empowerment as part of a process of turning a victim into a survivor.

However, in an attempt to demonstrate their knowledge and understanding of the Charter, some of the informants resorted to explaining and describing the standard procedures for handling victims of crime seeking assistance from the centre. The Polokwane parole board informant explained the board's mandate by describing the procedure for processing victims needing assistance, from their arrival, including the stage when the offender is sentenced, to the point when the offender is eligible for parole. It was even indicated that when mediation sessions are convened between victims and offenders, it is usual practice for parole boards to invite a social worker and a chaplain to facilitate the victim-offender mediation session. In the case of parole hearings, it was also revealed that the right of the victim to information is met in terms of making available a detailed profile of the offender to members of the parole board to ensure that it made informed decisions. It was made clear, though, that the work of tracing victims of crime to ensure that they participated in parole hearings was handled by the NGO. The informants believed that the NGO is better suited to handling the task of tracing the victims of crime

Based on the interviews conducted with the informants from the two institutions, it is reasonable to conclude that they had sufficient awareness of the issues relating to the VC, victim empowerment and the service standards to be rendered to the victims by the Correctional Services facilities in the province.

1.1.2. Internal Skills Development/Capacity Building

Informants identified the shortage of staff as a key problem for the correctional facilities identified for the study in Limpopo. The Thohoyandou parole board informant argued that the recruitment of personnel with the necessary skills for DCS facilities is not a function of the board. Apparently this is the function of the DCS regional office. However, once the personnel have been recruited, the board is responsible for proper induction and ensuring the retention of skilled and qualified staff. In terms of ensuring that Correctional Services officials undergo ongoing skills training and acquire relevant expertise to implement the Victims Charter and its minimum standards of service, the Thohoyandou parole board insists that such skills training is provided. For the year under review for instance, the chairperson, deputy chairperson and secretary were sent for training sessions, although no information was provided regarding the nature of the training provided. For the Polokwane parole board, only the chairperson was able to attend training sessions offered by officials from DCS's head office in Pretoria. Here again, it was not clear what type of training was provided. However the Polokwane parole board did indicate that there is a severe shortage of personnel with relevant skills training in the areas of mediation, social work and psychology. Informants from both parole boards insisted that they had a high turnover of social workers.

1.1.3. Availability of Relevant Resources

This first issue identified by informants from both parole boards was lack of funding/ budgetary resources. Both boards indicated that no allocations were made for implementing the VC, even though they acknowledged that the Charter was a strategic priority area. This lack of funding affected other operational areas, such as the ability of officials to carry out community outreach activities in local communities. The informant from the Polokwane parole board pointed out that lack of resources has also affected the board's ability to ensure that the victims participated in parole hearings – a central requirement of the Charter.

In terms of available facilities, the Makhado correctional facility, which falls under the Thohoyandou parole board, had only a small room to accommodate participants during parole hearings. Equally, there was inadequate space to serve as waiting rooms for offenders and victims before the hearings started. As a result, there was a great risk of victims and offenders coming into close contact with each other while waiting for parole hearings to begin – a real risk for the safety of the victims which is contrary to the requirements of the VC. However security was adequate for both correctional service facilities, both inside and outside.

For the Polokwane parole board, security was also adequate. However there was insufficient space to provide separate waiting rooms for both the victims and their family members and the offender, thereby increasing the risk of intimidation of the victim. The Polokwane facility did have ramps for the disabled and adequate information, including clearly visible signposts for visitors. Information posters and pamphlets were available at the reception desk and on the walls, providing information on the VC and toll-free numbers.

It could therefore be concluded that both correctional facilities had some of the basic facilities to enable them to carry out some of their operations and tasks. However key limitations and inadequacies were noticeable, particularly in terms of private waiting rooms to ensure security for victims and their families during parole hearings.

1.1.4. Monitoring and Evaluation

The two parole boards did not have proper monitoring and evaluation mechanisms. The Thohoyandou board referred to monthly reports that contain information about the number of victims assisted by the correctional facility. The Polokwane facility also relies on monthly reports to monitor its performance, although the informant pointed out the monthly report provides additional information relating to compliance with the VC's requirements. Both correctional facilities, however, have admitted that this tool is ineffective.

The NGO (i.e. Victim Empowerment Programme) revealed that for monitoring its performance it has contracted an external monitoring and evaluation coordinator to handle this function. The monitoring and evaluation coordinator reviews internal systems and tools for all projects, including the provision of skills training for staff in the development of monitoring tools. Given that the NGO carries out some of the key functions related to the implementation of the VC, including handling responsibilities referred to it by other departments such as the DSD, DOH, SAPS, NPA and Correctional Services, an effective monitoring and evaluation system becomes critically important.

Based on the information obtained on monitoring and evaluation from the two facilities, it is clear that the current tools are not effective, and focus merely on collecting the numbers of the victims that had been assisted by the correctional facilities rather than reviews of performance of functions, achievement of strategic goals, and meeting targets related to minimum standards of services as required by the VC.

1.2. Services Rendered to Victims

As indicated above, limited resources due to limited budgetary allocations have resulted in both parole boards being unable to meet many of their operational requirements. Both boards pointed out that no budget had been allocated for their operations. This lack of necessary budget allocation hampers their capacity to deliver key services to victims of crime as required by the VC.

Despite this, both parole boards pointed out a number of services that are available for victims. For instance, educational campaigns, including community outreach activities, were mentioned as services rendered to promote awareness among victims about their rights. Specific professional and specialist services were mentioned, including counselling by psychologists/psychiatrists and social workers where available. Victims are also helped in preparing themselves to appear before parole hearings. Both parole boards alluded to the fact that the victims are generally reluctant to be part of the board processes as a way of avoiding having to relive the trauma of their experiences at the hands of the perpetrators.

However, on the contrary, the NGO insists that it had assisted many victims of crime since the opening of their trauma centres in 2001. The NGO mentioned assisting 40 rape and 80 domestic-violence survivors every month, claiming that 58 per cent of all rape survivors are children, 38% per cent of those being under the age of 13.

1.3. Key Challenges/Constraints

A number of key constraints were identified as presenting obstacles for the DCS facilities selected in Limpopo province. The first key constraint is the lack of funding and lack of budget allocation for implementing the VC. The informants argued that the lack of adequate financial resources made it impossible to pay greater attention to the standards of service required by the Charter.

The second key constraint is the limited participation of victims of crime in the activities of the parole boards, particularly the hearings. Not only are the correctional facilities unable to afford the costs of transport of many of the victims to participate in their hearings, but it would appear that the victims themselves are largely not keen to participate to avoid re-living the traumas of what the perpetrators did to them.

Thirdly, the shortage or high turnover rate of skilled personnel such as social workers, psychologists, mediators and counsellors, undermines the capacity of these correctional services facilities to render effective services to victims of crime in line with the requirements of the Charter. It would seem that the presence of an NGO such as the Victims Empowerment Programme has provided some relief of the pressure under which the DCS facilities are placed, especially in regard to activities that the parole boards do not have the necessary resources to handle. These include tracing victims of crime, and preparing victims for parole hearings or for court appearances.

Finally, the DCS facilities lack effective systems of internal monitoring and evaluation of their programmes and capacity to meet the standards of service delivery prescribed in the Charter.

2.2.3. Conclusions

This report has presented the findings of a study aimed at assessing the progress and effectiveness of the DCS in terms of its implementation of the Victims Charter. The DCS has put into place a system of parole boards across the country to handle applications for parole by convicted offenders. The system is an integral part of the principle of restorative justice in South Africa, as it seeks to create conditions within which victims of crime are able to have a say in the decisions relating to the paroling of offenders.

The DCS has also created a framework of relevant policies, legislation and programmes to ensure that its parole boards and officials are guided in their delivery of appropriate and quality services to victims of crime. A number of conclusions are therefore drawn in terms of the way the parole boards discharged their responsibilities and duties towards serving the needs and interests of victims of crime.

In considering the implementation of the VC in line with guiding policy documents, the findings of the study lead to the conclusion that the DCS has established the necessary structures and processes to provide guidance to its parole board members and other relevant officials dealing with services to victims of crime. In addition the VC and related guidelines put in place by the Department of Justice provide sufficient guidance in terms of the work of parole boards and the participation of victims of crime in parole processes. However, the implementation of the VC by the parole boards has not always complied with existing policy documents. The findings of the study show clearly that, owing to a number

of factors, including the lack of resources, lack of knowledge of the rights of victims of crime, and even lack of knowledge among the victims themselves, the parole boards have generally struggled to meet some of the key aspects of the rights of the victims of crime. For instance, many of them were unable to keep track of victims of crime and to inform them accordingly, as prescribed in the VC, regarding developments in the case, including applications for parole by the offenders and the holding of parole hearings in terms of which victims are required to participate and give inputs. In many cases the victims of crime were absent from parole hearings, often intentionally, and parole boards lacked the necessary institutional capacity and resources to minimise such absences.

In terms of whether or not the services, conditions and infrastructure at the correctional services facilities meet the minimum standards of services as prescribed in the VC, the evidence showed unequivocally that many parole boards did not have the necessary conditions and infrastructure to meet the minimum standards of service for victims of crime. The findings of the study showed largely that the parole boards struggled to maintain adequate facilities to render a reasonably good quality of services to victims of crime. Many of these facilities had not been allocated specific financial resources to deliver services in line with the VC. It can also be concluded that because of insufficient resources (both financial and physical), the operational activities of many of these parole boards were severely hampered and undermined. It can also be concluded that victims of crime living in the more rural and inaccessible areas were more likely to suffer neglect and violations of their rights compared to those living in the more rural and affluent areas of the country. The parole boards situated in the rural areas were less likely to have the resources and the institutional capacity they needed compared to those in more urban areas, with negative consequences for the rights of victims of crime.

With regard to the gaps and challenges, it is concluded that the parole boards' major challenges and constraints were resource related. It would appear that the DCS has yet to make the necessary financial/budgetary allocations specifically for activities and projects related to implementing the Victims Charter. Many of the correctional facilities were unable to cover the costs of transporting and accommodating the victims of crime to attend parole hearings as required by the VC. This shortage of financial resources has repercussions affecting related areas such as procurement of skilled professionals, the training and skills development of existing officials, and the maintenance of existing facilities and office equipment.

One of the findings of this study was that the administrative and service delivery boundaries of various departments within the crime, justice and security cluster are conflicting and incompatible, and have often become obstacles in the way of integrated services to victims of crime. On the basis of this finding, it is concluded that in spite of official statements of commitment to integrated and coordinated services to victims of crime, the departments concerned have failed to develop appropriate collective operational and administrative strategies to ensure that such boundaries do not hinder a smooth delivery of services to intended beneficiaries on the ground.

Finally, it is concluded here that the DCS has not put in place an effective mechanism for monitoring and evaluating the work of its correctional facilities throughout the country. As a result, the department does not have any systematic way of determining the effectiveness of its own internal systems and practices in meeting delivering quality services to, and meeting the needs of, victims of crime.

2.2.4. Recommendations

Based on the findings of the study on the work of the DCS parole boards, a number of recommendations were developed. These are outlined below.

- It is recommended that the DCS undertakes a thorough review of its internal programmes and processes aimed at implementing the VC to improve strategic planning and the allocation of the necessary resources to such programmes. Currently, there is a lack of information, transparency and consistency across DCS facilities in the different regions and provinces regarding the way the department allocates resources to its facilities for the purpose of implementing VC activities and programmes. This exercise should also review current internal systems and policies for allocating and managing the financial and other vital resources intended to cover the costs related to implementing the VC (e.g. the transport and related costs of ensuring that the victims of crime attend parole hearings).
- The DCS should review its current policy and practices relating to the capturing, storing and periodic/regular updating of the information and contact details of victims of crime. This exercise will be crucial for ensuring that DCS correctional facilities maintain regular contact with victims of crime to improve tracking victims effectively as and when vital information has to be communicated to them or their next of kin. This review should involve other critical stakeholders, such as the SAPS, DSD, NPA and NGOs currently assisting in the tracing of victims of crime.
- It is recommended that the crime, justice and security cluster departments and other institutions of state involved in the implementation of the VC develop a common operational strategy and system to ensure that the different and sometimes incongruous administrative boundary demarcations are managed effectively to avoid fragmented and disintegrated approaches in delivering various VC-related services to victims of crime.
- It is vital that the DCS institutes an effective and reliable, preferably independent, system of regular reviews, monitoring and evaluation of the performance of its correctional facilities. Such a system should have a wide scope, focusing on the effectiveness and relevance of internal and external operations, systems, policies and practices of DCS facilities throughout the country. It should be utilised to augment the current system of monthly reports which seems severely limited and relying mainly on staff members collecting statistics on the numbers of victims of crime assisted by DCS officials.
- Finally, it is recommended that the DCS institutes a system of regular and on-the-job training and skills development of officials tasked with implementing the VC and rendering services to victims of crime in line with the minimum standards of service outlined in the Victims Charter.

SECTION 3:

Overall Conclusion

SECTION C: OVERALL CONCLUSIONS

It is clear that the key challenge facing both the DOH and the DCS is not so much the lack of appropriate policies, legislations, programmes and even official commitment to implementing the VC. The key challenge, and a severe constraint, was in the conditions prevailing at the various correctional facilities, healthcare and TCCs on the ground across the country.

Officials and experts at correctional centres in the regions and in the provinces, as well as healthcare workers and professionals in various hospitals and TCCs, were largely operating under overwhelming shortages of financial and physical resources, while attempting to translate policy, and strategic and legislative objectives into practical outcomes intended to uphold and realise the rights of victims of crime in line with the VC's requirements.. While the study found amazing levels of dedication and commitment among healthcare and correctional service officials in the midst of less than ideal conditions, and without the necessary resources, these conditions on the ground will continue to overwhelm healthcare professionals and prevent the meeting of the minimum standards of service for victims of crime. The willingness of the political and administrative leadership of the two departments will play a crucial role in dealing with these conditions, as this might be the missing ingredient in terms of improving the prospects of turning the goal of restorative justice into reality.

SECTION 4: Apendices

APPENDICES

A. Number of hospitals & TCCs selected per province

Province	Hospitals	TCCs/Crisis Centres
Gauteng Province	3	2
Free State Province	4	4
Northern Cape Province	2	0
KwaZulu-Natal Province	3	4
North West Province	3	2
Eastern Cape Province	5	5
Mpumalanga Province	0	1
Limpopo Province	5	3

B. Number of Parole Boards selected per province

Province	Parole Board
Gauteng Province	3
Free State Province	4
Northern Cape Province	1
KwaZulu-Natal Province	5
North West Province	2
Eastern Cape Province	5
Mpumalanga Province	1
Limpopo Province	2

C. List of other selected informants interviewed for the study

Name of informant	Institution (e.g. NGOs, VEP Forums, etc.)
Masikhwa Tshilidzhini (Legal Officer)	Thohoyandou Victim Empowerment Programme

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