GBV AoR HELPDESK

Gender Based Violence in Emergencies

Research Query: One Stop Centers – Models, Standard Operating Procedures (SoPs) And Guidance

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Contents

1. Introduction

A common strategy for addressing sexual and gender based violence is through the establishment of one-stop centers (OSCs), which provide integrated, multi-disciplinary services in a single location, or they can be organized as a "system" of either formal or informal networks.[1] The basic services of the OSC model in low resource settings tend to comprise health care (including psychosocial support), police and justice sector responses, and ongoing social support. These are often provided within the context of a health facility due to the need to attend to and mitigate any harmful health consequences of GBV as a priority for survivors. Whatever the exact model at the core of the OSC approach is a system of integrated medical, legal and

[1] A review by Hattery et al (2020) found no example of this systems approach in lower income countries possibly because of the costs involved. However, they did identify examples of a partial approach.

counseling and case management services.[2]

In their guidance for OSCs IRCW (2020: p12) outline the following advantages and disadvantages of an OSC model:

- Advantages: More efficient and coordinated services; Full range of services (sometimes including police, prosecutors, social workers, counsellors, psychological support) for survivors; Reduces number of times survivors must repeat their story and amount of time they spend in seeking services.
- Disadvantages: More space and resources required; Client load may be small (in rural areas, for example), raising cost concerns; May draw staff and resources out of other services; May not be fully integrated into general health services; If administered by the judicial system, may focus too much on prosecution and not on women's health and wellbeing; Resource-intensive.

Further a medicalized approach; does not address forms of violence that do not require medical attention; often place insufficient emphasis on counselling, peer support, creating space for solidarity and support among women and girls, gender-transformational approaches.

While this query focuses on OSCs, it is important to mention Women and Girls Safe Spaces (WGSS) as a particularly relevant component of GBV prevention and response built on feminist, survivor-centered and woman-centered principles of empowerment, solidarity, accountability, inclusion, and collaboration. WGSS overlap with OSCs and have been used for decades by GBV actors in humanitarian programming as an entry point for women and adolescent girls to report protection concerns and voice their needs. At the most basic level, WGSS are physical spaces where women and adolescent girls can be free from harm and harassment. They are also places where women and adolescent girls can gain knowledge and skills; access GBV response services or other available services; and foster opportunities for mutual support and collective action in their community. WGSS are defined as '*a structured place where women's and adolescent girls' physical and emotional safety is respected and where women and adolescent girls are supported through processes of empowerment to seek, share, and obtain information, access services, express themselves, enhance psychosocial well-being, and more fully realize their rights'* (IMC and IRC, 2019; p26).

International evidence shows that integration of GBV into health systems is often slow and incremental and requires all elements of the health system to respond to GBV. There is no one model that works for all health systems; rather, the global consensus is that countries need to develop approaches that fit with their health system, and work towards a comprehensive response to GBV that includes multisectoral and multi-level coordination across government and social spheres. (García-Moreno et al, 2014).

This query briefly examines the main OSC models before providing information about how they have been implemented in practice in different contexts with lessons learned. Example standard operating procedures (SoPs) and guidance are also provided in the final section.

Research strategy: Resources were identified through online desk-based research related to guidance on one stop centers. The search strategy used keywords, phrases and acronyms associated with women and girls, and variations of search terms on violence (e.g. GBV and VAWG and specific forms of violence such as intimate partner violence (IPV)), and search terms related to services (e.g. One Stop Centers, Family Protection Centers and One Stop Shops) in lower income countries and humanitarian settings. Examples from middle income and higher income countries where lessons learned appear relevant and useful are included.

The author reached out to contacts at, or searched the websites of, relevant organizations including Spotlight, UN agencies and the International Rescue Committee and the websites of specific OSC examples were also

[2] End Violence Now website - https://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html

searched for information. The author also contacted the AoR Community of Practice and independent consultant, Fiona Hale, for inputs. A researcher for the GBV AoR Helpdesk provided a short list of key resources.

Limitations: The resources in this annotated bibliography are limited to English documents, and mainly include publicly available online materials. INGOs and other organizations and GBV actors may have produced more resources, which are not easily available online or on request.

2. A brief history of OSCs

Sexual assault response teams and sexual assault referral teams were first developed in the US and UK in the 1970s with the objective of making facilitating reporting and medical examinations for survivors, to coordinate investigation and support services and prevent survivor re-traumatization when seeking care.

The vision of a Family Justice Center model was first proposed in 1989 in San Diego, California. It was believed that women who had experienced violence would have an easier time receiving needed services if they only had to go to one place to get all the necessary help as the current system was too hard for survivors to navigate. It was not until 2002 that the Family Justice Center opened in San Diego, a center where survivors of domestic violence could now come to one location to talk to an advocate, get a restraining order, plan for their safety, talk to a police officer, meet with a prosecutor, receive medical assistance, counsel with a chaplain, get help with transportation, and obtain nutrition and pregnancy services counseling.

In 2003, President George W. Bush announced the creation of the President's Family Justice Center based on the San Diego Family Justice Center model. The $20 million initiative began a movement toward more co-located, multi-disciplinary service centers and specifically set out to create fifteen additional Family Justice Centers around the United States. In 2006 the National Family Justice Center Alliance was launched as a program of the San Diego Family Justice Center Foundation and in response to the increasing demand for technical assistance from existing and developing Centers across the world.[3]

Elsewhere, the original OSC was developed in a tertiary hospital in Thailand and aimed to provide acute services to survivors of violence. OSCs were established in Malaysia in 1994, and the model was replicated throughout South East Asia and Western Pacific regions. It has now been widely implemented with donor support in several African countries, and similar models are emerging in Latin America. The majority of OSCs are hospital-based, typically within tertiary care facilities, while others are standalone centers that provide basic health services on-site and referrals for specialized and emergency services. Some OSCs are more strongly linked to the judicial system as in the case of the OSCs in Mongolia, Zambia, Delhi, Namibia and the Women's Justice Centers in Latin America. They may be managed by the government or nongovernmental organizations (NGOs) or a combination. (Olsen et al, 2020).

3. Different models

The main types of OSC models identified are as follows:

- Hospital based, tertiary care OSCs: in this model, the health facility-based OSC is owned by a hospital, implemented by the health facility itself with/without additional support from other external actors, and working directly with funders to establish and manage OSC functions that are integrated into the health facility's routine activities.

[3] The Family Justice Centre website - https://www.familyjusticecenter.org/about-us/history/

- **Health facility-based OSCs run by NGOs:** managed (or co-owned with the government) by a non-governmental organization (NGO), in which NGOs establish separate centers within existing health facilities to provide wrap-around services that strengthen and expand existing clinical services provided by the health facility.
- **Stand-alone OSCs:** are NGO-owned OSCs which provide primarily legal and psychosocial support onsite, while survivors are referred elsewhere for health services. Such services for women and girls including Women and Girls Safe Spaces (WGSS) can have strong referral pathways, invite sector specific specialists in or have other services based within them, such as health screening and a legal advisor on a range of rights issues. The overarching goal of a WGSS is: "to be a safe place where women and girls are supported through processes of empowerment." (IMC and IRC, 2019. P.26)
- **Located in other sector services:** For example, services that are integrated into a police department and based out of a local police office.

Most of the OSC examples provided in this query are services located in hospitals. However, there are also examples of OSCs that are located elsewhere (for example, within communities, other health facilities or police stations). A number of countries operate more than one model (see examples in section 4.1).

The table below gives an *at a glance* indication of each model's comparative advantage with providing different types of services. However, it should be noted with the right funding and commitment each model could provide the main services needed by survivors of GBV.

Model	Type of GBV	Who usually leads	GBV case management	Clinical Management of Rape (CMR)	Legal	Psychosocial	Referrals within.	Referrals outside
Hospital based, tertiary care OSCs	Mainly physical and sexual	Govt.	x	x			x	
Health facility-based OSCs - NGO managed or co-managed	Possibly better able to help with broader types	NGO.	x	x		x	x	
Stand-alone OSCs (including WGSS)	All types of GBV	NGO.	x	x	x	x		x
Located in other sector services centers/institutions e.g. a police station	Possibly a range of rights violations	Govt. (if in police stations).	x		x			x

Findings from the examples included in this report and studies that compare contextual variations of the OSC model (Olsen et al, 2020; Hattery et al, 2020; Sreekumaran Nair et al, 2017), such as hospital-based versus stand-alone centers are summarized in the table below. However, it should be noted that the ability of models to support women and girls who have experienced violence is highly context specific and depends on a number of factors such as the level of government commitment, funding available, available and trained female staff, having dedicated women/girl only areas within these facilities and the understanding in communities about

GBV, gender equality and related rights. Resourcing of GBV service provision with all models is well below what is needed to meet the scale of need and this lack of sustainable funding impacts on the quality and range of services offered at OSCs and other types of GBV services.

Model	Findings
Hospital based, tertiary care OSCs	Better equipped to provide medical services but not so equipped to support women's psychosocial care. Power differentials between doctors and counsellors can lead to the services doctors are better able to provide getting priority and counsellors getting less priority. Mainly focus on physical and sexual GBV that cause physical harm and less adept at recognizing and dealing with a broader range of GBV such as psychological and economic violence, or using feminist or gender-transformative approaches. More accessible to larger sectors of the population including minority groups (but not for people who live a distance from the hospital). Better allow multisectoral collaboration. May be more expensive and not feasible in rural settings. The hospital may operate as a central site with satellite staff in more remote areas.
Health facility-based OSCs - NGO managed or co-managed	NGO-run OSCs provide better psychosocial support and tend to have a better understanding and approach to gendered power dynamics than government run services where the NGO is a trained GBV specialist service provider with trained female staff. Having One Stop Centers within other facilities such as primary or maternal health care clinics has the potential for broader reach, but they tend to be dependent upon referring women externally to a range of specialized services.
Stand-alone OSCs	May offer a safe non-discriminatory environment not always possible in hospital settings where staff are not necessarily all GBV specialists. OSCs in Women's Justice Centers (a model employed in Latin America based on the San Diego model) are successful in creating access to legal pathways for survivors to pursue justice. Better to able to support women's psychosocial needs. May increase risk of survivor stigmatization if they are seen entering or leaving the service. May not meet medical needs of survivors, especially emergency and specialty needs. There can be challenges identifying suitable and accessible locations, staffing them and ensuring 24 hour security and services. Can be better able to address VAWG prevention, provide a broader range of social and economic support over a longer period of time and enable women and girls who have survived violence to leave abusive situations. Can provide more gender-transformative approaches that focus on women's

	empowerment and gender equality.
Located in other sector services centers/institutions	OSCs located in police departments can be strong in terms of safety, legal, policing and psychosocial services, but the provision of health care and mental health care remains a challenge. They are not always appropriate, particularly in contexts where the legal and justice system is highly discriminatory against women.[4] Police-based OSC's may raise considerations related to survivor-centered approach and confidentiality. Some survivors may not feel comfortable going to a police OSC because they are afraid the perpetrator may also be at the same police station, also the police station may not provide a welcoming environment.

OSCs can also be characterized as follows:

- Provider-level integration - The same provider offers a range of services during the same consultation. For example, an emergency room nurse is trained to screen for IPV, counsel the patients, and refer them to external services. It is the least expensive model to implement and does not rely on multiple stakeholder buy-in. However, because the model relies on training individuals, when a practitioner decides to retire or change profession, the investments in human resources are lost. This emphasis on individuals also affects OSC outcomes. Well-trained, committed practitioners may be able to make a huge impact in their communities, but those who are not well-trained or committed, or either, will not.
- Facility-level integration - A range of services is available at one facility but not necessarily from the same provider. Some see this example as a classic One Stop Centre (Columbini, Mayhew and Watts, 2008). A nurse in accident and emergency may be able to treat a woman's injury, but may not be able to counsel a woman who discloses domestic violence, and may need instead to refer the woman to the hospital medical social worker for counselling.
- Systems-level integration - There is a facility-level integration as well as a coherent referral system between facilities to ensure the client is able to access a broad range of services in their community. These are rare in lower income countries because of the costs involved in ensuring that services that are part of the referral network are fully on board with the initiative and fully integrated into government structures. However, certain initiatives implemented in Zambia, DRC, Nepal, Sierra Leone, Kenya, Rwanda and Sri Lanka aim for system-level integration and rely on a set of external networks to provide services that cannot be provided in one place. In Nepal active, well-networked One-stop Crisis Management Centre Focal Points are key factors in making coordination with external agencies work well and make referral happen.

Sources: End Violence Now website - https://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html; Hattery et al, 2020

While a number of the examples explored in section 4 provide good health services (particularly those located in health settings), there was generally weak coordination across sectors which limits their ability to provide quality, accessible and timely support to GBV survivors. There is also a general lack of legal outcomes for survivors due largely to social norms that hinder such a route and to the complicated legal processes involved.

[4] UNFPA (2020) Guidance: GBV One Stop Centers, Somalia - https://somalia.unfpa.org/sites/default/files/pub-pdf/guidance_gbv_one_stop.pdf

Only the Women's Justice's Centers in Latin America appear to be successful in creating access to legal pathways for victims/survivors to pursue justice, and in Zambia there was an increase in legal outcomes with the linking of village-led and hospital OSCs to fast-track courts. Most examples focus largely on sexual and physical violence, with few examples of OSCs explicitly addressing other forms of violence such as economic violence, emotional or psychological violence, or early and forced child marriage. Women and Girls Safe Spaces are more focused on these areas.

There are challenges and enabling factors that are shared by all models and there are also contextual factors that influence how well an OSC is implemented wherever it is located related to the legal framework, social norms, sustained resource investment and political commitment to address GBV. In contexts that are highly patriarchal and restrictive and do not acknowledge women's rights or gender equality, conflict affected settings and where there is little political, cultural or social buy-in to addressing GBV, models that include the police and justice systems may not be appropriate.

OSCs run by governments in health settings are generally less adept at meeting the psychosocial needs of women than services run by NGOs yet this is a key service for women and girls to recover from different types of GBV they may experience. Some of the models featured in section 4 recognize the importance of working closely with communities and community-based organizations to address GBV and with survivors to support their understanding of a range of rights and their psychosocial needs over a longer period of time. Only a very few OSCs examples appear to be embedded in a wider system and build a sustainable response due to the resources and government commitment required.[5]

Despite the contextual factors, there are key barriers and enablers across different contexts. For example, a recent a systematic review of barriers and enablers of the implementation and effectiveness of the one stop center model for intimate partner and sexual violence in low-and middle-income countries (Olsen et al, 2020) found the following:

Enabling factors

- Supportive laws and policies on VAWG
- Standardized policies and procedures
- Regular interagency meetings to coordinate services and support, address challenges, and delegate tasks
- Support from higher leadership
- Available, on-site psychological services and support groups
- Minimized return visits and points of care to receive necessary diagnostics and medications
- Affordable medical services
- Community awareness activities
- Strong interprofessional staff relationships
- Sensitive staff attitudes, and behaviors where service users feel that staff are there to help them
- Referral by sensitive healthcare worker
- Champion, dedicated OSC staff leaders

The review found 15 barriers to implementation of the OSC model and to achieving its intended results. These included barriers to implementation such as staff time constraints and lack of basic medical supplies, which lead to barriers to achieving intended results like accessible care due to long wait times and out-of-pocket fees.

[5] Similar conclusions were made by Hattery et al (2020) in their review of 80 OSCs in 20 countries.

All male staff, which was more common at police stations, were also seen as a barrier for women accessing services.

Lessons from CARE Zambia and partners' (CARE Gender & Empowerment, 2013) implementation of a one-stop model of support for survivors of GBV found the following factors contributed to service user satisfaction:

- Friendly and welcoming environment
- Cases treated with privacy and without bias
- Positive and respectful interactions with staff
- Consistent follow-ups on cases
- Handling cases without corruption or bribery
- Free services that anyone could access
- Linkage to safe houses for certain survivors who need this service.

It is through *implementing* models that enablers and barriers to effectiveness become apparent. Therefore section 4 focuses on lessons learned from the implementation of different models in different country contexts.

4. Examples of OSC in practice

4.1 Comparisons of different models

Resources included here provide comparisons of models implemented at country level.

One Stop Coordinated Response Centers for GBV operated by Care International, Zambia

Background: Eight one-stop Coordinated Response Centers (CRCs) led by CARE were set up in seven districts to help survivors of GBV access a comprehensive package of integrated medical, legal, and psychosocial support. CRCs were embedded into a network of government (health and police) and nongovernmental (counseling, legal, shelter) services. CRCs provide direct services which focus primarily on medical services, psychosocial and paralegal counseling, and also refer clients to social services, support groups, and shelters. The eight CRCs include two CRCs operating outside the hospital set up in Lusaka and Chipata, and six CRCs in hospital settings in Lusaka, Kabwe, Mazabuka, Ndola, Kitwe, and Livingstone.

Key features:

- The main focus of the CRCs was counseling and follow-ups by other service providers, especially the police. The CRC counselors continuously followed up with clients and kept track of the process of service delivery for each survivor. These services include trauma prevention, HIV pre- and post-test counseling, and PEP adherence counseling.
- CRC paralegals, trained by one of CARE's local partners, Women in Law in Southern Africa, also provided counseling to prepare survivors for the justice system. Each CRC was equipped with specialized medical kits for the proper collection, documentation, and preservation of evidence, and a vehicle to provide transportation to clients living ten or more kilometers away.
- 1,111 caregivers, who are volunteer community members trained in providing home-based care to people living with HIV, were also trained in GBV case management and were engaged as a primary mechanism to support GBV survivors at the household level, provide care and support, and refer as necessary to CRCs.
- Sixteen survivor support groups were formed to provide support to fellow survivors through group therapy, and also to work together on economic initiatives, such as the sale of fish, sale of secondhand clothes, rearing and sale of chickens, vegetable gardening and sale of produce.

- The project supported the development of the National Guidelines for the Multidisciplinary Management of Survivors of Gender Based Violence in Zambia, and the adaptation of the In Her Shoes Toolkit (2013), spearheaded by the GBV Prevention Network (a network of GBV activists in the Horn, East and Southern Africa). In Her Shoes is an interactive, educational tool originally developed by the Washington State Coalition on Domestic Violence to raise awareness among service providers and community members about the day-to-day reality for women experiencing abuse.

Lessons learned: Each model had advantages and disadvantages.

- The **stand-alone setting** is more private and more flexible in terms of use of space than hospital settings, and can be located in remote areas where other health centers or hospitals may not be commonplace or easily accessible. However, in the stand-alone model, medical staff are not usually available 24 hours a day and survivors need to be driven and escorted to a health facility for services not available at the stand-alone centers (e.g., surgery, stitches, x-rays), also during which time evidence may be lost.
- The **hospital-based model** has 24-hour guaranteed medical staff on site and usually more direct access to medical services, such as Post Exposure Prophylaxis (PEP) and antiretroviral drugs.
- Due to awareness raising and sensitization activities in communities, the number of survivors coming to CRCs from distant places increased, and therefore the CRCs did not have adequate resources to follow-up on these cases. At the same time, some survivors refused to be referred to service providers in their home districts, such as clinics, hospitals and Victim Support Units, because the level of service provision there was perceived as ineffective.
- There is a need for additional training, support and mentoring for counselors, particularly on topics such as child counseling, and addressing HIV-related issues. Paralegals also need periodic refresher training, as well as mentoring and backstopping support. Problematic reliance on volunteers to provide core services (counseling and paralegal), given the challenges of retaining volunteer staff and keeping them motivated in the face of high time demand, heavy case loads and potential secondary traumatization.
- To ensure quality of care in CRCs, quality assurance mechanisms should be built into program design and adapted or enhanced as necessary during implementation. Examples include: client satisfaction surveys to assess client experiences of care, CRC Advisory Councils, ongoing training and mentoring of counselors, developing standard protocols for counseling sessions, and developing safety plans for survivors.
- There is a need for greater linkages with the health sector to provide survivors with immediate access to PEP and emergency contraception, e.g., by locating GBV services or one-stop centers within hospitals and government health facilities. At a minimum, any centers without 24-hour services should aim to have a counselor on-call during off hours and/or to offer a safe place where survivors can stay overnight to receive services in the morning.
- The lack of permanently assigned police and other government officers to support CRCs negatively impacted case follow-up.
- To ensure the sustainability of future GBV programming, it is critical to engage with local government ministries as well as NGOs and community-based organizations to integrate these activities into the national GBV response plan. This requires significant coordination among stakeholders. It is important for the government to create a funding line in the national budget to sustain and expand these services, as well as a separate line item for coordination.

Source: CARE Gender & Empowerment (2013) *One-Stop model of support for survivors of gender-based violence: lessons from care Zambia.* Atlanta: CARE - https://www.care.org/wp-content/uploads/2020/05/GBV-2013-ZMB-CARE-ASAZA-OSC-Case-Study.pdf

Village-based OSCs, hospital-based OSCs, fast-track GBV courts, and savings groups: a multi-pronged GBV

strategy in Zambia

Background: Village-led one-stop centers (VLOSC) in 21 districts (with a further 6 planned) serve as a community platform for GBV outreach efforts and first-line response, before referral to other service providers. Phase one of the Joint Programme on GBV established GBV Village Led One Stop Centers (VLOSCs) in 21 out of the 288 chiefdoms. In Phase two of the Joint program (2019-2022), the program will roll-out to 6 more chiefdoms. The strengthening and roll out of VLOSCs will provide a platform for communities to champion local prevention and response interventions.

Key features:

- VLOSC emanating from traditional practices in select geographical locations embody collective local-level action. UNDP is leveraging these community structures to respond to high-levels of GBV by providing first-level support to survivors, outreach to communities and other prevention efforts.
- VLOSC provide multisectoral GBV services. Combined with 4 hospital-based OSCs and 6 GBV fast track courts in provincial capitals, servicing over 100 districts, the processing of GBV cases reduced from an average 24-36 months to an average 3-6 days in 2019.
- VLOSCs play a role in continually sensitizing the community on the need to report and support survivors of GBV as well as discouraging all forms of GBV from occurring, especially challenging social and cultural norms that perpetuate GBV.

Lessons learnt:

- Village-led OSCs provide a method of delivering GBV services that is cost-effective compared to hospital based OSCs which are expensive. The village-led OSCs have been found to be effective in providing first line services to survivors that include awareness creation, counselling, para-legal advice and referrals (but not health services) and the centers are easily accessible as they are located in the communities. They are also supported by chiefs, which gives them legitimacy and increases the prospects for sustainability. However, some of the centers and their related men's and community networks are resource constrained and therefore provide limited services due to communication and transport challenges.
- Hospital Based OSCs: For sustainability, the OSCs need to be integrated within the Ministry of Health budgetary and planning frameworks, and personnel running them should be government employees. Multi-skilling of the OSC service providers is therefore essential so that each employee can offer a number of services e.g. a nurse or a police officer can also offer counselling and para-legal services. Some nurses have been trained to offer counselling services in specific hospital based OSCs. For better quality assurance and oversight and accountability it is suggested that the district hospital OSC become centers of excellence which provide oversight and support to the VLOSC. The hospital based OSCs have already been involved in outreach programs where they have facilitated the establishment of men's networks (that engage men as a core part of prevention and response efforts) and community networks.
- GBV Fast Track Courts were established in six provinces, namely: Lusaka, Eastern, Central, Western, Southern and Copperbelt. The authors of the program evaluation recommend that they should be scaled up but a sustainability plan needs to be developed and implemented particularly for the maintenance of the expensive court equipment.
- Own Savings and Wealth Creation (OSAWE) savings groups: the concept needs scaling up with the program facilitating linkages with financial institutions that can offer affordable loans for expansion and diversification of the women's businesses.

Sources: UNDP IEO (2021) *Independent Country Programme Evaluation: Zambia* - https://issuu.com/undp-evaluation/docs/report_icpe_zambia; Government of the Republic of Zambia (GRZ)/United Nations (UN) (2019) J*oint Programme on Gender Based Violence Phase II November 2019 – December 2022* -

https://info.undp.org/docs/pdc/Documents/ZMB/Signed%20Prodoc%20ZMB%20%20JP%20GRZ-UN%20GBV%20Phase%20II%2010%20Jan%202020%20pdf.pdf; United Nations Zambia (2017) *Independent evaluation of the Government of the Republic of Zambia/United Nations (GRZ/UN) Joint Programme on Gender Based Violence* - https://erc.undp.org/evaluation/documents/download/10567.

Three OSC models in Kenya and Zambia

Background: The basic services of the OSC model in low resource settings in Kenya and Zambia comprise health care (including psychosocial support), police and justice sector responses, and ongoing social support. An assessment explored the effectiveness of different OSC models in terms of health and legal outcomes for survivors, and the cost-effectiveness of these models. The assessment was conducted in three sites in Zambia and two in Kenya.

Key features:

Three distinct OSC models were examined to determine the core strengths and weaknesses of each.

- The first type is the **health facility-based OSC**, owned by a hospital, implemented by the health facility itself, and working directly with donors to establish and manage OSC functions that are integrated into the health facility's routine activities.
- The second type is the **health facility-based OSC**, owned by a NGO, in which NGOs establish separate centers[6] within existing health facilities to provide wrap-around services that strengthen and expand existing clinical services provided by the health facility. This is a common model across African countries.
- The third type is the **stand-alone,** NGO-owned OSC which provides primarily legal and psychosocial support onsite, while survivors are referred elsewhere for health services. This is similar to the WGSS model.

Findings:

- None of the OSC models assessed was considered by key stakeholders as adequately meeting the needs of GBV survivors because they did not offer the complete range of medico-legal and psychosocial services under one roof. Although the hospital-owned OSCs provided good clinical and psychosocial services, linkages to the legal and justice system remained weak.
- The NGO-owned OSCs did not have the adequate infrastructure, supplies, equipment and, relevant staff to offer clinical management of rape (or other kinds of violence) to survivors. This could be due to a lack of sustained investment to train staff compared to the hospital-owned OSCs or challenges in sustaining drug supplies. However, the report did not comment on this in specific detail.
- The authors conclude that the health facility-based, hospital-owned OSC model is best-suited for achieving the broadest range of health, psychosocial and legal outcomes; a multidisciplinary team of staff ensures the best health outcomes for survivors. However, it is unclear if the authors also factored for economic ,empowerment and educational outcomes which WGSS usually also contribute to through the range of activities provide for women and girls.

Source: Keesbury J, Onyango-Ouma W, Undie C, et al. (2012) *A review and evaluation of multi-sectoral response services ("one-stop centers") for gender-based violence in Kenya and Zambia.* Nairobi: Population Council - http://www.endvawnow.org/uploads/browser/files/popcouncil_one_stops.pdf

[6] This could include a distinct WGSS incorporated within this service if the area is kept gender segregated.

UNFPA-supported one-stop service centers (OSSCs) and shelters for survivors of gender based violence, Mongolia

Background: Services in four geographical areas: Ulaanbaatar (the capital city), Bayankhongor, Gobi-Altai, and Zavkhan aimags (provinces). The revised Law on Combating Domestic Violence (LCDV) became effective in February 2017. It defines the duties and responsibilities of the health, justice and social sectors, the police, NGOs and other service providers in the delivery and coordination of multi-sectoral services for GBV response. These services are aligned with the services identified in the UN Essential Service Package Guidelines (2015). Essential services are provided free of charge, regardless of where the survivor resides.

Key features: There are three distinct types of OSSC models in Mongolia:

- Health facility-based model where some or all of the OSSC's management and operations are integrated into the health facility's administration, providing easy access to the broadest range of health and psychological services, but with weaker links to the legal and justice systems.
- OSSC owned and fully integrated into the police department and based out of a local police office, such as in Zavkhan. This model was strongest in terms of safety, legal, policing and psychosocial services but the provision of health care remains a challenge.
- Independent OSSC managed by a local NGO and financed by the local government, such as in Bayankhongor. This offered a wider range of essential services including safety, psychosocial and legal support, but the health care provision was also challenging.

Lessons learned:

- The OSSCs play a vital role in their communities by providing greater access to quality essential services for survivors of GBV. The OSSCs enable the survivors to access services under one roof, without the inconvenience of travelling to multiple locations to seek help or services. Therefore, it provides greater accessibility through a survivor-centered approach and reduces the risk of re-traumatization.
- However, coordination with other sectors and agencies was weak across all OSSC models. OSSC service provision should be strengthened to ensure that all necessary services are provided in an integrated manner, and fully aligned with international standards such as the UN ESP.

Source: Khorloo E (2018) *Assessment report on one stop service centers for victims of violence in Mongolia. Ulaanbaatar* - https://genderhub.mn/contents/download/8145ab08-f875-4f62-8b40-45aba3ca13fe.pdf

The Sri Lankan health-sector response to intimate partner violence

Background: A review of the Sri Lankan health-sector response to intimate partner violence found that the health-sector response to IPV in Sri Lanka is evolving, and consists of two models of service provision: (i) gender based violence desks, which integrate selective services at the provider/facility level; and (ii) Mithuru Piyasa (Friendly Abode) service points, which integrate comprehensive services at the provider/facility level and some at the system level.

Features:

- The GBV desks and Mithuru Piyasa service points have integrated IPV services into the health sector in Sri Lanka at the provider/facility and system-wide levels, respectively. GBV desks showcase an NGO-led initiative utilising community capacity and resources without much dependence on government resources.
- Mithuru Piyasa, in contrast, is a state-led institutionalisation of services, which is being scaled up to a national-level program replacing the GBV desks.

Lessons learned:

- NGO staff collaborating in service provision at GBV desks have reported a lack of support from hospital staff and marginalization by doctors at their hospital. At some GBV desks, care provision has been affected because hospital staff lacked knowledge about and/or held negative attitudes towards IPV. NGO staff have been able to use their own networks and resources to offer women a wide range of services, including access to safe homes, legal aid and social services that are located outside the hospital setting.
- The Mithuru Piyasa model, unlike the original One-Stop Crisis Centre model, allows for a much wider range of services and integration at multiple sites and levels. For example, hospital staff are able to refer women to out-of-hospital services because the training and capacity-building they receive through this program enables them to identify local resources, create networks and formalize referral mechanisms with a range of service providers, including the police, NGOs and social services.
- Challenges include lack of collaboration within and between institutions, lack of skills and commitment from health-care professionals.
- In moving forward from an NGO-led model to a government-led service, opportunities for building on the existing partnerships with NGOs have not been fully utilized. NGOs continue to provide vital, out-of-hospital services to Mithuru Piyasa service points and the authors conclude that they should receive the necessary program and policy support to continue such work.

Source: Guruge S, Jayasuriya-Illesinghe V, Gunawardena N (2014) 'A review of the Sri Lankan health-sector response to intimate partner violence: looking back, moving forward.' *Prehosp Disaster Med.* 2014 Oct;29(5):503-7 - https://www.who-seajph.org/article.asp?issn=2224-3151;year=2015;volume=4;issue=1;spage=6;epage=11;aulast=Guruge

4.2 Hospital based

There are many examples of hospital based OSCs, including examples described above in section 4.1. Summarized below are strong examples from lower income countries which have had relative success while at the same time offering lessons learned for improvement.

The One Stop Centre at Panzi Hospital in eastern Democratic Republic of Congo

Background: The DRC especially in the eastern part rape in combination with extreme bodily harm has been used as a war tactic by armed groups and has 'escalated as a new pathologic societal behavior among civilians.' The OSC Care model at Panzi Hospital was developed to provide holistic care and complementary services in Bukavu and surrounding health care facilities and communities aimed mainly at women following extreme sexual violence. The Survival of Sexual Violence project (of which the OSC is a part) is mainly funded by the European Commission's Humanitarian Aid and Civil Protection department (ECHO), PMU Interlife Sweden, the Swedish International Development Cooperation Agency (Sida), and, recently, by läkarmissionen and musikhjälpen in Sweden.

The OSC comprises four pillars, covering medical, psychosocial, legal, and socioeconomic care needs, which are fulfilled in partnership. OSC aims to give more than holistic individual care; it provides a platform for achieving a healthy life at the micro- (the person) and meso- (local society) levels and, if conscientiously and systematically implemented in all health care structures, facilitates achievement of the right to health for all on the macro (national) level.

Key features: The OSC Care model treats women who seek care as a dignified person with value, rights, will, and capabilities, which necessitates trying to understand the situation as the woman understands it.

- This is done first by carers carefully and actively listening to her narrative and identifying her care needs

according to the four pillars.

- Second, the care plan in any of the pillars is developed in partnership with and decided in agreement between the woman and the professional specialist (psychologists, lawyers, economists, and other professionals needed for holistic care).
- Third, the partnership is safeguarded through documentation of all care in structured care plan templates.
- Several protocols for the different pillars of care are developed and used to ensure that all needs are explored and performed as necessary and/or wanted.
- In addition, specific care is given for minors by staff trained in treating children such as pediatricians, pediatric surgeons, child psychiatrists, and psychologists. The OSC also organizes sessions of family mediation and reunification[7]. On a community level, its paralegals organize awareness sessions and education on human rights and collective protection.
- A personal psychosocial worker, a nurse, remains a service user's contact person, leading and coordinating the woman's care plan and treatments throughout her stay. Care is performed both at the hospital as well as in so-called "transit care houses" just outside the hospital, in which patients coming from far away can stay until they are ready to return to their communities. Patients can, after the first treatment started at the Panzi Hospital, get further care in an OSC closer to their homes.

Lessons learned:

- The person-centered OSC model of care requires a multi-professional team comprising doctors, nurses, midwives, laboratory technicians, radiology technicians, pharmacy assistants, lawyers, paralegals, administrative resources, and social assistants facilitating women's reintegration in society. As applied at Panzi Hospital, with its high capabilities in human resources, equipment, and infrastructures, it cannot be exactly replicated in resource-limited areas. A reduced and adapted OSC model, which brings it closer to communities, has been designed and is functioning in some rural areas (such as in Mulamba and Bulenga).

A guide based on the OSC experience - *Handbook: Holistic Care For Survivors Of Sexual Violence In Conflict* by Dr. Denis Mukwege Foundation for the Panzi Foundation (2019) - summarized in section 5.

Source: Mukwege D, Berg BM (2016) 'A holistic, person-centered care model for victims of sexual violence in Democratic Republic of Congo: the Panzi Hospital one-stop center model of care.' *PLoS Med 2016;13:e1002156*- https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002156

The Center for Assault Recovery-Eldoret (CAR-E): A novel Emergency Department-based sexual assault center in western Kenya

Background: The Center for Assault Recovery-Eldoret (CAR-E) was established to provide timely, culturally sensitive treatment of Kenyan sexual assault survivors using a standardized evaluation/treatment protocol. The CAR-E is based in the Accident & Emergency Department (A&E) of MTRH in Eldoret, Kenya, the fifth-largest city in Kenya. Its protocols were developed over a period of 10 months as a collaborative effort between the A&E; the Department of Reproductive Health; the Academic Model for Prevention and Treatment of HIV/AIDS; physicians from Brown University and Indiana University; and community representatives, including police, lawyers and social workers.

Key features: The collaboration decided that CAR-E should have three primary goals.

[7] According to IASC GBV case management guidelines mediation is not recommended in IPV/domestic violence cases.

- Provide a safe, kind and respectful location for evaluation and treatment of sexual assault survivors. To this end, the hospital provided a private room adjacent to A&E, as well as a nurse whose primary responsibility was management of CAR-E. It also committed to providing free care for survivors, a previously unaddressed governmental mandate.
- Guide practitioners in timely provision of locally available disease prophylaxis. A standardized set of treatment guidelines were developed to reflect both international prophylaxis standards and local availability of medicines; these guidelines offered options depending on patient pregnancy status, time elapsed since assault and allergies.
- (Hoped to) facilitate prosecution of assault. With this goal in mind, physicians, police and medicolegal specialists worked together to develop a standardized encounter form and to improve reporting to the police force. Although local resources preclude collection of forensic DNA samples, clothing and any other potential evidence is stored in sealed, labelled paper bags in a locked cabinet in the CAR-E office.
- A&E and reproductive health staff underwent four 1-hour lectures and in-service training on the approach to, and care of, the sexual assault survivor. The training concentrated on the elements of the newly developed standardized encounter form. The hospital also dedicated a part time nurse to the management of the center. She underwent extensive training and supervision, including 3 weeks of supervised history and physicals, attendance of a 1-week UNICEF course and a 1-week UNHCR course, participation in multiple 2-day workshops and ongoing quality review.

Lessons learned:

- The majority of CAR-E's patients were single women under the age of 16. This may suggest that adult, and particularly married, women may need further information about rape, the appropriateness of treatment throughout their life-cycle and the availability and relevance of the services on offer for them.
- The service is geared to supporting rape and sexual assault survivors or IPV survivors who experience sexual violence rather than providing comprehensive support to survivors of other forms of GBV.
- The protocol-based history and physical form resulted in thorough chart documentation.
- The completeness of documentation suggests that the designed charting form could meet Kenyan legal standards. Although the rate of reporting was quite high, no cases are known that progressed to prosecution over the year of study, so the legal usefulness of the chart could not be tested in reality. Increased effort is needed to support the process from reporting to prosecution.
- The low rate of patients receiving counseling is likely due to the fact that the A&E department had one counsellor, who was present only 40 hours per week. Of note, since completion of the chart review, the hospital has hired a second counsellor for A&E.
- Most importantly, the chart review shows a high rate of appropriate testing and treatment of survivors. This shows not only that it is feasible to institute a de novo sexual assault center in the Emergency Department of a regional hospital in sub-Saharan Africa, but also that a protocol-based center can achieve high rates of compliance with care guidelines in this resource-poor setting.

Source: Ranney ML, Rennert-May E, Spitzer R, et al. (2011) 'A Novel ED-based Sexual Assault Centre in Western Kenya: description of patients and analysis of treatment patterns.' *Emerg Med J* 2011;28:927–31 - https://pubmed.ncbi.nlm.nih.gov/20947922/

One-Stop Crisis Management Centers (OCMCs) for gender-based violence, Nepal

Background: The Ministry of Health and Population (MoHP) was tasked with providing integrated services to survivors of GBV by establishing hospital based OCMCs. MoHP initiated the establishment of OCMCs in 2011. By the end of 2018/19, 55 OCMCs had been established in 54 districts. Fourteen more OCMCs will

be established in 2019/20 and the MoHP intends to complete scale-up across the country in 2020/21. The MoHP has been incrementally providing inputs to strengthen the systems and capacity of OCMCs since their introduction.

Key features:

- The OCMCs provide free hospital-based health services including identification of survivors through screening by case managers, treatment, psychosocial counselling and medico-legal services, and coordination with multisectoral agencies that provide survivors access to safe homes, legal protection, personal security and rehabilitation. They also refer clients for specialist health services as required.
- An OCMC self-assessment scorecard was completed by 50 OCMCs in March 2020. This scorecard is introduced as a management tool in the latest version of the OCMC Operational Manual (2020) (currently waiting for final approval from the MoHP Secretary - the 2016 version is available online). The scorecard includes indicators that relate to the capacity of the hospital to deliver OCMC services and the quality of coordination and collaboration of the OCMC within the health service and with external agencies.
- Case Management Committees (CMCs).

Lessons learned:

- Hospital leadership commitment to OCMCs is a key enabling factor for their success. Supportive leaders provide resources to OCMCs, generate commitment to GBV across the hospital, motivate staff and improve the quality of care.
- Many doctors and staff nurses who have received GBV- and OCMC-related training have been transferred to facilities without an OCMC, as part of general staff adjustment process.
- Standards and guidelines and related training on the Clinical Protocol (2015) and OCMC Operational Manual (2016), medico-legal training of doctors to undertake forensic examinations of rape victims and to prepare medico-legal records that stand up in court, and psychosocial counselling training of nurses have been critical investments. Feedback from doctors and nurses trained was overwhelmingly supportive of the quality of the training and the impact this has had on their care and underlying attitudes towards GBV survivors. Despite the rollout of training, this has not covered all OCMC staff and capacity gaps persist.
- Staff nurses who received psychosocial counselling training note how they have changed the language they use with survivors, become more sensitive to their needs and show respect and empathy.
- Access to OCMC budgets by OCMC staff was reported to be an issue in several hospitals. Nurses reported how accounts officers do not provide allocated petty cash to the OCMC and hinder requests for equipment and other necessary supplies, finding the budget has sometimes been used for other purposes.
- Coordination and collaboration at the operational level through regular Case Management Committees (CMCs) is uneven. Coordination on a case-by-case basis seems to be the norm. Frequent turnover of staff and the heavy work burden of OCMC Focal Points have a negative impact. Case studies of Koshi and Hetauda OCMCs show how active, well-networked OCMC Focal Points are key factors in making coordination with external agencies work well and make referral happen.
- Community awareness of OCMC services is low, and few women reach them directly.

Source: Government of Nepal (2020) *Review of the scale-up, functionality and utilization, including barriers to access, of One Stop Crisis Management Centers* - http://www.nhssp.org.np/Resources/GESI/OCMCs_health_systems_response_to_GBV_in_Nepal.pdf

Isange One Stop Centre (IOSC), Kigali (UN and Government of Rwanda), Rwanda

Background: The initial phase of the IOSC program started in 2009 as a pilot project between the One UN in Rwanda and the Rwanda National Police (RNP) - the first center was located in the Police Hospital. The "National Scale up of IOSC model in Rwanda" is a joint program between the government of Rwanda represented by Ministry of Gender and Family Promotion (MIGEPROF), Ministry of Health (MOH), Ministry of Justice (MINIJUST), (RNP) and One UN.

Key features:

- The IOSCs provide a holistic response to GBV under one roof, to minimize the risk of re-victimization, spoilt evidence and delay justice. The centers provide free, 24-hour medical, psychosocial/counselling, legal and safe house services to the survivors. Toll free telephone lines that facilitate quick emergency reporting, information access and rapid response to GBV survivors are some of the facilities provided to IOSCs for more efficiency.

The national scale up focuses on the three strategic priorities:

1. Upscaling the IOSCs from 6 to 23 centers and provision of holistic services to prevent and respond to GBV and child abuse;
2. Promoting behavior change through public awareness and education in relation to laws and policies on GBV and child abuse;
3. Strengthening institutional frameworks for effective coordination, monitoring and evaluation as well as information management for evidence based planning and policy advocacy.

Lessons learned:

- The program's awareness component focuses on community level prevention measures through sensitization and has led to a greater understanding of GBV and child abuse issues in communities throughout the country, leading to increased confidence in the IOSC model by survivors and their families.
- However, awareness of the existence of IOSCs is low and access to IOSC is limited due to their relative scarcity (for many survivors who are not in close proximity to an IOSC).
- It remains complicated to get sufficient proof for successful court cases against GBV and child abuse perpetrators.
- The IOSC is largely managed as a project, rather than a regular government service, fully integrated in government structures, which has implications for reach and sustainability.

Source: Bernath T, Gahongayire L. (2013) *Final evaluation of Rwandan government and one un Isange one stop center.* Kigali: One UN partnership (UNICEF, UN Women, and UNICEF); RAD Consult Ltd (2016) *Report of the final evaluation of the project for the national scale-up of the Isange one stop center model in Rwanda.* Government of Rwanda and the United Nations Rwanda - https://gate.unwomen.org/EvaluationDocument/Download?evaluationDocumentID=9065; United Nations Rwanda website - https://rwanda.un.org/en/15872-rwandas-holistic-approach-tackling-different-faces-gender-based-violence-gbv; the Ministry of Gender and Family Promotion (2019) Final Report On The Study On Knowledge, Attitude And Practices On GBV, Perceived GBV Root Causes and IOSC Service Delivery - https://www.migeprof.gov.rw/fileadmin/user_upload/Migeprof/Publications/Reports/Final_Report_on_GBV_perceived_root_causes_and_IOSC_service_delivery-July2019.pdf

4.3 Based in a health facility - NGO managed and operated

See summaries in section 4.1:

- An assessment explored the effectiveness of different OSC models in Kenya and Zambia in terms of health and legal outcomes for survivors, and the cost-effectiveness of these models (hospital-based, NGO run and standalone).
- The Sri Lankan health-sector response to intimate partner violence consists of two models of service provision: (i) gender based violence desks, which integrate selective services at the provider/facility level; and (ii) Mithuru Piyasa (Friendly Abode) service points, which integrate comprehensive services at the provider/facility level and some at the system level.
- One stop Coordinated Response Centers (CRCs) for GBV operated by Care International, Zambia - the eight one-stop Coordinated Response Centers were set up in seven districts to help survivors of GBV access a comprehensive package of integrated medical, legal, and psychosocial support and run by CARE.

The Family Support Centre (FSC) health services for urban survivors of gender based violence in Lae, Papua New Guinea

Background: The FSC at the National Department of Health's provincial hospital in Lae (Angau Hospital) had a core group of staff committed to addressing GBV. Médecins Sans Frontières Operational Centre Amsterdam provided medical, management, human resource and material support to the FSC for the provision of medical care and counselling services from late 2007 until June 2013.

Key features: MSF-supported services were free of charge and could be accessed directly by patients without requiring referral documentation. Services included:

- medical treatment for injuries;
- provision of tetanus and hepatitis B vaccination;
- emergency contraception;
- pre- and post- HIV testing counselling and adherence counselling for HIV prophylaxis;
- treatment and prevention of other sexually transmitted infections;
- provision of medical certificates documenting the service provider's findings of the medical examination;
- referral for further medical treatment or other services; and
- therapeutic counselling services based on principles derived from brief trauma-focused therapy, including psychological first aid (providing reassurance and normalizing emotions and feelings after a traumatic incident), and basic general and informative counselling to support the patient to express concerns and identify solutions. Counsellors also assessed client safety, and if required discussed safety measures.

Community awareness regarding health services for survivors was raised through outreach activities including disseminating printed health promotion materials, radio messages and participative dialogue with community groups.

As a medical organization, provision of non-medical services such as legal and protection support was beyond the scope of the program.

Lessons learned: Community awareness of the availability of free, best-practice, accessible, confidential medical and counselling services for sexual and GBV in Lae, PNG resulted in many survivors presenting for care. Key findings:

- The low rate of referral from police of women experiencing IPV, compared to survivors of non-partner sexual violence, suggests that policing services are less accessed by survivors of IPV.

- Medical certificates are considered by service providers as important in supporting criminal proceedings or compensatory claims in village courts. Medical certificates were more likely to be provided in cases of non-partner sexual violence compared with IPV, suggesting a considerable bias towards pursuing such avenues in cases of non-partner sexual violence compared with IPV.
- Safety assessment or planning interventions were limited to referral of patients to appropriate services such as community welfare, policing or legal services. This is concerning in a context where much of the violence is perpetrated by known individuals and therefore is likely to recur unless resolved definitively. High levels of ongoing intimate partner violence and child sexual abuse by known abusers indicates that alongside comprehensive medical care, access to effective services in non-health sectors such as policing, protection and legal services are needed if survivors are to be safe and not experience further incidents of violence.

Source: Lokuge K, Verputten M, Ajakali M, et al. (2016) 'Health services for gender based violence: Médecins sans Frontières experience caring for survivors in urban Papua New Guinea.' *PLoS One* 2016;11:e0156813 - https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0156813

The Dilaasa model, India

Background: The Dilaasa model is a joint initiative of the Municipal Corporation of Greater Mumbai (MCGM) and CEHAT[8]. It is a redesigned OSCC adapted to the country context. It has focused on training existing hospital staff to respond to violence against women and integrate violence against women in their roles and responsibilities, as this is more sustainable than a traditional OSCC recruiting specialist project based staff brought into the hospital setting.

Features:

- A GBV screening process conducted during the outpatient or inpatient consultation.
- Once identified through the intake and screening process, survivors are provided with medical treatment, their history of abuse is documented, evidence is collected in case of sexual violence if appropriate, medicolegal support offered (including referrals to legal aid) and patients are given information about the Dilaasa crisis intervention center. A key component of this comprehensive care includes informed consent.
- The hospital has put up posters and distributed cards, and pamphlets to create awareness about violence against women as a public health issue.
- The model also includes violence support services currently missing in the health sector, namely crisis intervention and psycho-social support.

Lessons learned:

- An external evaluation highlights that the location of the crisis center in a public hospital enhances accessibility and early detection of violence amongst women, with a large number of women identified through an active GBV screening program within two years of abuse starting. For example, women were reached during their antenatal care visits. The center has established protocols for documentation of the abuse, its severity, assessment of safety, mental health impact and development of a safety plan.

Toolkit for Designing One-Stop Crisis Centers for Survivors of Gender-Based Violence: Learnings from the

[8]CEHAT is the research center of Anusandhan Trust set up in 1994. It works on health and human rights issues through research, policy advocacy and interventions. For more information visit: http://www.cehat.org/

Dilaasa Model. by Bhate-Deosthali P, Pal P and Hogan, M (2020) is summaries in section 5.

Source: Bhate-Deosthali P, Pal P and Hogan, M (2020) *Toolkit for Designing One-Stop Crisis Centers for Survivors of Gender-Based Violence: Learnings from the Dilaasa Model.* Washington DC - https://www.icrw.org/wp-content/uploads/2021/01/ICRW_DRLToolkit_Dec.2020_ENGLISH.pdf: ICRW; Garcia-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-McLain J, Colombini M, Feder G. (2014) 'The health-systems response to violence against women'. *The Lancet.* vol 385 - Appendix: Additional information on health infrastructure and health financing - https://www.thelancet.com/cms/10.1016/S0140-6736(14)61837-7/attachment/e8be4d4d-60e3-4188-9aa2-7ff70cc4d594/mmc1.pdf

Sexual Assault Referral Centres (SARC) / Rainbo Centres, Sierra Leone

Background: The Rainbo Centre is a place where a person can get help after they have been raped or sexually assaulted. The centers do also see survivors of domestic violence and other types of GBV. There are five centers in total based mainly in government hospitals. The wider aims of the Rainbo initiative include:

- respond to the multiple needs of survivors of sexual assault through direct service delivery
- raise awareness and educate the community and all partners about sexual assault and other forms of gender-based violence
- encourage structural reforms in the health and legal systems to improve survivors' access to the existing justice system
- advocate for and support longer-term efforts for legislative reform aiming to enhance and protect women's rights.

They were initially set up and run by the International Rescue Committee. Given the success of this initiative IRC helped build the capacity of national institutions to assume leadership. In November 2006 a multiagency National GBV Programme Coordination Committee (N-GBV-C) was set up, bringing together five ministries (health, social welfare, gender and children's affairs, justice and education), human rights organizations and several international NGOs. The N-GBV-C seeks to develop new sustainable methods of integrating sexual assault referral services and activities into the public health care system and other national structures. The NGBV-C ensures that the complex needs of sexual assault survivors are adequately addressed by promoting long-term country ownership of project activities and gradually assuming managerial responsibility for the Rainbo Initiative.

Key features: All services at the Rainbo Centre respect each person's wishes and choices and always keep confidentiality. The Centers provide:

- Clinical care and medical treatment for rape and sexual assault counselling to help cope with emotional and psychological effects of sexual violence.
- Inform the legal system if a survivor wants to take her case to court and provides a medical report and certificate for litigation for survivors to access justice.
- Referrals to other service providers (agencies and government) for further support not provided by Rainbo including legal, protection, livelihood and advanced medical help. Help reporting the incidents to police.
- Additional care including dignity kits, refunds of transport fees, food.
- Follow up counselling and further support including court monitoring.

Lessons learned:

- Scaling up Rainbo required strengthened government institutions, a national sexual assault network, joint advocacy and shared learning.
- IRC realized that capacity building for country ownership was a major commitment requiring long term investment. IRC examined both technical and organizational capacity – including motivation, environment, training, monitoring and evaluation, strategic planning, understanding of GBV, case management, referral protocols, vicarious trauma, formal and traditional legal systems and community development to determine capacity needs.
- In 2020, it was noted that the lack of investment in establishing a forensic lab contributes to impunity of perpetrators.

Sources: Rainbo Initiative website: https://rainboinitiative.org; Abirafeh, L (2007) 'Building capacity in Sierra Leone.' *Forced Migration Review* 28 July 2007 - *https://www.fmreview.org/capacitybuilding/abirafeh-sl/;* Pan African Visions (2020) 'Sierra Leone : Rainbow Initiative Calls On Government To Invest In Forensic Lab To Increase Convictions On Sexual Assault Cases' - https://panafricanvisions.com/2020/07/sierra-leone-rainbow-initiative-calls-on-government-to-invest-in-forensic-lab-to-increase-convictions-on-sexual-assault-cases/

4.4 Stand-alone services

The examples summarized below illustrate different models of OSC in practice.

See also the following examples summarized in section 4.1:

- One stop Coordinated Response Centers for GBV, Zambia - Eight one-stop Coordinated Response Centers (CRCs) were set up in seven districts to help survivors of GBV access a comprehensive package of integrated medical, legal, and psychosocial support. CRCs were embedded into a network of government (health and police) and nongovernmental (counseling, legal, shelter) services.
- Village-based OSCs, hospital-based OSCs, fast-track GBV courts, and savings groups: a multi-pronged GBV strategy in Zambia - Village-led one-stop centers (VLOSC) in 21 districts (with a further 6 planned) serve as a community platform for outreach efforts and first-line response, before referral to other service providers.

Women's Justice Centers (WJC) throughout Latin America

Background: The WJC is based on the Family Justice Center model of the United States in recognition of the need for a specialized service center for survivors of violence. They are founded on six key principles: access to justice and the prevention of violence as a crosscutting strategy that includes surveillance, empowerment, investigation, evaluation, transparency, and accountability. All services are designed holistically and are available under one roof.

Key features: Services include providing access to attorneys and private investigators, as well as a health service for women and children. For example:

- The Women's Justice Center of the State of Hidalgo (WJCH), is a single building consisting of an office area for partner institutions, a temporary shelter and cafeteria, a play area for children, a multipurpose room, offices for medical and psychological professionals, a training room with computers and other technology, and a courtroom.

Lessons learned

- The WJCH was highly successful in addressing the needs of survivors in a holistic way. Women received medical care, mental health support, and orders of protection and legal support in divorce and custody

cases.

- The single-site approach resulted in many women building networks that contributed to their economic well-being. For example, some women who lived at the WJCH together formed a co-op to sell their handicrafts.
- However, the WJCH is underfunded, which threatens its sustainability, and its ability to respond to all the women who need their services and although the WJCH is built on a systems model, the center has not been able to have an impact on the larger systems it encompasses.

Source: Hattery et la (2020) *Select Gender-Based Violence Literature Reviews: The effectiveness of One-Stop GBV resource centers*. USAID

https://pdf.usaid.gov/pdf_docs/PA00X5BV.pdf

ABAAD's (Resource Center for Gender Equality) Emergency Safe Houses or 'Dar' and their eight Model centers, Lebanon

Background: The Dars are located in three different governorates in Lebanon. At these spaces, a specialized team dedicates its time to the women and girls who experience violence and abuse.

ABAAD also operates eight Model Centers throughout Lebanon, which are based at the Social Development Centers of the Lebanese Ministry of Social Affairs. The Women and Girls Safe Spaces provide a safe, non-stigmatizing environment for women and girl survivors of GBV and their children to receive comprehensive holistic care services.

Key features:

- The Dars are spacious, secure and large. The shelters offer immediate safe-housing, services and support (24/7), crisis counselling, emergency support and information on legal rights and legal consultations, psychosocial support, referrals for long term welfare provision income assistance and access to resources.
- The Model Centers offer: case management; legal consultations and court representation; psychotherapy and/or psychiatric evaluation and follow up; clinical management of rape (CMR) services; referral to emergency safe housing (Dar); soft skills/economic empowerment for women and girl survivors of GBV and their children; the safe spaces have been selected in a manner that ensures wide geographical coverage, to facilitate the reach of women in different areas of Lebanon.

Lessons learned: No learning is available on their website which focuses on what the service offers.

Source: Information about the Al Dars and Model Centers is available on Abaad's website - https://www.abaadmena.org/direct-services/safe-shelters#:~:text=ABAAD's%20Emergency%20Safe%20Houses%20or,at%20the%20Dar%20since%202013

Women and girls safe spaces in Syria

Background: A safe space is a dedicated formal or informal place where women and girls feel physically and emotionally safe. The term 'safe,' in the present context, refers to the absence of trauma, excessive stress, violence (or fear of violence), or abuse. These spaces may take different names such as women centers, women community centers, or listening and counseling centers, to name a few. Women safe spaces are not the same as shelters or safe spaces at reception centers or one-stop centers. However, this example is included here as an example of a service that offers multi-sectoral support to survivors of GBV in a crisis affected context.

Features: The key objectives of a safe space are to provide an area where women and girls can:

- Socialize and re-build their social networks;
- Receive social support;
- Acquire contextually relevant skills;
- Access safe and non-stigmatizing multi-sectorial GBV response services (psychosocial, legal, medical);
- Receive information on issues relating to women's rights, health, and services.

Lessons learned to support GBV survivors:

- Having a clear referral pathway articulating services specific to the needs of both adult and child survivors can prove extremely beneficial.
- All WGSS staff should be familiar with the referral pathway, and their respective roles within it.
- Depending on the specific services available at the safe space, clients may be referred to the following (if they choose): Case worker (for case management services); health provider (for medical care and post-rape treatment, if available); a lawyer or legal association (for legal recourse); and police (for safety).

Source: UNFPA (2015) *Women and girls safe spaces in Syria: A guidance note based on lessons learned from the Syria crisis* https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf [focus is on safe spaces

Ciudad Mujer Centres, El Salvador

Background: 'Ciudad Mujer' (CM) or City of Women is a government-led program run through the Department of Social Inclusion. It aims to improve the quality of life of Salvadorean women through the provision of essential services in Cuidad Mujer Centers (CCM in their Spanish acronym).

Key features: The CCM are rooted in work for gender equality. They offer free and integrated services covering sexual and reproductive health, response to gender based violence, and economic empowerment. They bring together 18 state bodies in a single center, and provide more than 20 services which respond to the needs of the women. They are open to anyone, free to access, and are particularly sensitive to the individual situation of each woman. The CCM also provide childcare up to 12 years to enable the mothers to use the services while their children are looked after. They also include an element of collective education. There are six centers in El Salvador, with a further three being planned.

The GBV component provides the following:

- Legal services to address economic violence:
- acknowledgement of paternity
- legal access to receive food parcels
- legal ownership of property and goods
- birth certificates for women

Psychological, medical and legal services for women survivors of violence:

- Emotional support
- Legal support
- Protection measures
- Medical attention
- Support with transport

- Support to file a police report

Lessons learnt: (Note: The evaluation by the InterAmerican Development Bank focused on understanding whether the provision of integrated public services reduces the costs and increases the demand among women aged 18-60. It aimed to quantify changes in women's use of public services related to sexual and reproductive health, women's economic empowerment, and GBV, as a result of the introduction of CCMs.)

Findings show that this integrated model is effective in facilitating specialist services for women by reducing barriers to access. Key achievements include:

- Increased access to specialist public services, with women using the CCMs having higher rates of use of services including sexual and reproductive health services, legal services related to economic empowerment, and support for GBV. Mammogram and pap smear services were also used much more by women attending CCMs than those that did not.
- Increased use by women using the CCMs of legal services to obtain a National Identity Document and birth certificates.
- Increased use by women using the CCMs of services providing food parcels and registration of legal ownership of property and goods.
- Increased perception of quality of life among women using the CCMs.

The findings support the CCMs as effective at improving the lives of women who use them, and increasing their access to public services. Aspects that could be strengthened include improving:

- economic empowerment by providing work-related training, support for small businesses, and access to microcredit.
- demand for GBV services by improving access to psychological support, police intervention and recourse to justice.
- the monitoring and evaluating of the CCM's activities by strengthening data management and links between new and existing CCMs.

Source: Bustelo M, Martinez S, Millard MP, et al. (2016) *Evaluación de Impacto del Proyecto Ciudad Mujer en El Salvador. San Salvador: Inter-American Development Bank*
https://publications.iadb.org/publications/spanish/document/Evaluaci%C3%B3n-de-impacto-del-Proyecto-Ciudad-Mujer-en-El-Salvador.pdf

4.5 Located in other sector services

See also:

- Comprehensive Standard Operating Procedure (SOP) for "One Stop Centre in Delhi" - To *'facilitate 'the best humane, psychological and medical treatment to the victims of crime both during investigation, trial and even thereafter'* (page 3) the OSCs are in two tier centers - First Tier – based in the hospitals and second tier operating from the Court complexes. Summarized in section 5
- Gender-Based Violence Protection Units (GBVPU), Namibia are overseen by the Namibian Police Force. Medical, law enforcement and social service agencies coordinate the professional evaluation, treatment, protection, investigation, case review and ongoing advocacy for children and adult survivors of sexual and physical violence. The SOPs are summarized in section 5
- UNFPA-supported one-stop service centers (OSSCs) and shelters for survivors of gender based violence, Mongolia - There are three distinct types of OSSC models in Mongolia: health-facility based, OSSC owned and fully integrated into the police department and independent OSSC managed by a local

NGO. The OSSC owned and fully integrated into the police department and based out of a local police office was the strongest in terms of safety, legal, policing and psychosocial services but the provision of health care remains a challenge. See section 4.1 for a full summary.

One Stop Centre Meheba Resettlement Scheme, Zambia

Background: The newly established GBV One Stop Centre (OSC) was launched on 24 June 2020, in Meheba Resettlement Scheme, Kalumbila District, North Western Province. Meheba Resettlement Scheme, like many other communities in Zambia, have experienced challenges with the availability and coordination of GBV services. Despite the efforts by Government and other stakeholders to respond to GBV, the area has continued to record an increase in the incidences of GBV, especially violence against women, and a lack of coordination to manage GBV survivors, which spurred the establishment of the Center.

Key features:

- The GBV One Stop Centre functions as a key node for provision of comprehensive support against GBV to protect the diverse community in the Meheba Resettlement Scheme and surrounding areas, comprising Angolans, Congolese, Rwandese and Zambians.
- The key stakeholders involved in the provision and coordination of services to GBV survivors include the Zambia Police Service, Ministries of Health, Social Welfare, Community Development, as well as civic and traditional Leaders, working together to provide any array of services including health, legal, justice, counselling, psychosocial support, protection and long term prevention of recurrence of GBV to survivors.
- The OCC will be used as a Centre for education in GBV and data management.

Lessons learned: no lessons learned are available.

Source: UNDP Zambia (2020) *Launched One Stop Centre is a key node in protecting GBV victims in resettlement schemes | UNDP in Zambia* - https://www.zm.undp.org/content/zambia/en/home/stories/launched-one-stop-centre-is-a-key-node-in-protecting-gbv-victims.htm

5. Standard operating procedures and guidance

Resources not solely on OSCs but that may be relevant:

- Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers by WHO (2017). This resource Includes guidelines on how to create SoPs.
- The Minimum Standards for Gender-Based Violence in Emergencies Programming by UNFPA (2015). This resource mentions OSCs, and the standards of care are applicable for any GBV services.

Guidance: GBV One Stop Centers, Somalia by UNFPA (Updated 2020)

This guidance is developed to standardize service provision across GBV one stop centers and to ensure that survivors are provided services in line with the standards and guidelines of GBV service provision. It also defines the kind of services and support that is provided by the one stop centers and type of human resources that is required to deliver quality, timely and confidential services to GBV survivors. The guidance states that all service providers should prioritize the safety and security of survivors (and of their families and

of workers providing care). Due to the dramatic disruption of the legal system in areas where this SOP applies, security actors such as police, are not included in the referral pathways. Further, due to the insecurity and judicial vacuum or uncertainty of the area where these SoPS apply, the legal response in areas where these SoPs are implemented is limited. It is important that service providers present survivors with full and up-to-date information in order for them to make a decision on which institutions to access, especially since the systems in place are subject to sudden changes. No automatic referrals to legal institutions should be made. The strategic location of most of the centers within health facilities improves safety and security of GBV survivors when accessing services, in this context at the time of writing. It will also facilitate a possible transition to government management in future.

Women and Girls Safe Spaces: A toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings by International Medical Corps and International Rescue Committee (2019)

Within humanitarian settings WGSS are defined as both a concrete and abstract space which ensures the physical and emotional safety of women and girls. The main purpose of safe spaces is transformational change, providing a counterspace created within a larger unequal space, such as humanitarian settings. WGSS within the GBV program are also a key entry point for survivors to disclose experiences of violence, and seek access case management and psychosocial support services hosted in the WGSS.

Core Feminist Ethics and Principles governing WGSS
While varying in different parts of the world, there are some common core principles and distinctly feminist ways of working: • Creating less hierarchical structures of leadership and participation towards a more horizontal, participatory and equal collaboration. • Definition of gender as socially-constructed not biologically-determined; gender-based inequality is 'man made' and can be changed. • Ensuring a voice and role for all key stakeholders, internal and external. • Understanding that patriarchal society has been divided into public and private, with the private sphere associated with the devalued, and exploited role of women in the family and in reproduction, and the public with respected and remunerated roles of men in leadership and productive labor. • The personal is political - feminist consciousness and women's liberation starts with freeing the self, analyzing your own oppression and taking action to transform it. • Agency - Every woman has the capacity to challenge oppression. Women are not just victims of patriarchy but can be active agents of change.

The aim in developing this toolkit was to fill a gap in existing global guidance for WGSS in humanitarian settings, harmonizing the approach while accounting for contextual differences and support women's and girls' sense of self and empowerment by providing a global blueprint for WGSS programming. It offers field staff 38 tools and 9 databases with step-by-step instructions and guidance on how to apply feminist principles, approaches and strategies in practice, within an accountable, women and girl-led process.

Interdepartmental standard operating procedure for One Stop Centre (Guichet Unique), Mali by Government of Mali and United Nations Mali (2018) (in French)

Signatories to the SoP agree to a number of undertakings, including:

- Knowing and understanding the ethical and security recommendations set out by the WHO for research, documentation and treatment of sexual violence in emergency contexts.
- Cooperating and working together as much as possible to prevent and respond to GBV, to avoid duplication of efforts and to facilitate a shared approach by different actors.
- Establish and maintain carefully coordinated interagency and multisectoral interventions to prevent and respond to GBV.
- Engage the community to understand and fully promote gender equality and protection of and respect for the rights of women and girls.
- Ensure the equal and active participation of women, men, boys and girls in the evaluation, planning, monitoring and evaluation of programs through the systematic use of participatory approaches.
- Ensure accountability at all levels, including to survivors, other stakeholders, donors, etc.
- All those involved are required to sign a Code of Conduct, and agree to a number of principles including regarding: security, confidentiality, respect for dignity and self-determination, non-discrimination, creating an environment of trust and safety, data management, appropriate language, keeping up to date with information and media relations.

The SoP details the responsibilities of: various ministries, including the Ministry of Public Health, Ministry of Women, Children and the Family, Ministry of Solidarity and Humanitarian Action, Ministry of Justice, the medical sector, psychosocial sector, justice sector, police and security sector. It also sets out referral pathways between the different actors.

Standard Operating Procedures Manual Gender-Based Violence (GBV) and Violence against Children (VAC) in Namibia by United Nations Namibia and Government of Namibia (not dated, however, some of the tools included are dated 2018)

The SoPs manual describes the clear procedures, roles and responsibilities for each sector, whether these are utilized within a Gender-Based Violence Protection Unit (GBVPU) or any other office. GBVPUs focus on specific types of GBV, namely, sexual abuse, physical abuse, emotional abuse and neglect.

- The Namibian Police Force oversees these specialized centers. Medical, law enforcement and social service agencies coordinate the professional evaluation, treatment, protection, investigation, case review and ongoing advocacy for children and adult victims/survivors of sexual and physical violence.
- Some GBVPUs operate as one-stop centers where all members of the multidisciplinary team are under the same roof, whereas other GBVPUs may not have all services under one roof but have agreements with other service providers to provide integrated services.
- Key principles that should guide all assistance and protection measures that different role players involved at the GBVPU and in the entire supporting process take include: respect for and protection of human rights; best interests of the child, do not harm; non-discrimination, informed consent/assent (caveats are explained for children); survivor-centered approach.
- The SoPs give guidance on the following: roles and responsibilities of the Multi-Disciplinary Team; core case registration at the GBVPU/relevant office; risk assessment; interviewing perpetrators of gender-based violence; medical assessment; forensic interview (for rape cases); statement taking, case opening and preliminary investigation; collecting forensic evidence; counselling and therapeutic care; preparing

for court etc. There is also a SoPs flow chart depicting service order for rape survivors.

Standard Operating Procedures for GBV Services at 'One Stop Centre' by Liberia UN and the Liberian Government (2013)

This SoP, developed by representatives of the UN and Liberian Government, establishes clear procedures, roles and responsibilities for each actor involved in the response to the GBV survivor through the One Stop Centers. The SoPs for GBV services are relatively basic and cover: medical examination and treatment; psychosocial counselling protection; law enforcement and legal issues; short stay accommodation for survivors that are brought at night or on holidays. Information is also provided when the service user is a child.

The Ebola outbreak had a significantly detrimental impact on the functionality of the OSCs embedded within health facilities with some specific services decimated eg. forensic capacity and with women and girls fearful to access medical facilities. However, IRC stepped in and with Irish Aid's funding support revived and re-capacitated these centers in partnership with the Government of Liberia. IRC has now handed over the delivery of these services whilst Irish Aid has recently recommitted to continue providing funding support to these centers (Government of Ireland, 2020). SoPs for the OSCs in Liberia may therefore have been amended and updated.

Toolkit for Designing One-Stop Crisis Centers for Survivors of Gender-Based Violence: Learnings from the Dilaasa Model by Bhate-Deosthali P, Pal P and Hogan, M (2020) Washington DC: ICRW

The primary aim of this Toolkit is to build the capacity of the NGO partners to develop Action Plans to conceptualize and implement "one-stop shops" (similar to the Dilaasa model) for survivors of GBV in Morocco. The Toolkit highlights the context, background, philosophy and road map used for conceptualizing Dilaasa centers in India and its institutionalization and replication in several Indian states. It presents resources, materials, activities and information to support the development of a "one-stop shop" model for providing support to women survivors of GBV. As well as information about and exercise on the role of health systems, understanding VAW, the role of other stakeholders, the interface of a survivor with the formal and informal system, multisectoral collaboration, there is also a budget tool and a reporting tool. Various other useful resources are provided in the annexes including the Programme implementation Plan 2013-14 of the Ministry of Health and Family Welfare, Government of India.

Comprehensive Standard Operating Procedure (SOP) for "One Stop Centre in Delhi" by Delhi State Legal Services Authority, Central Office, Patiala House Courts (2015)

To *'facilitate 'the best humane, psychological and medical treatment to the victims of crime both during investigation, trial and even thereafter'* (page 3) the OSCs are in two tier centers. The first tier are based in the hospitals and the second tier operate from the Court complexes.

The SoPs give a detailed outline of infrastructure and facilities to be provided at each tier, as well as a list of stakeholder departments and their role, proposed range of cases to be covered, referral centers, human resources needed for both tiers, guidelines for treatment and medical examinations, collection of forensic evidence, SoPs for dealing with the 'victim' at the OSCs, role and responsibilities of counselors, award and disbursal of compensation, witness protection, role of the support person, police, confidentiality, publicity and awareness of SoP, role of public prosecutors and courts and what to do in the event of an acid attack.

National Commission for Women and Children, Royal Government of Bhutan, Standard operating Procedure for Gender Based Violence Prevention and Response by the National Commission for Women and Children, Royal Government of Bhutan (2020)

The SoP aims to provide clear guidelines on a multisector response to and prevention of GBV, and provides for a continuum of care and support services at every stage and for every GBV case. The intention is to strengthen a coordinated approach among all relevant stakeholders, governance and accountability mechanisms. It covers the One Stop Crisis Centre (OSCC) that is integrated into the Jigme Dorji Wangchuck National Referral Hospital (JDWNR) in Thimphu.

Health care providers are expected to have an understanding of GBV core concepts, guiding principles and practices of confidentiality, informed consent/assent and mandatory reporting requirements for children and adolescents. OSCC providers are required to be familiar with and implement the National Guideline for Management of Victims of Intimate Partner Violence and Sexual Violence in Healthcare Settings that sets out standard operating procedures and standards of care for the interviewing, assessing, documenting, treating and reporting of GBV cases in healthcare settings. As well as providing these services and survivor-centered care at each stage, the OSCC has the responsibility to:

- Train health workers in dealing with GBV and create awareness;
- Conduct GBV awareness raising;
- Collaborate with Village Health Workers and Outreach Clinics to create awareness on GBV;
- Ensure signage for survivors to access OSCC.

This SoP appears to be strongly multisectoral, build in collaboration between medical, psychosocial, mental health, safety and legal support, and be survivor centered. It outlines special considerations for child and adolescent survivors. The OSCC guidance includes trauma-aware practices, including listening, empathizing, validating, and ensuring safety. There are detailed OSCC guidelines for 8 steps of survivor-centered care:

STEP 1: Preparing the survivor for an examination

STEP 2: Taking the history

STEP 3: Collecting forensic evidence

STEP 4: Performing a physical examination

STEP 5: Prescribing treatment

STEP 6: Psychological first aid and counseling

STEP 7: Medical certificates

STEP 8: Follow up care

Detailed Reference Material On Standard Operating Procedures For One Stop Centre by the Ministry of Women and Child Development Government of India (2017)

The SoPs provide the ethical and professional principles as well as step-by-step guidance on providing appropriate services to the survivors who approach the Centre, either directly or through referral from other agencies such as the police, helplines, hospitals, Protection Officers, community level outreach workers etc. Following are the key functionaries of the OSC who are covered in the SoPs: center administrator, case worker, health worker/doctor, police facilitation officer OSC lawyer prosecutor.

National Guidelines For Provision Of Services For Physical And Sexual Violence: Chikwanekwane One Stop

Centers by the Republic of Malawi (2014) - SoP attached

After introducing the One Stop Centers chapters 2, 3, and 4 explain the intersection between medical, legal and social welfare, and the principles which guide the design of one stop centers, including the roles and responsibilities and standard operating procedures for each of the multidisciplinary team members. Included in this are referral mechanisms so that police investigators, prosecutors, social welfare, and hospital staff all become involved when a survivor is registered at any one of the individual, outside offices. Review meetings and linkages are held amongst key stakeholders periodically to discuss progress and address any gaps in the provision of services. Linkages to NGOs and faith based organizations further ensure that psychosocial services are provided to survivors of abuse. Several sections can be printed as stand-alone documents, including: the best practices' roles and responsibilities for law enforcement, medical and mental health, and social welfare; and the referral protocol for one stop centers.

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The GBV AoR Help Desk

The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

The GBV AoR Helpdesk

You can contact the GBV AoR Helpdesk by emailing us at:
enquiries@gbviehelpdesk.org.uk

The Helpdesk is available 09.00 to 17.30 GMT Monday to Friday.

Our services are free and confidential.