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A GBV Resource Center in Uganda. Photo by: Wgefund

SELECT GENDER-BASED VIOLENCE LITERATURE REVIEWS

THE EFFECTIVENESS OF ONE-STOP GBV RESOURCE CENTERS

Prepared under Contract No.: GS-10F-0033M / 7200AA18M00016, Tasking N008

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(OCTOBER 2020)

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ACRONYMS

CEDAW	Convention on the Elimination of All Forms of Discrimination Against
CONAVIM	National Commission to Prevent and Eradicate Violence against Women
CRV	Center for Rape Victims
ER	Emergency Room
GBV	Gender-Based Violence
IDB	Inter-American Development Bank
OAG	Office of the Attorney General
OASG	Office of the State Attorney General
OSC	One-Stop Center
PEP	Post-Exposure Prophylaxis
SEGOB	Secretariat of the Interior
SESNSP	Executive Secretary of National Public Security System
SGBV	Sexual and Gender-Based Violence
SOS	Safe on Seven
STI	Sexually Transmitted Infection
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAWA	Violence against Women Act
WJC	Women's Justice Centers
WJCH	Women's Justice Center Hildago

EXECUTIVE SUMMARY

This United States Agency for International Development (USAID)-supported literature review is one of a series of 11 literature reviews contributing to Agency efforts to better understand gender-based violence (GBV) and its impact on the empowerment of girls and women. The literature reviews include peer-reviewed and gray literature on various issues related to GBV, synthesize evidence on contextual factors, and identify promising practices that address GBV around the globe. The current literature review addresses: How effective are one-stop GBV centers?

Though GBV is a global phenomenon, according to the World Health Organization, rates are significantly higher in developing countries, ranging as low as 20% to 25% in the United States and Western Europe and nearing 40% in parts of the Middle East and Africa. High rates of GBV are often concurrent with low rates of literacy, high rates of child marriage, and low rates of women's labor force participation. It can be argued that intervention and prevention of GBV is critical to continued economic development in underdeveloped regions of the world.[1] To this end, practitioners, policymakers and researchers look to a number of measures to tackle GBV. One-stop GBV resource centers or one-stop service centers (OSCs) are an increasingly common strategy for addressing GBV through the provision of a variety of integrated services, such as health, psychosocial, legal and police support for victims and survivors of GBV. This report surveys the current literature on the performance of GBV OSCs.

The review considers, in order, the purpose of OSCs, OSC models and funding approaches, how well OSCs perform, as well as the challenges centers face in providing services to GBV victims and survivors. Results are summarized below.

KEY FINDINGS

- Our review of OSCs in 20 countries and meta-analyses of OSCs in more than 80, revealed widespread agreement that OSCs make a difference in the communities where they are located. In hospital or medical clinic settings, victim/survivors of GBV are able to receive much-needed medical attention to address acute injury and exposure to diseases, most notably STIs and HIV.

- OSCs located in WJCs are quite successful in creating access to legal pathways for victim/survivors to pursue justice.

- Despite OSC successes studies and analyses show divides in results reflecting divergent outcomes in countries of differing income levels. Not only do high-income countries have somewhat lower rates of GBV to begin with, but the OSCs in high-income countries are, overall, more successful than those in low-income countries.

[1] This analysis is based on research and evaluations conducted in 20 countries, including: Bangladesh, Benin, Democratic Republic of Congo, El Salvador, Ghana, India, Kenya, Malawi, Malaysia, Mexico, Morocco, Rwanda, Somalia, South Africa, South Sudan, United States, Thailand, West Bank/Gaza, Zambia, and Zimbabwe.

RECOMMENDATIONS

The review offers a set of recommendations to strengthen the impact of OSCs.

- *Increased funding.* The number one recommendation is to increase funding for all OSC-related services. Increased funding will allow existing OSCs to fulfill their missions and create the opportunity for scalability.

- *Address infrastructure and access.* In rural communities across the globe, from the United States to Thailand to Zambia, access to OSCs is limited to those who live in or can easily travel to urban areas. Improvements in infrastructure, including telehealth, will increase the centers' reach. If OSCs, particularly those in hospitals or medical clinics, could purchase telehealth equipment, and if staff in both the OSC and in rural community clinics were trained to use telehealth systems, many of the most successful services could be delivered to rural communities.

- *Develop clear processes to maintain confidentiality.* Staff working in OSCs in nearly every country for which we reviewed data identified confidentiality as one of their consistent problems. OSCs, therefore, need to develop clear guidelines to protect the confidentiality of victim/survivors while offering them the opportunity to file an official report later if they chose not to do so immediately. Additionally, OSCs with multi-sector partners may need to develop memoranda of understanding to clarify which agencies and persons therein have access to particular information. This will go a long way to ensure that victim/survivors experience the OSC as a safe environment.

- *Address GBV as a "gender issue."* Research indicates when organizations and their staff do not view incidences of sexual violence as central to their mission and/or jobs, staff are more reluctant to do the work involved in reporting rape or sexual violence; and institutions do not invest in, and may even sabotage, individual efforts to address rape in their organizations. Moreover, when professionals are reluctant to handle or process rape cases, victims of rape/sexual violence rarely get the services and support they need to recover.

- *Address the issues that underlie GBV.* Despite a plethora of research identifying gender inequality as a root cause of GBV, even the most successful OSCs were not able to affect the issues underlying GBV, such as literacy, education, employment opportunities, representation in politics and government, or reductions in cultural practices like genital cutting or child marriage. In order to truly reduce GBV, funding must be directed toward a multi-sector approach that includes education, employment opportunities, laws banning child marriage and genital cutting, and any and all programs that shift deeply embedded cultural norms around gender and gender relations.

A two-page summary for this Literature Review can be found at: https://pdf.usaid.gov/pdf_docs/PA00XM36.pdf.

INTRODUCTION

Gender-based violence, including sexual and intimate partner violence and child sexual abuse, remains a significant threat to women and children globally. Gender-based violence, or GBV, has significant and negative health outcomes for victims, including physical, emotional, and sexual injury; unwanted pregnancy; and exposure to sexually transmitted infections (STIs). Though GBV is a global phenomenon, according to the World Health Organization, rates are significantly higher in developing countries, ranging as low as 20% to 25% in the United States and Western Europe and nearing 40% in parts of the Middle East and Africa. High rates of GBV are often concurrent with low rates of literacy, high rates of child marriage, and low rates of women's labor force participation. It can be argued that prevention of GBV is critical to continued economic development in underdeveloped regions of the world.[2] To this end, practitioners, policymakers and researchers look to a number of strategies for addressing GBV. One-stop GBV resource centers or one-stop service centers (OSCs) are an increasingly common strategy for addressing GBV through the provision of a variety of integrated services, such as health, psychosocial, legal and police support for victims and survivors of GBV. With this in mind, this report surveys the current literature on the performance of GBV OSCs. The report considers, in order, the purpose of OSCs, OSC models and funding approaches, the successes of OSCs as they are currently implemented, and the challenges centers face in servicing GBV victims and survivors. We conclude with a set of recommendations.

This report is based on analyzing research conducted in the Americas (excluding the United States and Canada), South Asia, and Africa. Analysis relied on reviewing the findings of research reports, organizational reports, and scholarly articles that were published in peer-reviewed journals. We reviewed data on OSCs in 20 countries on five continents, and reviewed published meta-analyses that include data from more than 80 countries. As we will document in this report, one of the main challenges to assessing the impact of OSCs in addressing GBV is the lack of methodologically sound research. The vast majority of data on OSCs is based on anecdotal data, limited samples, and a research design that fails to define measures of success. In the recommendations section we will offer suggestions for how to effectively assess OSCs, gauge their impact, and provide funders the kind of data they need to consider future investment.

THE PREVALENCE OF GENDER-BASED VIOLENCE

USAID's Strategy to Prevent and Respond to Gender Based Violence Globally defines Gender Based Violence or GBV as:

> "...violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. Gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse;

[2] This analysis is based on research and evaluations conducted in 20 countries, including: Bangladesh, Benin, Democratic Republic of Congo, El Salvador, Ghana, India, Kenya, Malawi, Malaysia, Mexico, Morocco, Rwanda, Somalia, South Africa, South Sudan, United States, Thailand, West Bank/Gaza, Zambia, and Zimbabwe.

> neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting. Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control."

In addition to the immediate harm, GBV results in a series of negative health outcomes for women and children, including unwanted pregnancy, exposure to sexually transmitted infections (STIs) including HIV, sexual injury, premature birth, maternal mortality, birth injuries including fistulas, and a host of other negative health outcomes (Dunkle et al. 2004; Heiss et al. 2002). Gender-based violence is also associated with negative mental health outcomes, including depression, substance abuse, and suicide (Heiss et al. 2002). Kessler et al. (2017) analyzed survey data from more than 68,000 respondents suffering with PTSD in 24 countries that spanned high, medium and low income. Kessler and colleagues found that of traumas that were linked to PTSD, 14% of traumas that reported were either intimate partner violence or the witnessing of intimate partner violence, and, an additional 13% of the traumas reported were sexual violence. Among all trauma's that produced symptoms of PTSD, the only forms more common were car accidents and other acts of physical violence. The authors conclude that GBV is a *major* cause of PTSD globally.

Finally, it is well documented that GBV coexists as both a cause and a consequence of other forms of gender inequality, including illiteracy (UNESCO 2014), low rates of employment, child marriage, lack of representation in government, etc. (World Bank 2019).

Globally, rates of gender-based violence vary significantly, although women in all countries and regions of the world experience sexual violence, street harassment, intimate partner violence, stalking, and femicide at rates that are deeply concerning. In the United States, intimate partner violence homicide is now the leading cause of death for women (Petrosky, et. al. 2017). And, though global statistics on intimate partner violence homicide are not available or reported on a country by country basis, we can speculate with great confidence that rates are lower in post-industrial economies and higher in the developing world. No status can protect women and children from GBV. That said, structural and cultural conditions, including educational attainment, literacy rates, employment rates, representation in government, religious doctrine, and male dominance in society are all correlated with GBV rates. In short, regions with low gender equality have higher rates of GBV (see Figure 1, below).

Figure 1. World Health Organization Statistics for GBV

The UN Global Database on Violence Against Women (https://evaw-global-database.unwomen.org/en/countries) provides data on a variety of forms of GBV by country. The data reported in the UN database come from a variety of official sources, including the most recent observations of the Committee on the Elimination of Discrimination Against Women (CEDAW) reported to the United Nations. There are several challenges to using the database that make providing a country by country analysis significantly more difficult than the "regional" variation represented in the previous figure. First, the database is not organized in such a way as to be able to rank order individual countries with the highest to the lowest rates of GBV or by individual forms of GBV such as child marriage, femicide or lifetime risk for IPV. Second, the UN database does not include a regional designation for North Africa and the Middle East (MENA). Countries like Afghanistan and Iran are included in the "Asian" region, whereas countries like Egypt and Morocco are included in the "African"

region. One of the primary data challenges when evaluating the impact of prevention and intervention programs by country and region is the fact that there are no OSCs in the MENA region. Therefore, the assessment of the impact of OSCs on prevention and intervention on GBV will be limited to global south regions of the Americas, Africa, and South Asia.

ONE-STOP CENTERS

Beginning in the early 2000s, One-Stop-Centers emerged as an innovative model for addressing Gender Based Violence in developing countries of the global south. At their inception there was much enthusiasm that OSCs would have an impact on GBV, at both the intervention and prevention levels.

This report explores the impact of OSCs in the global south as reported in research literature and policy reports. In short, as we will demonstrate, overall there is a lack of data from which to draw conclusions. What this review will do is analyze the impact of OSCs as it is reported, note the challenges that have been identified, synthesize the relationships between funding strategies and implementations of OSCs, identify methodological challenges, and make recommendations for both analyzing and better implementing OSCs globally.

OSCs have been established across several continents in the global south, including Mexico, Central and South America, Africa, South Asia, and Eastern Europe, where rates of GBV are the highest world-wide. As is well documented, survivors of GBV face a myriad of immediate, short term and long term impacts from their experiences with and exposure to violence. They may need immediate medical care, they may need ongoing medical care as a result of unwanted pregnancy or exposure to HIV, they often need immediate, safe housing, assistance in seeking legal remedies, and long-terms strategies for economic independence. Thus, One-Stop Centers (OSCs) were developed as a holistic and multi-sector approach to reduce the prevalence of GBV and provide wrap-around intervention services to address the medical, psychosocial, and legal impact of GBV on individual survivors and strengthen communities. OSCs are designed to simultaneously address a shared set of goals while being individually tailored so as to address context specific factors.

First, OSCs should truly provide “one-stop service provision” for women and children experiencing GBV. A survivor should be able to access medical services for physical injuries, mental health services for psychological issues (including trauma), law enforcement and legal services, and shelter services. Second, in order to address all of the needs of survivors, OSCs should use a coordinated, multi-sector approach rather than re-creating each of the services independently. Third, in an ideal implementation, OSCs should be positioned to play a pivotal role in collaboration with other organizations in the overall set of strategies designed to address co-variate inequalities, such as literacy, child marriage, and women’s employment as part of their comprehensive approach to reducing GBV. Finally, OSCs should be sustainable, scalable, and portable to multiple sites in the same country and/or region, depending on the overall similarities or differences in rural/urban, economic development, war, immigration, ethnic and religious diversity and so on. The development of the Thutuzela Care Centers (TCCs) in South Africa is one example of such an approach. To date, 51 TCCs have been established across the country.

OSC MODELS

OSCs are organized around the principle that multi-disciplinary approaches are the most effective strategies for intervention and, to a lesser extent, prevention of GBV. These centers are typically organized in one of three ways, depending upon their funding sources: (1) government owned centers, (2) centers that are co-funded by the national, regional or local government in partnership with an NGO, and (3) centers that are operated and funded entirely by an NGO. In addition, centers can be organized as "integrated" with all services under one roof or they can be organized as a "system" of either formal or informal networks.

SERVICE DELIVERY MODES

The *integrated model* houses all resources and provides all services under "one roof" by focusing on cross-training the service providers. For example, in many OSCs in hospitals, the ER nurse is trained to screen for intimate partner violence, counsel the patients, and refer them to external resources. The advantages to this model are all related to efficiency: it is the least expensive model to implement, does not rely on multiple stakeholder buy-in, and theoretically can be implemented in multiple locations, which is one form of scalability. For example, a central hospital in a city like Nairobi could offer provider training to dozens of nurses, who are then deployed back to rural health clinics where they can respond to sexual and intimate partner violence in those communities.

The challenges associated with the provider model include sustainability and impact. Because the model relies on training individuals, when a practitioner decides to retire or change her profession, the investments in human capital 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 neither, will not. OSCs in South Africa and Zambia are an example of this type of resource integration.

The *system model* involves "systems-level integration," namely a referral system among facilities including shelters and mental and behavioral health services. The benefits to this approach are many, including the potential to meet all of the needs of a GBV survivor. We reviewed several OSCs organized via the system approach in Europe, Canada, and the United States; however, none of the OSCs for which we could find data in low-income countries was organized at the systems level. As we will address below, this may be the result of the relatively high cost of such comprehensive OSCs.

An example of the system model can be found at an OSC in North Carolina called "Safe on Seven: Forsyth County Domestic Violence Center" (SOS) on the seventh floor of the county courthouse (Hattery and Smith 2020). SOS is a multi-agency service center for victims of domestic violence. The center, in Winston-Salem, North Carolina, provides a "one-stop shop" by bringing together key service providers such as law enforcement, victim advocates, legal advocates, and social services. Clients of the center are able to obtain legal advice, advocacy, referrals, and protective orders as well as information concerning their court cases. Previously, victims had to seek out services at multiple locations throughout the community. The center helps minimize the difficulties victims face as they navigate the legal system, and above all focuses on victim safety and offender accountability. On-site partners include the District Attorney's Office, Family Services, Clerk of Court, the Forsyth County Sheriff's Office, Legal Aid of North Carolina, the Department of Social Services, the Winston-Salem Police Department, and the Winston-Salem State University Center for Community Safety.

Among the many challenges of this approach, foremost are costs. The systems model requires multiple facilities near the OSC. Even when all of the facilities exist in the same community, OSC designers must be committed to use the various facilities to meet client needs, and invest in stakeholder buy-in. Very few cities in the developing world have the resources to implement OSCs using the systems approach. This raises a corollary challenge: how to expand a system-approach center to reach people across an entire country or region.

Though there were no examples of full-blown systems models in the global south, there were many OSCs that relied on a set of external networks to provide services they could not provide. For example, in Mexico, clients arriving at the OSC in Hidalgo who required immediate medical attention were transported to the local hospital or clinic (Cervantes and Lopez 2018). Similarly, in Kenya and Zambia, patients arriving at a hospital based OSC who were in need of a shelter were connected with local churches who provided these resources (Keesbury et. al. 2012).

TYPES OF INSTITUTIONS: HOSPITALS VERSUS JUSTICE / WOMEN'S CENTERS

In all of the research reviewed, with no exception, there are two primary types of institutions that have implemented OSCs: medical or health facilities, and justice or women's centers. The most common OSCs we reviewed provided services using an integrated model, where all of the needs of the survivor were met within one facility. One of the most common models was a hospital that offered integrated services. For example, a hospital or clinic provided medical care as well as psychosocial and legal support by relying on an integrated network of psychologists, social workers, and volunteers, all of whom had office space and could see patients and clients in the hospital or clinic. Hospital based, integrated OSCs can be found on nearly every continent, in a vast array of countries including in Thailand, across Africa, including in Zambia, Tanzania, Kenya, the Democratic Republic of Congo, and South Africa, and in Latin America as well.

As noted by Garcia and colleagues, who conducted an in-depth case study of OSCs in health-care systems in four European and Latin American countries, health-care sites are often selected to host OSCs for a variety of reasons. First, women who experience either sexual or intimate partner violence are more likely to seek health care, including treatment for physical injuries and mental-health services, than women without abuse histories. Second, all countries have clinics or hospitals where OSCs can be placed. Third, GBV survivors often most immediately need medical care, so locating OSCs in hospitals can bring a variety of interventions to survivors at their first point of contact. Finally, as public-health scholars have argued, GBV is indeed a public-health epidemic (Gupta and Falb 2017). Thus health-care facilities have a major role to play in GBV intervention.

OSCs located in medical or health settings were, not surprisingly, better at delivering medical and mental-health care than at meeting the psychosocial and safety needs of GBV survivors. In their comprehensive 2015 review of GBV interventions, Ellsberg and colleagues confirm, "Most one-stop centres provide services for both intimate partner violence and sexual violence. However, in much of sub-Saharan Africa, the demand for sexual-assault services and access to post-exposure prophylaxis to prevent HIV infection after rape has spurred the creation of post-rape care centres in many hospitals, which are not necessarily linked with services for intimate partner violence."

In addition to the challenges Ellsberg and colleagues (2015) identify, other research suggests that even in sub-Saharan African countries where the rates of sexual violence and risk for STIs, including HIV, are

high and thus the demand for sexual and reproductive services is high, not all systems are able to meet that challenge, let alone provide interventions and support for the other negative health outcomes associated with GBV. For example, in the early 2000s, the Kenyan government's Division of Reproductive Health deployed a "horizontal" approach to providing post-rape care that focused on providing anti-STI medications and PEP (Post-Exposure Prophylaxis against HIV), and making rape kits available in the emergency rooms where survivors were most likely to seek initial assistance. In an evaluation of these measures, Kilonzo and colleagues (2009) identified several challenges to the horizontal approach. For example, despite the presence of anti-STI drugs and PEP, physicians were not allowed to prescribe them without approval from a government office that tracked the dispensing of drugs. OSCs in Kenya faced a challenge not often seen in the United States, but which is quite common in sub-Saharan Africa as well as countries in south Asia where child marriage is prevalent: the child victim. As noted by Kilonzo and colleagues (2009), the OSCs in Kenya were overwhelmed by the number of child victims, yet lacked sufficient staff with training in pediatrics.

Counselors were often confused about confidentiality when patients disclosing trauma also needed medical treatment. For example, if a teenager spoke with a counselor and reported that in addition to being raped she was also sexually active, the counselor was unsure how to obtain contraceptive and other reproductive treatments without breaking confidence. "Currently, the lack of a cadre of counselors in the Kenyan government system has hampered post-rape care. Many health-care workers end up doing HIV testing and also trauma counselling in addition to their normal duties. This translates into provider stress attrition rates and inconsistent service delivery that challenge the investment in capacity building" (Kilonzo and colleagues 2009).

Garcia-Moreno and colleagues (2015) note that in contrast to health-based settings, police-based or justice centers were far more effective at addressing legal issues, but often were not that effective in connecting victim/survivors to health-care or mental-health providers.

In Latin American countries, the most common model for implementing OSCs is through law and justice centers or stand-alone women's centers. Women and girls living in Latin American countries experience extremely high rates of GBV. In Mexico, for instance, a survey conducted in 2006 revealed that almost half of women, 43.2%, experienced intimate partner violence during the course of their relationship (Cervantes and Lopez 2018).

Although there is a high prevalence of GBV in Latin America, the majority of Latin American countries have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Additionally, Latin American constitutions declare that access to justice is a fundamental human right and individual equality must be protected. As a result, government monies have been earmarked for Women's Justice Centers (WJC) throughout Latin America. As Cervantes and Lopez (2018) articulate, "The WJC is based on the Family Justice Center model of the United States, which developed from several government agencies and community organizations responsible for filing criminal complaints with affiliates of the Office of the Attorney General (OAG), in recognition of the need for a specialized service center for victims [of violence]. Services include providing access to attorneys and private investigators, as well as a health service for children. WJCs 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."

Cervantes and Lopez conducted a 2018 case study of the WJC in the Mexican states of Chihuahua and Hidalgo, where there are extraordinary rates of GBV. Women living there report physical abuse, emotional abuse (nearing 90%), economic abuse (nearing 50%) and sexual violence. The center there, 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. Cervantes and Lopez (2018) found that overall 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.

The WJCH faced two significant challenges. First, like many of the OSCs reviewed in this report, it is underfunded and cannot reach all of the women who need their services. Second, although the WJCH is built on a systems model, the center itself cannot have an impact on the larger systems it encompasses. So, for example, staff there noted that employees in the Office of the State Attorney General (OSAG) were not trained in "gender empowerment" and did not see GBV as a gendered issue requiring gendered solutions. In this case they attempted to train OSAG staff, but they did not have the capacity to train every person in every institution with which they interact (Gupta et al. 2017).

FUNDING OSCS: THREE MODELS

There are three funding models for OSCs: (1) Institution only, (2) public-NGO partnerships, and (3) NGO only, the most common of which are public-NGO partnerships. Examples of institution only OSCs involved hospitals, which were always publicly funded, that set up OSCs inside of the medical facility and didn't rely on any other governmental funding or any support from NGOs. The OSC we reviewed in Thailand was the only example of this. Similarly uncommon were stand-alone NGO-funded OSCs. We identified one of this type, an OSC in the DRC that was in a hospital but funded entirely by NGOs and private philanthropy primarily from Sweden. Public-NGO partnership OSCs were the most diverse in both geography--these were present in Mexico, in many countries in Africa, and South Asia---and focus, both hospital or health settings and law centers. Based on their research, Cervantes and Lopez (2018) note that although this model is the ideal, it relies on navigating complex political relationships and stakeholder buy-in. Specifically, the federal government and foreign-aid organizations provide all of the funding, but it is up to the Mexican states to open WJCs. They report that some state leaders denied the existence of GBV, and completely refused to set up WJCs.

We were interested in the relationship between the type of funding agencies and the focus of the OSC, health or law and justice. In some cases there was a clear relationship and in others a diversity of funding streams resulted in different facility types. For example, in Malawi, an OSC was established through a public-NGO partnership. Public funds came primarily from the Ministries of Health and Social Welfare and UNICEF and the OSC is located in a hospital that provides integrated care through a network of physicians, nurses, social workers, victim-support services, and volunteers. In contrast, the TCCs in South Africa, which are also located in hospitals, were funded through public-NGO partnerships that included the US Department of State and Department of Justice. In other words, though in some cases the funding agency priorities were in alignment with the location of the OSC, for example in Malawi, this was not always the case, as we see in South Africa.

FUNDING STRUCTURE	FUNDING PRIORITY AREA	
	HEALTH	JUSTICE
Institution Only	Hospital (Thailand)	N/A
Public-NGO Partnerships	Hospital (Kenya, Zambia) Tanzania (Malawi)	Justice Centers (Mexico) Hospitals (South Africa TCC)
NGO Only	DRC (Hospital)	N/A

As this chart indicates, despite the funding structure or priority, the vast majority of OSCs are hospital based. This is likely for a variety of reasons, but the most important is that hospitals already have the infrastructure and personnel which makes the location of an OSC in a hospital setting both more efficient and cheaper. In many of the OSCs we reviewed, the implementation of the OSC focused primarily on providing gender sensitive training to existing medical staff and expanding staff through paid and volunteer positions to provide the psychosocial and "victims-advocate" services. In contrast, the justice center approach typically involves purchasing or building a physical center and staffing it entirely from scratch. There are several other advantages to hospital-located OSCs which include the ability to provide other health and medical services, including, as they do in Kenya, PEP as well as reproductive health services, treat all related injury and illness, and provide psychiatric services. Additionally, because hospitals provide a range of services, there is less (if any) stigma attached to entering as a patient. This factor alone makes a strong case for locating OSCs in existing hospital facilities.

In contrast, the benefit to locating OSCs in justice centers, as we see in the WJC in Mexico, is that many non-medical services can be provided alongside of legal services, including employment training, literacy and feeding programs. In order to reduce or eliminate the stigma attached to visiting a facility like the WJCH, we recommend locating it in a building or suite that provides other services so that women seeking help are not as easily identified as survivors of GBV.

The Thuthuzela Care Centres in South Africa are often hailed as model programs in the fight against GBV. As noted in the chart, they are located in hospitals or care centers, but their funding comes from both the health sector and the US Department of Justice. This combination of funding may be the key that allows for combination or fully integrated model. According to UNICEF's website,[3] the TCCs offer a range of services to survivors, including:

- Comfort from a site coordinator or nurse.
- An explanation of how the medical examination will be conducted and what clothing might be taken for evidence.
- A consent form to sign that allows the doctor to conduct the medical examination.
- A nurse in the examination room.
- After the medical examination, have a bath or shower at the center.

[3] See, https://www.unicef.org/southafrica/protection_998.html

- An investigation officer will interview the survivor and take his/her statement.
- A social worker or nurse will offer counselling.
- A nurse arranges for follow-up visits, treatment and medication for Sexually Transmitted Infections (STIs), HIV and AIDS.
- A referral letter or appointment will be made for long-term counselling.
- The survivor is offered transportation home by an ambulance or the investigating officer.
- Arrangements for the survivor to go to a place of safety, if necessary.
- Consultations with a specialist prosecutor before the case goes to court.
- An explanation of the outcome of the trial process.

UNICEF also claims that the TCCs have been highly successful in not only meeting victim's needs, but also that the model has resulted in increased prosecution of perpetrators. They attribute this success to the fully integrated design of the TCCs. According to Advocate Majokweni, "At the heart of the success of the Thuthuzela approach is the professional medical and legal interface and a high degree of cooperation between victim and service providers from reporting through investigation and prosecution of the crime, leading up to conviction of the offender."

SUCCESSES: DO OSCS MAKE A DIFFERENCE?

SERVING THE SURVIVOR

At hospital and medical sites in both Africa and South Asia, the presence of an OSC meant that women and girls received medical care needed to address injuries and illnesses related to GBV, including emergency contraception, antibiotics and other drugs to fight STIs, PEP to prevent HIV seroconversion, and even surgeries to repair fistulas that resulted from sexual trauma, teenage birth, or female genital mutilation practices. In Thailand and Kenya, the hospital-embedded OSC model offered the possibility of delivering much-needed mental-health services to survivors, but the OSCs were usually understaffed and unable to provide all of these services. Although hospital and medical OSCs were not always able to fulfill the needs of those seeking services, patients who were surveyed or interviewed about their experiences in multiple OSCs in different countries reported high levels of satisfaction with the staff and their treatment. For example, "When asked whether they thought the STOP GBV Programme [Zambia] was beneficial to their communities, male respondents responded positively , with 71.4% saying it was beneficial because it provided information on GBV, 22% because it supported GBV survivors and about 7% because it provided shelter/safe homes" (Samuels et al. 2015).

The results from evaluations of WJCs in Latin America were similarly positive. Of the reports analyzed here, victims reported that they found the OSC staff to be supportive and attentive to their needs. Because the WJCs' holistic approach also encompasses access to the justice system, many of the evaluations focused on criminal-justice outcomes rather than medical and mental-health outcomes. For example, a study in El Salvador revealed that of 99 victims who used the WJC, 97 had their cases

referred to court. In the evaluation of the WJC in Hidalgo, Cervantes and Lopez (2018) noted that one of the program's successes is the ability to transfer cases from the center to an intermediate court, thus giving women greater access to the court system and legal remedies. Despite the shortcomings of OSCs, every report, including meta-analyses, showcased that women and communities reported that they believed they were safer as a result of having an OSC in the local hospital, medical clinic, or WJC.

RAISING AWARENESS AND PROVIDING EDUCATION

In contrast to the satisfaction that survivors reported as a result of seeking services from an OSC, the data are mixed when it comes to the success of prevention through education and raising awareness about GBV. Research on OSCs reveals that educational training with health care workers raised their level of gender sensitivity and this impacted their ability to assist patients in "naming" the violence and agreeing to and in fact seeking interventions (Moreno et al. 2015). That being said, many of the OSCs we reviewed indicated, as we demonstrate below, that there remains a great need for more expansive staff training. Additionally, as the research of Ellsberg et al. (2015) reveals, there is no evidence that prevention education and attempts to raise awareness tricked out into the broader communities in which the OSCs were located. They note that the primary mechanisms for increasing awareness took place in programs specifically designed for that purpose, including in school-based programs, and not in OSCs.

Our review revealed four main challenges faced by OSCs: lack of resources, lack of access/differential access, training in gender-sensitive approaches and barriers to integration.

CHALLENGES FOR OSCS

LACK OF RESOURCES

A consistent challenge noted in the reviewed reports and meta-analyses was limited resources. The most commonly cited resource challenge was human capital. Despite infusions of capital from international aid organizations, national governments, and philanthropists, more services can be provided to more people when more resources are allocated. That being said, the different types of OSCs faced different challenges to service delivery.

Hospital-based OSCs were able to meet the medical needs of the patients seeking services, but often had difficulty meeting their psychosocial needs and providing trauma-informed law enforcement. For example, in hospital based OSCs in Kenya there were too few trained trauma-informed counselors to address the mental-health concerns of patients seeking treatment in the local emergency room (Kilonzo et. al. 2009). In Thailand, nurses trained in trauma-informed diagnosis were unable to refer patients because psychological services simply didn't exist (Grisurapong 2002). In Kenya, despite the ability of nurses to collect forensic evidence, they stopped collecting this evidence, critical to rape and intimate partner violence legal cases, because of "weak linkages" between the hospital and the police (Keesbury et. al. 2012: 12-13).

In contrast, stand-alone NGO OSCs, whether clinic based or legal based faced significant challenges in the delivery of medical care. In Zambia, "The stand-alone, NGO-owned model and the health facility-based, NGO-owned model...were not set up with the adequate infrastructure and relevant staff to offer

SGBV [sexual assault GBV] related health care services to survivors. The facility inventory data further revealed that these two OSC models were lacking in essential equipment and supplies required for a range of SGBV related clinical services. For instance, the OSCs did not have EC, analgesia, HIV rapid test kits, and PEP drugs (Keesbury 2012:13).

In Hidalgo, Mexico, the OSC that offered shelter services and computer training was bursting at the seams, able to serve only 10% of the women and children who needed their services (Cervantes and Lopez 2018).

LACK OF ACCESS / DIFFERENTIAL ACCESS

One of the most common problems in low-income countries — Zambia, Thailand, Kenya, Mexico, and the Democratic Republic of Congo — was insufficient infrastructure to deliver survivors to service providers. Because OSCs were typically located in areas with higher population density, and in pre-existing institutions like hospitals where OSCs could be deployed quickly, they were often inaccessible for the majority of the population who lived in rural, isolated areas where rates of GBV are equally high (Mcilwaine 2013).

As Mcilwaine's research points out, (2008; 2013), in developing countries, women face differential threats to their safety and experience different forms of GBV at different rates. In urban communities, women are more likely to be the victims of sexual violence by strangers, whereas in rural communities they are more likely to be victims of partner violence, which may be physical, but also sexual abuse, forced pregnancy, genital cutting and child marriage.

Differential risks for various forms of GBV coupled with the clustering of OSCs in urban communities shapes the types of services delivered and the types of survivors served. As we will discuss at greater length in the recommendations section, careful consideration should be given to the type of OSCs located in rural versus urban communities.

Table 1. Proportion of adult women experiencing physical and/or sexual violence by intimate partner or non-partner by rural/urban residence

COUNTRY	PERCENTAGE OF ADULT WOMEN EVER EXPERIENCED PHYSICAL AND/OR SEXUAL VIOLENCE BY *INTIMATE PARTNER*		PERCENTAGE OF ADULT WOMEN EVER EXPERIENCED PHYSICAL AND/OR SEXUAL VIOLENCE BY *NON-PARTNER*	
	RURAL	URBAN	RURAL	URBAN
Bangladesh	62	-	10	-
Brazil	37	29	23	40
Ethiopia	71	-	5	-
Namibia	-	36	-	23
Peru	69	51	18	31
Tanzania	56	41	19	34
Thailand	47	41	14	20

Source: Adapted from WHO (2005), *Multi-country Study on Women's Health and Domestic Violence against Women*, World Health Organization, Geneva, Pages 6-13; also McIlwaine, C (2008), "Gender- and age-based violence", in V Desai and R B Potter (editors), *The Campanion to Development Studies* (second edition), Arnold, London, pages 446-447.

LACK OF TRAINING IN GENDER-SENSITIVE APPROACHES

The degree to which staff in OSCs are trained in gender-sensitive and trauma-informed practices is largely determined by the type of OSC and its purpose. Many program evaluations of hospital based OSCs revealed that gender-sensitive, trauma-informed training was limited to nurses. Professionals to whom referrals were made, both internal to the OSCs and external to community partners, especially law enforcement and the courts, either did not receive gender-sensitive or trauma informed training or they were unable or unwilling to implement policies and practices designed to protect survivors and facilitate prosecution of perpetrators.

For example, as Arnoff and colleagues (2015:12) note, even in the landscape of South Africa, with GBV laws in place, and multiple TCCs, challenges in the criminal justice system remained. "Despite these important pieces of legislation, the legal infrastructure designed to respond to the high volume of domestic and sexual violence cases is lacking in South Africa. The vast majority of cases of GBV are not tried effectively within the legal system. In 2000, only 16.8% of rape cases were referred to court, and of those, half of the rape cases were seen through final stages. A guilty verdict was achieved in 7.7% of all reported rape cases. In a national audit of 56 courts across the country, it was found that 18 of the 56 courts audited dealt with sexual assaults only among adults and children, and 25 courts had specialist prosecutors in place. The infrastructure of the audited courts were lacking in facilities to assist with the processing of cases, such as including separate toilets for survivors. Only 22 courts had separate consultation rooms, and 21 courts had separate waiting spaces for survivors. The time that it takes to prosecute cases of GBV through the court system is notoriously long, dissuading many survivors from pursuing legal action." Keesbury et al. (2012) report similar challenges in Kenya and Zambia.

Justice based OSCs, like those throughout Mexico (Cervantes and Lopez 2018) were specifically designed, and therefore were better able, to deliver services in a way that created spaces where survivors felt supported and safe. Women who visited OSCs noted that it was precisely gender sensitivity that shaped the positive experience they had. At WJCH in Hidalgo: "The initial point of contact of WJCH users is typically the police officer located at its entrance who usually questions the reason for their visit, whether they have a scheduled appointment, or whether they are there to take advantage of its services. *Users have stated they were always treated politely and with respect*" [emphasis ours] (Cervantes and Lopez 2018: 30).

A woman who visited the OSC in Ramallah, the West Bank, noted: "The moment I entered the centre, I knew I was safe," said Maya Saeed [not her real name], a 25-year-old woman who frequently comes to the centre. With the legal support she received at the center, she recently filed a complaint against her abusive husband. "I feel empowered as I can show him that I have police and lawyer backing me up, and also a place to stay," she continued. "I have many friends who are in the same situation as me…now that I know there is a place you can trust, I will encourage my friends not to stay silent and come here and get help." (UN Women 2017)

One of the advantages of developing OSCs through a multi-sector approach is that such a resource-sharing model takes advantage of existing resources and coordinates them. This is much more efficient than developing entirely new services such as special law enforcement units, medical facilities, employment training programs, etc. This approach to addressing GBV is not without its challenges, however. "Partners" who are pulled in to multi-sector response models may have little training around and/or commitment to addressing GBV. For example, in her definitive investigation of organizations and professions that manage rape cases, Martin (2005) details many of the processes that organizations employ, which often result in individual and collective resentment of the job. Martin's research focuses on U.S. institutions charged with handling some aspect of a rape incident: law enforcement (police officers and sheriffs), the judicial system (prosecutors and judges), hospital emergency rooms, and rape crisis centers. Many of these institutions, with the exception of rape crisis centers, have larger missions and, at best, see rape as tangential to, and at worst a distraction from, their "real work." As law-enforcement agents poignantly note, "We're responsible for all crime and rape is only one crime" (Martin 2005: 53). Hospitals, which Martin terms "reluctant partners," may believe the requirement to perform a forensic rape examination competes directly with their real mission—to heal the sick and wounded. From the perspective of hospitals and their staff, a rape kit is a legal exam, not a medical exam; in many cases, they will do anything they can to avoid performing it. "We have one doctor…he will see a child with a cold before a rape victim" (Martin 2005: 74).

LIMITATIONS TO INTEGRATION

In addition to the challenges of providing gender-sensitive, trauma-informed services to survivors of GBV, Keesbury and colleagues (2012) also note that OSCs that rely heavily on integration with other stakeholders face challenges with the stability and reliability of those stakeholders on whom they depend. In Zambia and Kenya "Proponents of the ideal OSC argued that although the health facility-based, hospital-owned OSCs excelled in the provision of clinical and psychosocial services, linkages to the legal and justice system for purposes of achieving OSC anticipated outcomes remain weak. The weak linkage was attributed to poor coordination among stakeholders and unsustainable funding (e.g., for personnel). Stakeholders argued that without an integrated system, most clients will continue to

receive clinical and psychosocial support, but those interested in taking legal action will never realize justice. Stakeholders in the health sector also felt that medical, legal and psychosocial services should be provided in one physical location. An informant stated '*We need a laboratory, a medical room, and so on. We need a medical practitioner for gender issues (GBV). We need a shelter for survivors, we need a police desk and a lawyer stationed there.*'" (Keesbury, et. al. 2012: 22-23)

Based on this review, we raise one critical question: are any of the OSCs we reviewed actually meeting the definition of an OSC, a facility offering integrated services and providing holistic responses to GBV? Or, in fact, is it the case that hospital based OSCs are generally meeting the medical, health and psychosocial needs of survivors but they are not able to adequately address their legal and safety concerns. In contrast, justice centers are able better positioned to meet the psychosocial, legal and safety needs of survivors, but rely on a network of medical providers to meet their health needs, which may not be done in a gender sensitive or trauma-informed manner. Based on our extensive review, neither model as currently implemented is able to function as a stand-alone center positioned to address the needs of women and children experiencing GBV.

CONCLUSIONS

OSCs offer a critically important set of strategies for addressing GBV globally. Our review of OSCs in 20 countries and meta-analyses of OSCs in more than 80 revealed widespread agreement that OSCs make a difference in the communities where they are located. In hospital or medical clinic settings, survivors of GBV are able to receive much-needed medical attention to address acute injury and exposure to diseases, most notably STIs and HIV. Many such OSCs also have psychologists, counselors and other mental health providers on staff who are able to support survivors dealing with the emotional and psychological impact of violence. Where no psychological or mental health staff is on site, clients are referred to other units or facilities.

OSCs located in WJCs are quite successful in creating access to legal pathways for survivors to pursue justice. In addition to on-site courtrooms and access to emergency orders of protection, many WJCs are designed to provide temporary housing, job training, and networking events that often led to employment opportunities, including the creation of co-ops that allow victim/survivors to pursue economic self-sufficiency.

RECOMMENDATIONS

Though certainly not a comprehensive list, this review offers a set of recommendations to strengthen the impact of OSCs.

- *Increase research on effectiveness.* As the research we have reviewed in this report documents, the data on the effectiveness in meeting the goals of OSCs is lacking. There is no definition of success or any articulated let alone agreed upon performance metrics or benchmarks. Experts agree that GBV must be addressed more effectively in the global south and developing world where rates of GBV are the highest in the world and the OSC model is compelling. That being said, the data on "success," much of it cited in this report, are based on anecdotal data or amount to *measures of use, rather than measures of impact*. Future funding requests for OSCs must include budget lines for time and materials necessary to conduct program evaluation. And funders, including USAID and others are

encouraged to operationalize the missions of OSCs as well as develop metrics and benchmarks against which outcomes can be measured.

- *Consider integrated funding models*. Though there remains a need to fully assess the impact of the TCCs, and their structure may not be entirely portable to other countries, the data that do exist provide the strongest evidence of impact at the intersection of medical and psychosocial needs as well as legal remedies for GBV. Interestingly, the TCC model is very similar to the Safe on Seven model in the US that was highlighted in the report. We recommend that more research be done on the impact of the TCCs, and that if the data confirm that their success is a result of their integrated funding, dual missions, and structure, that future proposals from the global south be encouraged to consider such a model.

  Increase funding. Despite a lack of data on the overall impact of OSC services for survivors, it is clear that survivors who utilize OSCs are receiving valuable interventions, including medical care, testing and treatment for STIs and HIV exposure, and psychosocial support. At WJCs they are receiving much needed shelter, employment training, and support as they navigate the legal system. Increased funding will allow existing OSCs to fulfill their missions--either medical or justice-- and create the opportunity for country or region-wide scalability. One way to achieve scalability would be a milestone approach. Begin by funding limited services in a hospital, for example, nurses offering GBV services in an emergency room. As the success of implementation grows, further investments can be directed toward the facility transforming it into a full-blown integrated OSC with a wide range of services provided under one roof. This would significantly enhance the OSC's ability to serve more survivors and a wider variety of their needs. Finally, once a set of OSC is well-developed in a particular country, investments can create a truly multi-sector approach by linking multiple facilities together in a system that addresses the entire range of needs that GBV survivors seek: physical injury, mental health, access to legal services, safe housing, employment training, and so forth.

- *Address infrastructure and access.* In rural communities across the globe, from the United States to Thailand to Zambia, access to OSCs is limited to those who live in or can easily travel to urban areas. Improvements in infrastructure, including telehealth, will increase the centers' reach. If OSCs, particularly those in hospitals or medical clinics, could purchase telehealth equipment, and if staff in both the OSC and in rural community clinics were trained to use telehealth systems, many of the most successful services could be delivered to rural communities. This could include treatment of physical injuries and possibly diagnosis and treatment of disease, as well as mental health services.

  Based on Mcilwaine's (2008; 2013) work, we recommend that careful consideration be given to geographic variations. For example, given that the greatest threat to women's safety in urban areas is sexual assault by a stranger, OSCs in urban communities should be configured to provide treatment for acute physical, sexual and psychological trauma as well as court advocacy. In rural areas, where women are much more likely to experience violence in their intimate partner relationships, OSCs should be configured to provide treatment for chronic physical, sexual and psychological trauma, legal advocacy for pursuing a divorce, safe houses or shelters for transition, and employment training. By better understanding the needs of survivors of GBV in different contexts, not just national or cultural, but also geographic, appropriate services can be developed in existing and new OSCs.

- *Develop clear processes to maintain confidentiality.* Staff working in OSCs in nearly every country for which we reviewed data identified confidentiality as one of their consistent problems. ER nurses who

were treating physical injuries that resulted from GBV faced challenges when law enforcement agents asked them to interview a survivor, for example, especially if the patient was a minor. OSCs need to develop clear guidelines to protect the confidentiality of victim/survivors while offering them the opportunity to file an official report later if they choose not to do so immediately. Additionally, OSCs with multi-sector partners may need to develop memoranda of understanding to clarify which agencies and persons therein have access to particular information. This will go a long way to ensure that survivors experience the OSC as a safe environment.

- *Require gender-sensitive and trauma informed training.* As Martin's research (2005) reveals, when organizations and their staff do not view incidences of sexual violence as central to their mission and/or jobs, staff are more reluctant to do the work involved in reporting rape or sexual violence; and institutions do not invest in, and may even sabotage, individual efforts to address rape in their organizations. Additionally, as Martin further points out, when professionals are reluctant to handle or process rape cases, victims of rape/sexual violence rarely get the services and support they need to recover. Gender sensitive and trauma-informed training should be required of all OSCs that are funded. Proposals should include budgeting for providing initial training to all staff and network partners, evaluating the impact of the training, and developing and implementing recurring training on a cycle as indicated by best practices. The UN Women Training Centre Report, published in 2016, provides an excellent set of strategies that could be modified, implemented and *required* in all OSCs receiving funding.[4]

[4] See https://trainingcentre.unwomen.org/RESOURCES_LIBRARY/Resources_Centre/COMPENDIO_ONU-M-WEB.pdf

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