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Psychological support for women survivors of Gender Based Violence (GBV): Examining policy and practice in South Africa's Thuthuzela Care Centres

Lebogang M. RAMALEPE, Liberty T. MAMBONDIANI, Ayanda S. NDLOVU

ABSTRACT

Gender-based violence (GBV) against women is widespread in South Africa, with severe effects on survivors' physical, emotional, and psychological health. Thuthuzela Care Centres (TCCs), as crisis response facilities, play a critical role in delivering comprehensive, survivor-centred care services, including psychosocial and legal support to women GBV victims. Utilising a theoretical policy analysis approach, guided by trauma-informed care principles and the policy-practice gap framework, this paper critically examines the South African policy landscape to assess the extent to which psychological support for women GBV survivors is prioritised and operationalised within TCCs. Findings reveal that while policies acknowledge the need for psychosocial support for survivors, they often lack detailed, enforceable guidelines for consistent and contextually relevant implementation across TCCs. Challenges such as under-resourced facilities, location, high caseloads, a heteronormative approach and limited access to and availability of trained mental health professionals further constrain the service delivery capabilities of TCCs. This paper argues for strengthening policy directives and contextually relevant capacitation of the TCCs to explicitly prioritise psychosocial support as a core component of GBV response services, supported by contextually relevant adequate resources and monitoring frameworks.

KEY TERMS: *gender-based violence, mental health services, psychological support, South Africa, women survivors*

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AUTHOR DETAILS

- *Ramalepe Lebogang Manthibe, PhD, Compres Research Entity, Northwest University, Email: LMRAMALEPE91@gmail.com*
- *Mambondiani Liberty T, PhD, Gender Studies, University of KwaZulu-Natal. Email: liberty.mambo@yahoo.com*
- *Ndlovu Ayanda Sphelele, Department of Liberation Studies, Social Sciences and Humanities, University of Fort Hare, South Africa. Email: ASNdlovu@ufh.ac.za*

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INTRODUCTION

Gender-based violence (GBV) remains a pervasive public health and human rights issue globally, with particularly high prevalence rates reported across the globe and South Africa is no exception (Anwan, Dlamini and Reddy, 2023; Schutte, 2020 cited in Anwan et al., 2023). Enaifoghe et al, (2021) stated that for a country not at war, South Africa has some of the worst statistics regarding GBV. In the context of shifting societal dynamics and the evolving digital age, GBV encompasses a wide range of violence, including technology-facilitated gender-based violence (TFGBV), affectionately known as cyberbullying, sexual and gender-based violence (SGBV), and psychological violence, among others. GBV causes profound impacts on survivors' physical, emotional, and psychological well-being (Diko, 2023; Aubert and Flecha, 2021). Globally, governments have implemented different strategies to tackle this scourge. In South Africa, one of the strategies was the construction of multi-stakeholder facilities known as the Thuthuzela Care Centres (TCCs). These centres, designated as crisis response facilities, are central to the country's efforts to provide comprehensive, survivor-centred care, including medical, psychosocial, and legal support for women who have experienced violence. Some of the policies that guide the TCCs' work include the Mental Health Policy Framework and Strategic Plan (2023–2030) and the National Guidelines for the Management of Survivors of Sexual Violence (2013). Using these two documents, this study seeks to critically assess the (in)consistencies (alignment) between the aims of these policies and their practical implementation towards addressing the psychosocial needs of the GBV victims within the TCCs. This assessment is critical to ascertain the contextual relevance and implementation of these policies in line with the National Strategic Plan on Gender-Based Violence and Femicide (2020–2030).

BACKGROUND, RESEARCH PROBLEM AND JUSTIFICATION

Alarmingly, at least one in three South African women will experience rape in their lifetime, suggesting an unacknowledged gender civil war within the nation (Moffett, 2006). In a self-reporting survey conducted by Gender Links (2015), between 2012 and 2013, approximately 45% of women in the Western Cape and 36% in KwaZulu-Natal had experienced GBV, with a staggering 78% of male perpetrators in Gauteng admitting to violence against women. GBV is a continuum that affects civil, political, socioeconomic and cultural liberties, and is not merely interpersonal; it is a profound structural issue intertwined with broader societal factors, such as poverty, unemployment, and systemic inequalities (Russo & Pirlott, 2006; Boonzaier, 2005). The 'afterlife' of apartheid construes the idea that laws and policies aimed at preventing and addressing GBV, including the National Crime Prevention Strategy of 1996, which elevated violence against women and children as a national priority, were effective. At the centre of GBV are psychological aspects that do not find proper enunciation in the social policy framework.

The complex fight against GBV is more than just about the physically visible scars, but also the psychologically and emotionally invisible scars. There will be no way of claiming to win the fight against GBV if the focus is only on the physical scars, leaving the emotional scars unattended. Hence, the South African government's collaborative and inclusive approach in the form of TCCs encompassing several critical arms of the state directly involved in the fight against GBV and its consequences. The TCCs were established as models in the early 2000s; however, the challenge that continues to preoccupy many survivors of GBV is more than physical, but emotional, and psychological well-being (Bougard and Booyens, 2015). The prevalence of GBV in the late 1999s and early 2000s foregrounded what was called the Sexual Offences and Community Affairs (SOCA) unit under the National Prosecuting Authority (NPA) in October 1999 (National Prosecuting Authority, 1999). In the early 2000s, the SOCA began developing the Thuthuzela model, designed to create survivor-centred, multi-stakeholder approach that brings together medical, psychosocial and legal support for GBV victims within one location (Rape Crisis, 2025). As argued by Ndlovu, Ramalepe and Brenya (2025), GBV results in and has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation of the victims.

From the foregoing, the enduring question is how these TCCs implement and operationalise the psychological support which is fundamental in the recovery of GBV survivors. One of the greatest strengths of the TCCs is the multisectoral approach, bringing all services and stakeholders under one roof (i.e, National Prosecuting Authority (NPA), Department of Health, Department of Social Development (DSD), South African Police Service (SAPS) and various NGOs (FPD, 2017) which signifies important partnership for the goal of addressing GBV in line with Sustainable Development Goals. Discussing psychological support for women who survived GBV is essential to emphasise the pressing mental health requirements frequently neglected during policy execution. South Africa's TCCs provide a distinct perspective for assessing the implementation of trauma-informed care in action. Analysing these centres aids in recognising strengths and weaknesses in existing interventions, guiding more comprehensive and survivor-focused policy changes.

THEORETICAL FRAMEWORK

Trauma-Informed Care (TIC) is a framework developed by Elliott, Bjelajac, Fallot, Markoff and Reed (2005) to shift service delivery systems toward recognising and responding to the widespread impact of trauma. Rooted in principles of safety, trust, empowerment, collaboration, and cultural sensitivity, TIC aims to prevent re-traumatisation by embedding an understanding of trauma into all aspects of care (DeCandia & Guarino, 2015; Kimberg & Wheeler, 2019). Rather than asking "What is wrong with you?", TIC reframes the approach to "What happened to you?", emphasising individuals' lived experiences and resilience. This theory was selected for its relevance in contexts where survivors interact with institutions that may unintentionally perpetuate harm, such as healthcare and social services (Clements et al., 2020). In this paper, TIC was used as a lens to assess whether service environments, both in theory (as reflected in policy) and in practice, are designed to support healing, foster psychological safety, and avoid re-traumatisation for trauma-affected individuals.

RESEARCH AIMS AND OBJECTIVES

The study aims to critically examine how psychological support for women survivors of GBV is prioritised, conceptualised, and operationalised within South Africa's TCCs, assessing the alignment between policy commitments and practical implementation to identify gaps and opportunities for strengthening trauma-informed care. The study aims to do this by critically analysing the national policy documents specifically relevant to GBV response and psychosocial care within the TCCs. The discussion will also include some studies done on the provision of psychological support within the TCCs, capturing both survivor and care provider experiences within these vital institutions. The consistency (alignment) between the policies and their practical implementation towards addressing the psychosocial needs of the GBV victims within the TCCs will be explored. This assessment is critical to ascertain the contextual relevance and implementation of these policies.
The research thus aims to achieve the following research objectives:

4.1 To analyse key national policy documents relevant to GBV response and psychosocial care within TCCs, identifying explicit and implicit commitments to psychological support for survivors.

4.2 To synthesise empirical evidence from research studies on the provision of psychological support within TCCs, capturing survivor and provider experiences and operational realities.

4.3 To assess the alignment between policy commitments and practical implementation of psychological support within TCCs, identifying key policy-practice gaps.

4.4 To highlight structural and contextual barriers affecting the delivery of trauma-informed psychological care for GBV survivors within TCCs in South Africa.

METHODOLOGY

This study utilised a theoretical policy analysis approach to examine how psychological support for women survivors of GBV is prioritised and operationalised within South Africa's TCCs. To triangulate findings and enhance contextual understanding, the analysis included both national policy documents and empirical data in the form of peer-reviewed journal articles, theses and reports.

Policy document selection.

A purposive sampling strategy was used to select three key national policy documents centrally critical to GBV response and mental health service provision in South Africa, namely:
The National Strategic Plan on Gender-Based Violence and Femicide (2020–2030)
The Mental Health Policy Framework and Strategic Plan (2023–2030)**,** and
The National Guidelines for the Management of Survivors of Sexual Violence (2013)**.**
These documents were selected based on their relevance to TCCs' operations, explicit focus on psychosocial support for GBV survivors, and ongoing applicability in the South African context**.** The documents were identified through targeted searches of government websites and reference chaining from foundational GBV research.

Research documents selection.

To complement the policy analysis, a structured literature search was conducted across Google Scholar, PubMed, Scopus, Web of Science, and African Journals Online to identify research documents (secondary and primary) research studies which focus on psychological support of survivors of GBV in TCCs, research documents published between 2015 and 2025 focusing on psychological or mental health support within TCCs in South Africa. Search terms included combinations of "Thuthuzela Care Centres," "psychological support," "mental health," "counselling," "gender-based violence," and "South Africa."

The inclusion criteria for the research documents selection literature review required studies to be empirical or structured reviews explicitly focusing on psychological or mental health support within TCCs in South Africa, published and with full-text availability. Studies were excluded if they did not address psychological care within TCCs or focused solely on legal or forensic services.

Table 1: Summary of research documents on Psychological Support for Gender-Based Violence Survivors within South African Thuthuzela Care Centres (2015–2025)

Author (Year)	Type of Document	Aim	Methods	Key Findings
Randa & McGarry (2023)	Journal Article	To explore and describe the experiences of healthcare staff working in forensic care centres (FCCs) in Tshwane, South Africa.	Qualitative study using focus group interviews with 12 healthcare staff from two FCCs; data analyzed using the Analytic Hierarchy Model.	Identified three themes: helping survivors overcome self-blame, barriers to care, including cultural practices and poor infrastructure, and the emotional toll on staff. Highlighted the need for training, support, and systemic change.
Randa, McGarry, Griffiths & Hinsliff-Smith (2023)	Systematic Review	To explore the experiences of women seeking care from healthcare facilities in South Africa after sexual violence.	Systematic review of 5 qualitative studies using PRISMA guidelines; thematic synthesis of survivors' experiences.	Two key themes: experiences at the time of reporting (e.g., stigma, inadequate support), experiences during follow-up care (e.g., lack of mental health services). Emphasised the need for integrated, survivor-centred care and policy reform.
Vieweger (2019)	Master's Thesis (University of Cape Town)	To investigate women rape survivors' post-rape experiences and their experiences with counselling provided by Rape Crisis Cape Town Trust.	Qualitative study using unstructured interviews with 15 survivors; thematic narrative analysis within a feminist framework.	Identified nine themes, including stigma, psychological effects, help-seeking as a last resort, and the value of counselling. Emphasised the importance of safe, empowering counselling spaces and survivor-led healing. Suggested improvements like group therapy and broader outreach.
Skosana, B.S. (2016)	Master's Research Report (University of the Witwatersrand)	To explore provider perceptions of the quality of post-rape care and PEP services in Ekurhuleni District, Gauteng.	Qualitative case study; 17 interviews with doctors, nurses, auxiliary nurses, and lay counsellors across three Clinical Forensic Medical Services (CFMS) sites; thematic content analysis.	Providers were confident in managing survivors but lacked clarity on policies and guidelines. PEP provision varied. Challenges included lack of psychosocial support, poor infrastructure, staff shortages, and emotional toll on providers. Highlighted the need for standardised procedures and interdepartmental support.
Bougard, N.B. (2022)	Doctoral Thesis (University of Pretoria)	To investigate the quality of post-rape services rendered to adult female rape survivors within the criminal justice system in Gauteng, South	Qualitative study using semi-structured interviews with 17 adult female rape survivors and 28 service providers; thematic content analysis.	Found inconsistencies in service quality across medico-legal sites. While some services were satisfactory, others lacked coordination, sensitivity, and integration. Proposed a prototype model for post-rape service delivery based on participants' experiences and

		Africa.		recommendations.
Sibisi, Z. (2024)	Master's Research Report (University of the Witwatersrand)	To investigate the effectiveness of socio-economic interventions in empowering women's resilience against gender-based violence (GBV) in eMalahleni, South Africa.	Qualitative study using semi-structured interviews with GBV survivors; thematic analysis guided by Gender Transformative and Capability Approaches.	Socio-economic interventions (e.g., education, microfinance, community support) positively impact women's resilience. Survivors emphasised the need for long-term support and holistic services. Recommendations include community involvement, government funding, and a proposed framework for GBV intervention.
Childline Gauteng (2022)	NGO Research Report	To assess survivors' perceptions of the Criminal Justice System (CJS) in South Africa, focusing on children and adults affected by sexual and gender-based violence (SGBV).	Mixed methods: quantitative survey of 207 survivors/caregivers; qualitative interviews with 28 stakeholders, including SAPS, survivors, and experts; thematic and statistical analysis.	Survivors reported mixed experiences with the CJS. SAPS and medical services were often helpful, but courts and prosecutors were seen as weak links. Key challenges included poor communication, delays, lack of psychosocial support, and systemic barriers. Recommendations include infrastructure upgrades, trained personnel, better inter-agency coordination, and expanded psychosocial services.
Van der Heijden, Harries & Abrahams (2020)	Peer-reviewed Journal Article	To explore barriers to accessing gender-based violence (GBV) services for women with physical and sensory disabilities in Cape Town, South Africa.	Qualitative study using interviews and focus groups with 30 women with disabilities and 19 service providers; thematic analysis.	Women with disabilities face unique barriers to GBV services, including physical inaccessibility, communication challenges, stigma, a lack of disability-sensitive training among providers, and limited funding. Recommendations include disability-inclusive training, improved infrastructure, better coordination between GBV and disability sectors, and targeted outreach.
Sepeng, Makhado & Makhado (2023)	Peer-reviewed Journal Article	To develop a conceptual framework for managing rape survivors diagnosed with PTSD in the Northwest Province of South Africa.	Explanatory sequential mixed-methods design; quantitative survey with 98 rape survivors using PDS-5 and CMCM tools; qualitative focus groups with 21 mental health practitioners; framework developed using Practice-Oriented Theory and Donabedian's Structure Process Outcome model.	Developed a conceptual framework for PTSD management in rape survivors; emphasised task-shifting, collaboration, and decentralisation of mental health services; recommended use of CBT, EMDR, SSRIs, and BWRT; highlighted the need for training and supervision of non-specialist providers.

Masutha et al. (2025)	Peer-reviewed Journal Article	To explore how the Ubuntu philosophy can be applied to mitigate GBV in South Africa and recommend culturally relevant, community-centred measures.	Qualitative study using two focus group discussions with 18 stakeholders (nurses, social workers, psychologists, SAPS, NPA, NGOs, and academics); thematic analysis using Tesch's method.	Identified cultural norms, stigma, and workplace dynamics as drivers of GBV. Emphasised Ubuntu principles of collectivism, collaboration, consensus-building, and training ambassadors in schools as key strategies. Advocated for interprofessional collaboration and mental health support services.

ANALYSIS

The policy and research documents and reports were analysed using the TIC framework. This approach was guided by trauma-informed care principles (e.g., safety, trustworthiness, empowerment) (Fallot & Harris, 2009) and dimensions of the policy-practice gap, including the clarity of directives, enforceability, and barriers to implementation (Gilson, 2012; Walt, Shiffman, Schneider, Murray, Brugha and Gilson, 2008). Safety refers to creating an environment both in policy and practice that minimises the risk of re-traumatisation and ensures survivors feel physically and emotionally secure when accessing services (Fallot & Harris, 2009). Trustworthiness involves establishing transparent, consistent, and reliable practices that foster confidence in services providers and policy frameworks, particularly in contexts where survivors may have previously encountered stigma or institutional neglect (Fallot & Harris, 2009). Empowerment focuses on recognising and validating survivors' voices, choices, and strengths, positioning them as active agents in their recovery rather than passive recipients of care (Fallot & Harris, 2009). The analytical process began with familiarisation through thorough reading and re-reading of the documents to identify sections relevant to psychological support, trauma care, and GBV response within TCCs.

Following this, indexing and coding were undertaken to extract data related to policy commitments, implementation strategies, resource allocation, and documented challenges in practice (Srivastava & Thomson, 2009). Data were then charted against trauma-informed care principles and policy-practice dimensions to facilitate comparison across documents and articles. Finally, interpretation involved synthesising these findings to assess the extent to which policy intentions align with operational realities in delivering psychological support within TCCs (Gilson, 2012; Walt et al., 2008). This combined approach ensured a nuanced and triangulated analysis, capturing both policy-level commitments and the practice-level experiences of service providers and survivors, providing a comprehensive understanding of the systemic barriers and opportunities for strengthening psychological support services for GBV survivors within TCCs in South Africa.

Table 2: Map Policy-Practice Gaps in Psychological Support within South African Thuthuzela Care Centres

Policy Document	**Policy Intent**	**Practice Findings from Articles**	**Identified Gaps**
National Strategic Plan on GBVF (2020–2030)	Promote coordinated, survivor-centered GBV response; strengthen community involvement and prevention.	Ubuntu principles are not mainstreamed in GBVF implementation; lack of coordinated stakeholder collaboration; community-based mental health support is underutilized.	Limited implementation of community-driven, culturally relevant GBV mitigation strategies; insufficient interprofessional collaboration.
Mental Health Policy Framework and Strategic Plan (2023–2030)	Integrate mental health into primary care; improve access to psychosocial support	Lack of trained mental health professionals in TCCs; limited use of evidence-based therapies like CBT and EMDR; poor integration of PTSD screening and follow-up care.	Mental health services not integrated into primary care at TCCs; lack of training and supervision for non-specialist providers; inadequate survivor follow-up and referral systems.
National Guidelines for the Management of Survivors of Sexual Violence (2013)	Ensure comprehensive care, including medical, psychological, and legal support.	Stakeholders report fragmented services; survivors are unaware of available support; and there is a lack of follow-up and psychosocial care.	Poor implementation of integrated care; inadequate awareness and access to services; lack of survivor follow-up.

FINDINGS

This section presents the findings from the framework analysis of three national policy documents and ten research documents examining the prioritisation and operationalisation of psychological support for women survivors of gender-based violence (GBV) within South Africa's Thuthuzela Care Centres (TCCs). Guided by trauma-informed care principles (Fallot & Harris, 2009) and the policy-practice gap framework (Gilson, 2012; Walt et al., 2008), the findings highlight the alignment (and misalignment) between policy commitments and operational realities within the TCCs, as well as systemic and contextual barriers impacting the delivery of psychological care for survivors.

Fragmented and inconsistent GBV response

GBV responses remain fragmented and inconsistently implemented. Survivors and service providers report disparities in care quality across medico-legal sites, with some facilities offering holistic support, while others lack sensitivity, integration, and coordinated follow-up (Bougard, 2022; Skosana, 2016). Many survivors are unaware of available services, and poor interdepartmental collaboration further undermines access to comprehensive care (National Guidelines, 2013; Childline Gauteng, 2022). These challenges highlight a persistent gap between policy intent and frontline practice.

Mental health services are inadequately integrated

Although the Mental Health Policy Framework and Strategic Plan (2023 – 2030) aims to integrate mental health into primary care, implementation with GBV response services remains limited. Mental health support is often not embedded in key service points such as TCCs, and there is a lack of trained providers to deliver trauma-focused interventions like CBT and Eye Movement Desensitisation and Reprocessing Therapy (EMDR) (Sepeng et al. 2023). Screening and follow-up care for conditions such as PTSD are poorly implemented, leaving significant gaps in survivor recovery pathways (Randa & McGarry, 2023). These challenges reflect a broader failure to integrate mental health services into the continuum of GBV care.

Lack of training and interprofessional collaboration

Despite national guidelines promoting comprehensive, survivor-centred care, frontline service providers frequently lack adequate training and clarity on relevant protocols (Skosana, 2016). The absence of standardised procedures contributes to inconsistent service delivery and undermines the quality of care across sectors. Limited interprofessional collaboration between healthcare providers, social workers, law enforcement, and mental health professionals further weakens the GBV collaborative response system (Bougard, 2022; Masutha et al., 2025). Studies emphasise the need for coordinated, cross-sector training and supervision to support effective implementation of trauma-informed and culturally sensitive practices (Sepeng, Makhado & Makhado, 2023). Without these collaborative structures, service delivery remains fragmented and unsustainable.

Culturally relevant and community-based strategies are lacking

While national policies such as the *National Strategic Plan on GBVF (2020–2030)* emphasise community engagement, culturally grounded and locally driven strategies remain largely absent from implementation. Ubuntu principles, which emphasise communitarianism, collectivism, healing, and relational accountability, are not adequately integrated into GBV interventions (Masutha et al., 2025). Survivors often engage with services only as a last resort, highlighting a disconnect between formal systems and the lived realities of those affected (Vieweger, 2019). Community-based mental health support and survivor-led healing spaces are underutilised, limiting access to safe, empowering environments that resonate with local values and experiences (Sibisi, 2024). This gap reflects a broader failure to embed culturally relevant approaches into the design and delivery of GBV services.

Survivors' needs extend beyond immediate medical care

GBV survivors require more than emergency medical intervention—they need long-term, holistic support that addresses their psychosocial and economic well-being. However, current systems often fail to provide consistent follow-up care or ongoing psychosocial services (National Guidelines, 2013; Randa et al., 2023). Survivors highlight the value of counselling, peer support, and trauma-informed mental health care, yet these services remain limited and inconsistently delivered (Vieweger, 2019; Bougard, 2022). Socio-economic interventions, such as education, financial empowerment, and community support structures, have been shown to strengthen survivor resilience but are not widely integrated into GBV response frameworks (Sibisi, 2024). This lack of sustained, multidimensional support undermines survivor recovery and reinforces cycles of vulnerability.

RECOMMENDATIONS ACROSS EVIDENCE BASE

Across the reviewed policies and studies, there is a broad consensus on the need to strengthen coordination, integration, and sustainability in GBV response systems. First, service delivery must shift toward survivor-centred, integrated care models that provide medical, legal, and psychosocial support in a unified, trauma-informed manner (National Guidelines, 2013; Bougard, 2022). Mental health services, including PTSD screening and access to therapies like CBT and EMDR, should be embedded within primary care settings and forensic units, supported by task-shifting strategies and supervision for non-specialist providers (Sepeng, Makhado & Makhado, 2023; Randa & McGarry, 2023). Cross-sector training and interprofessional collaboration are essential to ensure that all stakeholders, from healthcare workers to law enforcement, deliver consistent, rights-based care (Skosana, 2016; Masutha et al., 2025). Additionally, the integration of culturally relevant, community-based approaches, such as those rooted in Ubuntu, can enhance prevention and healing by aligning services with local values and survivor realities (Masutha et al., 2025; Sibisi, 2024; Ndlovu et al., 2025). Finally, long-term investments in socioeconomic support, survivor follow-up systems, and disability-inclusive infrastructure are needed to ensure that services are not only accessible but also responsive to the diverse needs of all survivors (Childline Gauteng, 2022; Van der Heijden, Harries & Abrahams, 2020). These recommendations underscore the need for a systemic, well-resourced, and contextually grounded GBV response.

DISCUSSION

Citing the Global Burden of Diseases study, the South African National Mental Health Policy Framework and Strategic Plan, 2023 – 2030 reported that nearly 15% of life lost to mental disorders, making mental illness one of the most significant causes of disability worldwide. In South Africa, mental health disorders are the leading cause of Disability Adjusted Life Years, accounting for 13.8% of the disease burden (National Mental Health Policy Framework and Strategic Plan, 2023 – 2030). A recent systematic review of the prevalence of mental health problems in adolescents living in sub–Saharan Africa reported that the median point prevalence was 26.9% for depression, 29.8% for anxiety, 40.8% for emotional and behavioural problems and 21.5% for post-traumatic stress disorder (Jörns-Presentati et al., 2021). A study by Sepeng and Makhado (2019) reported that adult rape survivors who reported in the TCCs were not given follow-up care to screen and manage PTSD post-rape experiences, thus undermining the TIC principle of empowerment.

An earlier report by FPD (2017) revealed that long-term psychosocial support is a big concern since there are long waiting times for victims to access follow-up care. In some cases, victims wait up to two months to see a DSD-appointed psychologist or social worker (FPD, 2017). This happens against the backdrop of the National Mental Health Policy Framework and Strategic Plan, which boldly states that “it costs South Africa more to not treat mental illness than to treat it” (p. 17). This also raises concerns about the availability of social workers in the TCCs. In 2022, DSD revealed that South Africa has a shortage of 52,000 social workers (Opperman, 2022), yet universities churn out social work graduates every year. According to Prof Hanelie Malan from North-West University, “the emotional toll on social workers cannot be overstated” (John, 2025). They often find themselves in emotionally charged environments where they must support individuals facing severe adversities (John, 2025). This is all happening against the National Mental Health Policy Framework and Strategic Plan, which call for mental health to be considered in all legislative policy, planning, budgeting and monitoring and evaluation activities of the public sector.

The critical question is, does any department have the social workers’ and psychologists’ mental health and well-being in mind when planning and budgeting? Accordingly, the National Mental Health Policy Framework and Strategic Plan posits that the social costs of mental illness can include decreased quality of life. Therefore, both the social workers, psychologists and GBV victims will end up having mental illness, the former from high loads of work and the latter from GBV effects and unmet psychosocial needs. This undermines the TIC’s principle of trustworthiness and confidence in the system that is built to psychosocially help them yet seems to be failing them.

Under these circumstances, what quality of service will social workers provide if their work affects their mental health too? Randa et al. (2023) stated that mental healthcare management for rape survivors diagnosed with PTSD and depression requires about 12 sessions with the therapist when using treatment modalities such as cognitive behavioural therapy (CBT), exposure therapy (ET) and cognitive processing therapy (CPT). This kind of assistance is given in specialised care services such as hospitals, and it is impossible to manage rape survivors diagnosed with these disorders in TCCs. In addition to the TCCs' resource constraints, the GBV victims also face resource constraints, such as finances to transport themselves back to facilities for follow-up care (FPB, 2017).

According to Randa et al. (2023), to access the full range of support services, including pregnancy advice, sexually transmitted infections (STIs) information and PEP, survivors are required to report to a TCC within 72 hours of the event. It is worth observing that this time frame directly relates to the issue of PEP, which is only effective within 72 hrs of a possible exposure to HIV (Rohrs, 2011). Therefore, it is imperative that survivors either report directly to the police in order to gain the documentation for PEP to be issued or report first to a TCC or hospital for transfer to law enforcement. Steinbrenner et al. (2017) describe the totality of seeking help from three areas, namely the criminal justice system, healthcare facilities and/or social service agencies. They discussed how the six women survivors in their study described their experiences in each of these contexts, concluding that these can be categorised as 'fraught justice seeking', 'pragmatic help-seeking' and 'desperate help-seeking'. Consequently, this undermines the theory of care principle of safety and trustworthiness.

The present system, even with the establishment of TCCs, which have specialist trained staff, is described as wholly inadequate for survivors and can often 'impede justice and healing rather than facilitate resolutions and recovery' (Steinbrenner et al. 2017, p. 436). Several studies reported poor integration of mental healthcare services for rape survivors seeking treatment in TCCs in South Africa (Abrahams & Gevers, 2017; Petersen et al., 2012). A study conducted by the Foundation for Professional Development (FPD, 2017) found that there is a lack of public awareness of the TCCs, and within the TCCs, there is a lack of adequate psychosocial support for victims of GBV. The National Mental Health Policy Framework and Strategic Plan states that there is a considerable under-investment in mental health in South Africa, while the NSP (2020), through its budget reprioritisation, hopes to strengthen the existing architecture and promote accountability. However, we have not seen notable additions to the TCCs, social workers and psychologists. The addition of the TCCs will greatly assist by bringing such critical services to people and lessening the distances victims have to travel. In some places, the nearest TCC is over 100km away. This needs to be urgently addressed as it is not sustainable in the long term. This will respond to the National Mental Health Policy Framework and Strategic Plan, and the Mental Health Care Act's call on the right to access high-quality care close to home. We hope that R1.6 billion and the NSP's objectives, this will be addressed urgently. This should be done in line with the TIC principle of safety so that it minimises the risk of re-traumatisation for GBV survivors.

The survivors were grateful for the support received from TCC staff and felt that this provided the safety and comfort required at this time. However, any good work performed by staff in TCCs can quickly be undermined if the follow-up and dealings with police or responses from family and the wider community are unresponsive, negative or slow to act (Sebaeng et al. 2016). The FPD (2017) report reviewed that, regardless of the TCCs' best efforts, clients still experience secondary victimisation from other stakeholders. The report revealed that much of the secondary victimisation comes from the police, and there is a general belief that the police have become desensitised towards clients and their situations (FPD, 2017). Moreover, the report also revealed that male victims experience a lot of secondary victimisations from the SAPS (FPD, 2017). From the TIC perspective, there is indeed an urgent need for an intersectional collaboration between different sectors of the government, from national to local to ensure safety, trust in the system and empowerment. It is of no use having aesthetically pleasing to the ear bills, and yet we continue to face the same issues these bills are trying to address.

In line with the Sustainable Development Goals (SDGs), the study argues that this is where SDG 17: Partnership for the Goals comes into critical play. How can this be a reality when there is a shortage of social workers from the DSD side? How can this be a reality when some TCCs are located in high-crime areas, and this also compromises some social workers' safety? The work by Sebaeng et al. (2016) focused on one area in the North-West Province of South Africa, and one TCC was based in an acute setting. They categorised women's accounts of trauma into three areas, namely physical, emotional, psychological and social trauma. This should be the responsibility of the police to create a safe and enabling environment for the already few social workers who are there to do their work. A recent report by Hirsch in the Western Cape province revealed that there is an "alarming increase in attacks on social workers." This study also points out that creating a safe environment is not the police's responsibility alone, but also that of the community members.

Therefore, community members must be involved in community safety matters. This will help in responding to the National Mental Health Policy Framework and Strategic Plan call for a recovery model that should underpin TIC informed community-based services and care. How can this be possible or feasible if the communities are not safe in the first place? The policies are good; however, are they supported by strong and just institutions? SDG 16 speaks of Peace, Justice and Strong Institutions. We need strong, accountable and incorruptible institutions to fight this scourge. Government institutions, if they are strong enough, must be able to hold each other accountable for their shortcomings, just like they should also equally complement each other on their shortcomings. The report by FPD (2017) revealed that most TCCs do not have the full staffing complement as prescribed by the TCC Blueprint, and during the time of the research, none of the TCCs involved had a case manager appointed. How can we create sustainable cities and communities (SDG: 11) under these circumstances?

Furthermore, the NPA has been reported as not very involved in the management of some TCCs, and there is a lack of support from the NPA national office (FPD, 2017). The *South Africa we want*, as stated by President Cyril Ramaphosa (NSP, 2020, p. 4), is only possible if our institutions are strong enough collaboratively to build a psychosocially fit society. The NSP (2020) stated that an amount of R1.6 billion has been allocated and is to be implemented within six months to urgently respond to victims and survivors of GBV, strengthen the existing architecture, and promote accountability. However, we still hear of the justice institutions failing the GBV victims. Lastly, the TCCs together with the policies reviewed have a heteronormative approach in that there is a tendency to think that all GBV victims have been violated by males. Due to the gender essentialist thinking embedded in many African communities, this hinders many women who have sex with women (WSW) from seeking assistance in TCCs due to the heteronormative thinking of many service providers in these settings. Therefore, marking of the TCCs should also include information that you do not only need to be abused by a male, but that everyone who is a GBV victim no matter the gender and sexual identity can use the TCCs.

CONCLUSION

Overall, the TCCs are a great model as they are extremely helpful in many ways. Their strength lies in being a one-stop shop for immediate and urgent critical needs that a GBV victim needs. They are more like a service delivery mall for GBV victims; everything is under one roof. With a careful and contextually aligned collaborative implementation of the policies, the victims of GBV will surely get the psychosocial assistance they so critically need. There is an urgent need to address the shortage of critical role players, such as social workers and psychologists and the de-learning and re-learning of the police on how to handle GBV cases to avoid unintended secondary victimisation. Finally, there is also a critical need to train the TCCs staff to reduce heteronormative care.

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