



Advancing Institutional
Child Protection:

The 'One-Stop Centre'
Model as an Intervention
Tool to Support
Survivors of Violence

IMPRINT



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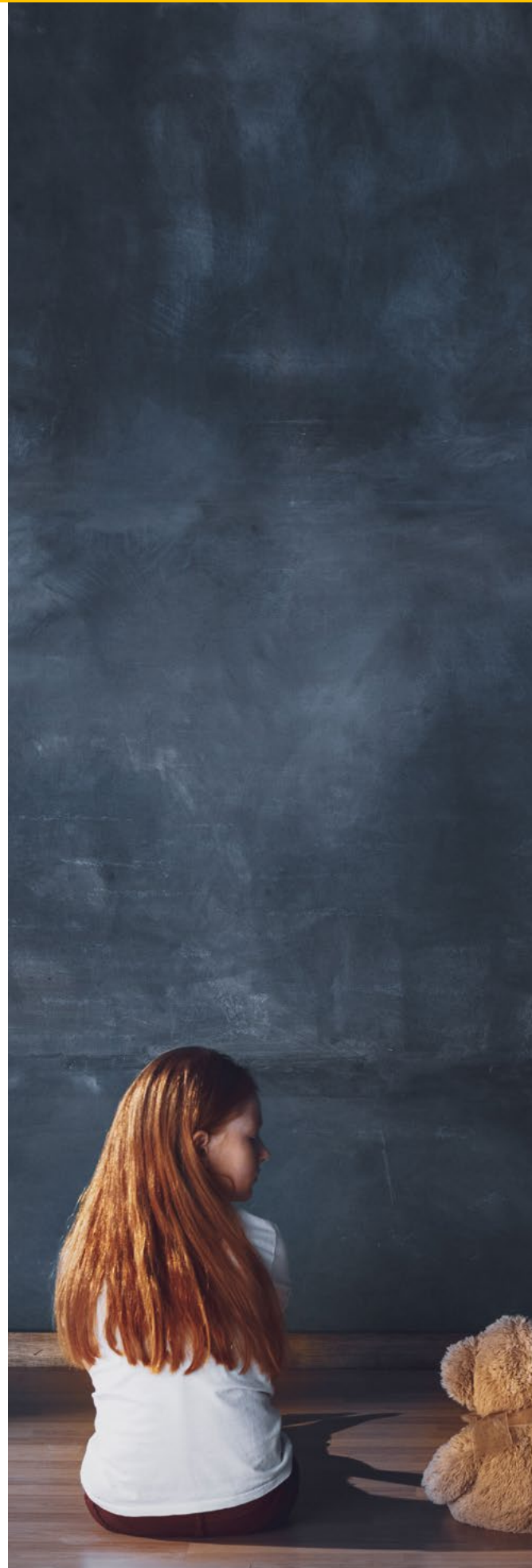


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FOREWORD

Every child should be living free from violence. However, we have known for decades that violence is a dire and common reality affecting children in each and every one of our societies throughout the world. With the COVID-19 pandemic, increased migration and conflicts, as well the climate crisis, the effects have become monumental. Both the immediate and far-reaching consequences have had an impact on every socio-ecological layer and generation.

Over the last few decades, however, we have made quantum leaps forward to ending this reality. Our commitments have been sealed, for example, in the Sustainable Development Goals and human rights treaties like the UN Convention on the Rights of the Child, and have been propelled through actions towards cohesively strengthening our child protection systems. This includes the implementation of many evidence-based prevention and intervention tools.

The semi-autonomous archipelago of Zanzibar is one example of where policymakers and stakeholders have come together to facilitate change and have pledged to secure a better and safe life and environment for its children. In 2015, it was this approach that won the Future Policy Gold Award for the creation and implementation of its outstanding Children's Act. The 2015 Future Policy Award was dedicated to policies that contribute to protecting and strengthening the rights of children, in partnership with the Inter-Parliamentary Union (IPU) and UNICEF. By consulting children throughout the legislative process, the Act, amongst other elements, codifies a child rights-based approach to providing a foundation for a coordinated child protection system.

What also emerged from this Act was a fascinating mechanism: the One-Stop Centre (OSC) model, which took inspiration from the model's implementation in its neighbouring country, Zambia. Fostering a multidisciplinary, multisectoral, and interagency approach, these centres have provided several necessary services to respond to cases of child abuse, violence, maltreatment, and neglect, all under one roof.

Recognising the success of the model within the region, the World Future Council (WFC) has committed to promoting this approach ever since, and in 2017 hosted an International Child Rights Conference in Zanzibar to facilitate the exchange of further dialogue around the model and other best practices. The outcome of this session revealed that there are many useful lessons to be learnt from different national contexts and experiences. Since then, we have been in contact with key official Ghanaian stakeholders, who have shown great interest in the One-Stop Centre model, and conducted a technical workshop in Ghana in 2018 with experts from Zanzibar.

Yet, despite the efforts sealed through our commitments and the establishment of tools such as OSCs and similar mechanisms, much still needs to be done, improved, and put into practice to address the gaps that still exist. Although, as we have learnt from facilitating dialogue and taking note of best practices and past mistakes, collaboration means that we can better our understanding of the appropriate and necessary responses to combat childhood violence, abuse, and neglect.

The aim of putting together this policy brochure, therefore, has been to decipher the essential ingredients for an OSC to effectively synergise within a child protection system that places the child at its heart. We hope that these unique experiences extracted from the important work conducted by the many researchers, evaluators, and experts can be utilised to improve our collective efforts in our fight. After all, as evidence clearly affirms, ending this cycle has monumental benefits, and gives every child the chance to develop to their full potential with fair and equal opportunities.

Our obligation to do this is one that we owe to our children, our grandchildren, and our future generations, so that they have the chance to live on a healthy and sustainable planet, with just and peaceful societies.

María Fernanda Espinosa Garcés

Co-Chair of the Rights of Children and Youth Commission, World Future Council, President of the 73rd General Assembly of the UN

Alexandra Wandel

Executive Director of the World Future Council (WFC)

ABOUT THIS POLICY BROCHURE

The aim of creating this policy brochure has been to delve deeper into individual country experiences to gauge at the best practices and lessons learnt to deduce some key requirements necessary to sustain One-Stop Centres (OSCs) responding to violence against children (VAC). Whilst utilising existing research, this policy brochure does not claim to be an exhaustive, academic, nor scientific review or evaluation of the use of OSCs and similar mechanisms around the world. Rather, it aims to observe and analyse the information that is readily available and has been gathered from various evaluations and articles that analyse OSCs.

These articles are varied in their nature. For example, some were systematic scientific reviews, some were national evaluations conducted by the independent evaluators, and some were policy handbooks. These varied sources were extracted from different fields engaging with OSCs, including from the health and legal spheres. The evidence studied and assessed in these sources also varies depending on the availability of data within the specific jurisdictions. Some consisted of and relied on anecdotal evidence to understand the success of OSCs within a particular area, while some were able to test effectiveness when data was adequately collected and available.

It should be noted that, as some assessments were unable to determine the true impact OSCs had within some jurisdictions, this brochure does not claim to be an exhaustive evaluation of the OSCs in those countries that have been studied. Moreover, some assessments and articles are not recent publications. Older evaluations have been included in this brochure when analysing these centres as they contain some key and important lessons learnt and recommendations used to strengthen OSC responses. Thus, it should be noted that those challenges presented in some country studies do not necessarily reflect the operation of OSCs today, but rather represent the challenges they have faced, and the necessary methods that were necessary to address them.

The OSCs studied in this brochure were selected since they share a similarity in responding, in one way or another, to child survivors of violence. There are plenty of OSCs throughout the world that have been utilised primarily as a response to the protection of women. It should also be noted that whilst some countries do not employ an OSC approach, they still have active and effective child protection tools in place to respond to VAC.

Representation was also a key consideration in this brochure. We aimed to include OSCs or mechanisms that adopt a One-Stop Centre/Shop approach from the six inhabited continents. In Africa and Asia the model has been integrated and adapted across many settings, and thus we focused on the centres that had a significant level of assessment to deduce key lessons learnt. In the Oceania region, Papua New Guinea's Family Support Centres have adopted the OSC approach, and their evaluations contained many valuable key lessons. In North America, the USA has adopted a similar model, namely Children's Advocacy Centers. This model has been transferred to other countries, such as Guyana in context of South America. In Europe, the Barnahus model has been established, which took inspiration from Children's Advocacy Centers. This brochure examines each experience, discusses their strengths and shortcomings, and extracts the key lessons learnt for the minimum requirements necessary to support OSCs.

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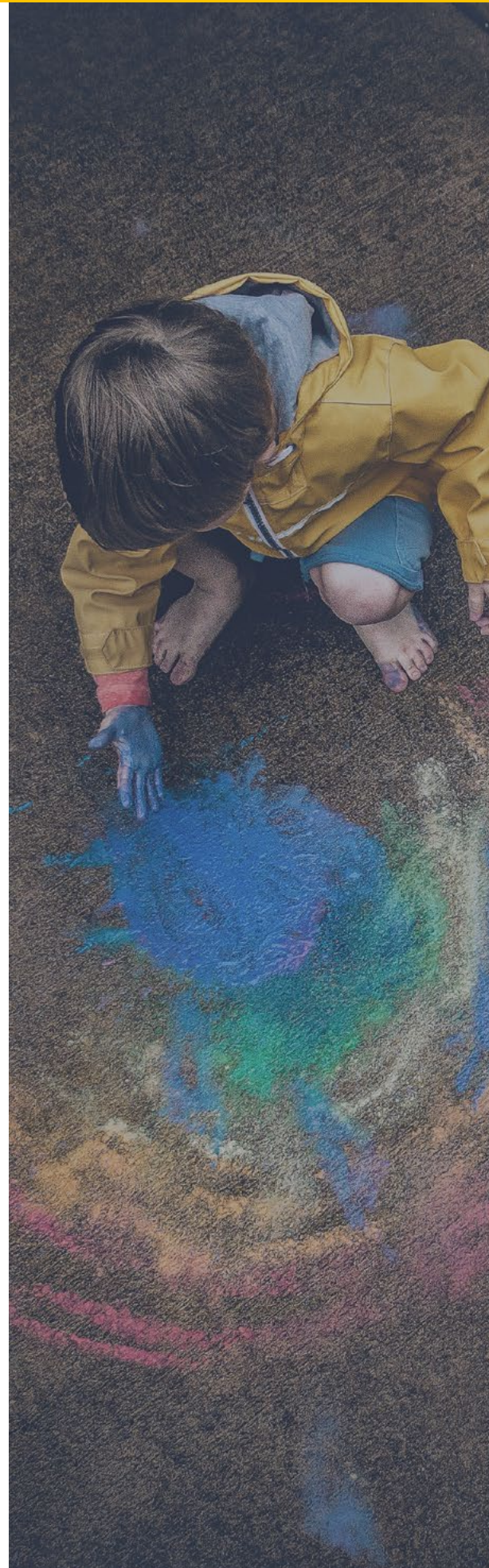
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LIST OF ACRONYMS

A&E	Accidents and Emergencies	KCC(s)	Kgomotso Care Centre(s)
ACE	Adverse Childhood Experiences	LGBTQIAP+	The Lesbian, Gay, Transgender, Queer, Intersex, Asexual and Pansexual+ Communities
ACERWC	African Committee of Experts on the Rights and Welfare of the Child	MICS	Multiple Indicator Cluster Surveys
ACHR	American Convention on Human Rights	MRI	Magnetic Resonance Imaging Scan
ACRWC	African Charter on the Rights and Welfare of the Child	MSF	Medicins Sans Frontieres/Doctors Without Borders
AU	African Union	NCA	National Children's Alliance
AUSEWPS	African Union Special Envoy of the Chairperson of the Commission on Women, Peace and Security	NGO(s)	Non-Governmental Organisation(s)
AUSRVAC	African Union Special Rapporteur on Violence against Children	NPA	National Prosecuting/Prosecution Authority
CAC	Children's/Child Advocacy Centers	OCD	Obsessive Compulsive Disorder
CBSS	Council of the Baltic Sea States	OCMC(s)	One-Stop Crisis Management Centre(s)
CEDAW	United Nations Committee on the Elimination of All Forms of Discrimination against Women	One UN	UN Delivering as One
CIDT	Cruel, Inhuman and Degrading Treatment	OSC(s)	One-Stop Centre(s)
CmRC	United Nations Committee on the Rights of the Child	OSCC(s)	One-Stop Crisis Centre(s)
CoE	Council of Europe	OSSC(s)	One-Stop Service Centre(s)
CPS	Child Protection System	PEP	Post-Exposure Prophylaxis
CRC	United Nations Convention on the Rights of the Child	PNG	Papua New Guinea
DALYS	Disability-Adjusted Life Years	PTSD	Post-Traumatic Stress Disorder
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms	SAARC	South Asian Association for Regional Cooperation
ECtHR	European Court of Human Rights	SCAN	Suspected Child Abuse and Neglect
End Violence	Global Partnership to End Violence Against Children	SDG(s)	Sustainable Development Goal(s)
EU	European Union	SGBV	Sexual and Gender-Based Violence
FGM	Female Genital Mutilation	SRSGVAC	United Nations Special Representative of the Secretary General for Violence against Children
FSC(s)	Family Support Centre(s)	STI/D	Sexually Transmitted Infection/Disease
GBV	Gender-Based Violence	TCC(s)	Thuthuzela Care Centre(s)
GDP	Gross Domestic Product	UK	United Kingdom
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome	UN	United Nations
HRC	United Nations Human Rights Committee	UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
ILO	International Labour Organisation	UNDESA	United Nations Department of Economic and Social Affairs
IOSC(s)	Isange One-Stop Centre(s)	UNDP	United Nations Development Programme
IPV	Intimate Partner Violence	UNFPA	United Nations Population Fund
JPO	Judicial Police Officer	UNGA	United Nations General Assembly
		UNHCR	United Nations High Commissioner for Refugees
		UNICEF	United Nations Children's Fund
		UNODC	United Nations Office on Drugs and Crime
		USA	United States of America
		VAC	Violence Against Children
		VAW	Violence Against Women
		WFC	World Future Council
		WHO	World Health Organisation

INTRODUCTION

The issue of violence against children (VAC) is not a new phenomenon, but its significance, gravity, multitude, and persistent cycle of interpersonal effects and harms, spanning not only across the past and present, but also for future generations, makes it arguably one of humanity's greatest issues. Whilst children are often portrayed in many popular narratives, they have, at the same time, long been subjected to violence in their daily lives too.¹ We know this because VAC is an epidemic, affecting over one billion children worldwide.²

A picture of this reality was painted in 2006, when the United Nations General Assembly (UNGA) was presented with a study on VAC conducted by the Independent Expert for the Secretary General: Paulo Sérgio Pinheiro. The results offered a stark caveat of the magnitude of cases that were seemingly manifesting in plain sight, yet with little repercussion. According to the study, **VAC exists in every state, cutting across different boundaries, including culture, class, education, income, ethnicity, and/or race.**³

Children also experience violence in many forms, whether physical, psychological, and/or sexual abuse; maltreatment or neglect; and within a care-setting or the community.⁴

Alarming, **the vast majority of perpetrators are usually part of the child's immediate environment**, as opposed to the smaller percentage of cases perpetrated by complete strangers.⁵

Yet usually **only a fraction of cases are usually ever reported and investigated**. It has also been found that self-reported cases taken from surveys have often proved to monumentally surpass official national reports of prev-



No violence perpetrated against a child is justifiable. The UN Convention on the Rights of the Child (CRC) urges States Parties to take all appropriate measures to ensure that every child is protected against all forms of violence, abuse, neglect, and punishment. General Comment 13 also underlines the importance of prevention and the implementation of a holistic child protection system in avoidance of fragmented and isolated mechanisms that have left some children behind. Over the last few decades, many One-Stop Centres have emerged, bringing together key sectors from existing institutional and protective structures to cohesively respond to all child survivors of violence. These centres have been a foundational tool contributing to strengthening national child protection systems.

Professor Benyam Dawit Mezmur, Current Member and Former Chairperson of the United Nations Committee on the Rights of the Child (CmRC) and Former Chairperson of the African Committee of Experts on the Rights and Welfare of the Child.

alence.⁶ This hidden nature of VAC is due to a combination of issues, such as inadequate reporting systems, shame, stigma, apathy, and potential repercussions,⁷ but also simply because children, especially very young children, may lack the capacity to report.⁸

Cases of VAC often occur due to wide-range acceptance. Whilst practice can differ in any community or society, it has been demonstrated that VAC can be deeply embedded in harmful practices, and cultural, societal, and/or religious

1 Jonathan Todres, 'Violence, Exploitation, and the Rights of the Child' in Ursula Kilkelly and Ton Liefaard (eds) *The International Human Rights of Children* (Springer 2019) 216.

2 Susan Hills and others, 'Global Prevalence of Past-year Violence against Children: A Systematic Review and Minimum Estimates' (2016) 137 *Pediatrics* 7 <<https://pediatrics.aappublications.org/content/pediatrics/137/3/e20154079.full.pdf>> accessed 1 June 2021.

3 Paulo Sérgio Pinheiro, 'World Report on Violence Against Children' (United Nations 2006) 5.

4 Ibid. 7.

5 Ibid. 11; Karen Devries and others, 'Who Perpetrates Violence against Children? A Systematic Analysis of Age-Specific and Sex-Specific Data' (2017) 2 *British Medical Journal Paediatrics Open* 7-8 <<https://bmjpaedsopen.bmj.com/content/bmjpo/2/1/e000180.full.pdf>> accessed 31 May 2021.

6 James A Mercy and others, 'Interpersonal Violence: Global Impact and Paths to Prevention' in Charles N Mock and others (eds) *Injury Prevention and Environmental Health* (World Bank 2017) 74.

7 Audrey Pereira and others, 'Disclosure, Reporting and Help Seeking Among Child Survivors of Violence: A Cross-Country Analysis' (2020) 20 *BMC Public Health* 6 <<https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-020-09069-7.pdf>> accessed 6 June 2021.

8 Pinheiro (n 3) 10.



customs and traditions.⁹ Its acceptance, therefore, may be more common than we might realise.

Yet, despite these attitudes of acceptance, **VAC has persistently proven to be a complex issue causing devastating, long-lasting, adverse, and multidimensional effects, which has been backed by a plethora of evidence-based data.** VAC can have a direct detrimental impact on a child's health both directly, and through acute and long-term impacts.¹⁰ Additionally, VAC affects national development with adverse economic consequences too. More of these effects will be discussed in Chapter 1.

Nevertheless, **it is well acknowledged by the international community that VAC must end.** In 2015, Agenda 2030 was set up by the UNGA, containing 17 Sustainable Development Goals (SDGs) that are interlinked “blueprint[s] to achieve a better and more sustainable future for all”.¹¹ These goals include the targets of ending abuse, exploitation, trafficking, and all forms of violence against and torture of children,¹² together with the elimination of all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.¹³

⁹ Ibid. 6.

¹⁰ World Health Organisation and others, ‘INSPIRE: Seven Strategies for Ending Violence Against Children’ (World Health Organisation 2016) 11 <<https://www.who.int/publications/i/item/inspire-seven-strategies-for-ending-violence-against-children>> accessed 5 April 2021.

¹¹ United Nations General Assembly, ‘Transforming our World: the 2030 Agenda for Sustainable Development’ (21 October 2015) UN Doc A/RES/70/1; United Nations, ‘Sustainable Development Goals’ <<https://www.un.org/sustainabledevelopment/sustainable-development-goals/>> accessed 10 May 2021.

¹² United Nations Department of Economic and Social Affairs, ‘The 17 Goals’ (United Nations) SDG 16.2 <<https://sdgs.un.org/goals>> accessed 15 April 2021 (The Sustainable Development Goals) (SDG).

¹³ Ibid. SDG 5.2.

Despite these commitments, **the unprecedented COVID-19 pandemic has had a devastating impact on this progress.** School closures have affected more than 1.5 billion children worldwide, disrupting their everyday lives.¹⁴ Movement restrictions, income loss, isolation, and overcrowding within homes has caused significant stress and anxiety for parents, caregivers, and children.¹⁵

The exact magnitude of the pandemic's impact on the scale of VAC is still largely unknown,¹⁶ but there has been a significant spike in calls to child abuse helplines, indicate to us the extent of its enormity.¹⁷ This list is non-exhaustive, but predictions estimate that the long-term effects are **expected to put VAC incidents up to (and even beyond) pre-lockdown levels.**¹⁸

Despite these serious warning signals, there is still time to act and reverse these effects. **Ending violence against children must be considered a priority** on the agenda. VAC in any of its form is never justified, and as Pinheiro rightly expresses, “all violence against children is preventable”.¹⁹

Since VAC is a multifaceted problem, **an integrated, holistic and multisectoral child protection system (CPS)** is necessary. The systems approach is required for implementing cohesive prevention and intervention measures that respond to VAC.

A **One-Stop Centre (OSC)** is a good example of multisectoral and interagency collaboration responding to cases of VAC that is incorporated into a CPS. It provides various services under one umbrella institution to respond to both the immediate and long-term needs of victims. **These services include four main elements: social welfare services, psychological services, medical and medico-legal services, and criminal investigation provided by law enforcement and legal services.**²⁰

By providing multiple services under one roof, **the main goal of an OSC is to avoid further retraumatization and revictimisation of survivors when seeking care,**²¹ as survivors do not need to retell their traumas at different institutions under a fragmented service system.²²

As this policy brochure will show, the OSC model has been implemented across various states globally. The aim of this brochure is to analyse its integration across these different jurisdictions to outline an ideal recipe for achieving an OSC in its best form. In doing so, this brochure will assess elements of enablers and barriers to its sustainability as well as its successes, benefits, and shortcomings, in order to better understand the lessons we can learn from it.

Entering this decade with a tumultuous start in the face of a global pandemic, there is no doubt that we all have collectively experienced disruption and change. These difficult times, however, do not excuse the obligations we have to protect our children, grandchildren, and future generations. We have committed ourselves to the obligation to end VAC once and for all. With spikes in incidents of VAC appearing across all states due to the pandemic, now, more than ever, is the time to act to prevent and respond to cases of VAC rapidly, appropriately, and adequately.

14 United Nations Children's Fund, 'Child Protection and COVID-19' (January 2021) <<https://data.unicef.org/topic/child-protection/covid-19/>> accessed 16 May 2021.

15 Ibid; World Health Organisation and others, 'Global Status Report on Preventing Violence Against Children 2020' (World Health Organisation 2020) xi <<https://www.who.int/teams/social-determinants-of-health/violence-prevention/global-status-report-on-violence-against-children-2020>> accessed 12 April 2021.

16 United Nations Department of Economic and Social Affairs, *The Sustainable Development Goals Report 2020* (United Nations Department of Economic and Social Affairs 2020) 57.

17 WHO (n 15) xi; UNICEF (n 14).

18 Ibid.

19 Pinheiro (n 3) 3.

20 World Future Council, 'Technical Concept Note: Establishment of the One-Stop Centre in Ghana' (World Future Council 2018) 2.

21 Rose McKeon Olson, Claudia Garcia-Moreno and Manuela Colombini, 'The Implementation and Effectiveness of the One Stop Centre Model for Intimate Partner and Sexual Violence in Low-and-Middle-Income Countries: A Systematic Review of Barriers and Enablers' (2020) 5 *BMJ Global Health* 2 <<https://gh.bmj.com/content/5/3/e001883>> accessed 14 March 2021.

22 Ibid.

CHAPTER 1

THE GLOBAL CONTEXT AND BURDEN OF VIOLENCE AGAINST CHILDREN

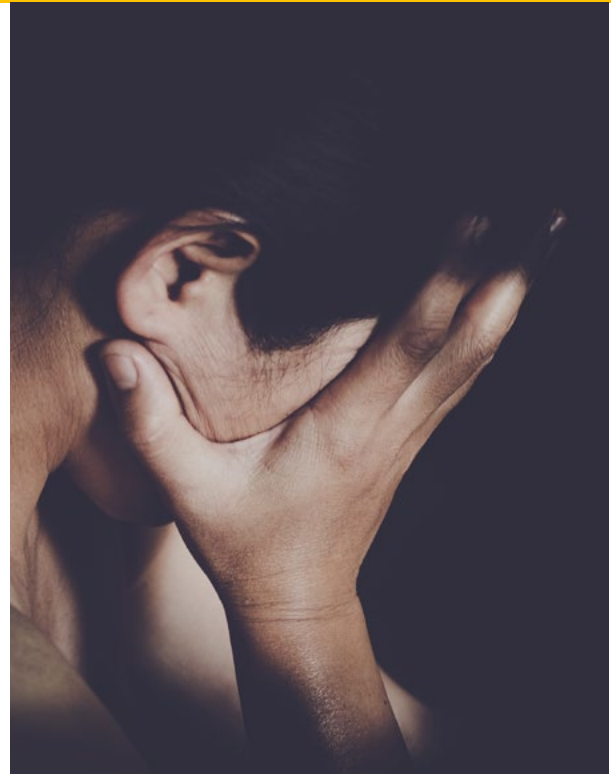
Violence against children in its various forms and components is rooted in multidimensional and complex issues that can systematically span across generations. Importantly, VAC is not one single experience for children that are victims to it, who are not one distinct homogenous group either. Of course, children bear different lives, and thus, there are different elements which put certain children at greater risk of being exposed to VAC than others. For instance, gender, economic and social status, race, sexual orientation, and age are all elements that can influence different risks, and subsequently bear different consequences on different children. VAC can also manifest in many forms, which can interact with together and occur simultaneously, whether targeting certain individual children or groups. However, as we have briefly addressed in the introduction, VAC does occur in every state, and the consequences of it are monumental that branch across multiple dimensions. These consequences can breed, reproducing other forms of violence both in present day and in future generations.

1.1 UNDERSTANDING VAC: THE COMMON MISPERCEPTIONS OF CHILDREN AND CHILDHOOD

It is a common misconception that children are passive subjects, mainly subsumed within their families and without full personhood.²³ Apolitical in nature and with their families (usually) acting as their primary social environments,²⁴ children are often misunderstood as a single group, and their individual personhoods with unique wants, needs, and opinions, are therefore not always considered. Of course, different traditional constructs, cultures, attitudes, customs, and religious practices can shape different perceptions of children, their childhood, and their responsibilities within certain societies too.

Yet the different stages of development that influence their capacity and vulnerability, in addition to their unique characteristics of individuality and the different circumstances they may face, demonstrates that children are not one homogenous group.²⁵ Childhood is not one singular nor static experience.²⁶ For example, a seventeen-year-old's capacity to think and assume responsibility is not the same as that of a younger child's, even though both are categorised in the same group of rights holders; a girl does not experience the same childhood as a boy (and vice versa); and if we take social and economic background components into consideration, a child subjected to living their life and/or working on the street does not experience the same life as a child growing up in a safe and secure home.

Although there are many other factors that can be assessed, it can be acknowledged that, generally, adults make decisions on behalf of children and represent them in most positions because of their evolving capacities and circumstances. Yet, as a result, this approach often depicts children as passive subjects, generalises their childhood,



and too often leaves them out of the decision-making processes, even those concerning issues that directly affect them. The use of public health emergency powers used in implementing COVID-19 restrictions at the beginning of the pandemic in 2020 accurately depicts this. Many initial decisions were not made by consulting children (or actors that worked directly with children) and failed to give them a right to participate. Yet, 1.5 billion children were affected by school closures, that have disrupted their everyday lives, their relationships, and their routines.²⁷

Accordingly, when addressing and deciding upon VAC matters, it is vital to acknowledge that children are intrinsically unique and lead different lives. VAC can affect individual children in a multitude of ways. One child's experience is not the same as another, and some children are at greater risk to some forms of VAC than others. This does not mean that certain children should not be accounted for. Responding to and preventing VAC means all children are accounted for, but acknowledges their different wants and needs, all whilst continuing to consult them in the process.

²³ Todres (n 1) 227.

²⁴ Murli Desai, *Child Welfare, Protection and Justice* (Cambridge University Press 2021) 8.

²⁵ Geraldine van Bueren, *The International Law on the Rights of the Child* (Martinus Nijhoff Publishers 1998) 50.

²⁶ Ibid.

²⁷ UNICEF (n 14).

1.2 THE MANY FORMS OF VIOLENCE AGAINST CHILDREN

VAC can occur in many ways and includes all forms of violence and harm perpetrated against any individual aged below eighteen.²⁸ Categorising VAC depends on different factors. For instance, who the perpetrator might be, what the victim experiences, or the setting it occurs in can be used to define certain forms. However, we must be cautious in this grouping as **different forms of violence are often not isolated**²⁹ since VAC is a heterogeneous issue.³⁰ As the United Nations Children's Fund (UNICEF) has iterated, "the boundaries between acts of [VAC] tend to become blurred".³¹ However, as the United Nations (UN) Committee on the Rights of the Child (CmRC) has outlined,³² there are certain types of VAC that can occur in all settings and in transit between these settings.³³ This includes, but is not limited to:

➤ **Physical violence** accounts for fatal and non-fatal physical forms of VAC, which includes (but is not limited to) physical abuse, harm, injury, and maltreatment; corporal punishment; all forms of torture, cruel, inhuman, or degrading treatment and punishment; physical bullying and hazing; physical violence in the guise of treatment; harmful acts (such as forced sterilisation and female genital mutilation); and the deliberate infliction of disabilities.³⁴

➤ **Sexual violence** takes on many forms, and constitutes acts including (but not limited to) non-consensual completed or attempted sexual contact;³⁵ non-consensual acts

of a sexual nature not involving contact (such as voyeurism or sexual harassment);³⁶ inducing, forcing, or coercing a child to engage in any unlawful or psychologically harmful sexual activity; the use of children in commercial exploitation; child pornography; child prostitution; sexual slavery; sexual exploitation online or in travel and tourism; trafficking; and the sale of children for sexual purposes and/or forced marriage.³⁷ Sexual violence is *prima facie* VAC; the vulnerability of the child due to a lack of physical strength, cognitive understanding, and experience, makes sexual violence one of the most unsettling violations of a child's rights and their dignity.³⁸ As the vast majority of perpetrators hold positions of authority in a child's life (mostly those whom they know and trust), sexual violence is fundamentally a crime of power.³⁹ Moreover, these same attributes of vulnerability act as a barrier to the disclosure of information.⁴⁰ This puts victims of childhood sexual violence in a position where they are unable to seek the required services and support they need. The psychological traumas and burden experienced from this are different and unique to children that have experienced sexual violence.⁴¹

➤ VAC is not limited to just physical or intentional forms either. **Emotional or psychological violence** equally exists, and includes psychological maltreatment, mental, verbal, and emotional abuse, or neglect.⁴² According to the CmRC this includes (but is not limited to) all forms of persistent harmful interactions with a child (for example, by conveying the message that they are worthless, unloved and unwanted); scaring, terrorising, threatening, exploiting and corrupting; favouritism, ignoring and rejecting; denying emotional responsiveness and neglecting needs; degrading and humiliating treatment (such as name-calling, belittling and ridiculing); exposure to witnessing

28 United Nations Committee on the Rights of the Child, 'General Comment No 13: The Right of the Child to Freedom from all Forms of Violence' (2011) UN Doc CRC/C/GC/13 para 4; WHO (n 10) 12.

29 United Nations Children's Fund, 'Hidden in Plain Sight: A Statistical Analysis of Violence against Children' (UNICEF 2014) 8 <<https://www.unicef.org/reports/hidden-plain-sight>> accessed 5 June 2021. NB: This does not rule out the possibility of isolated acts of violence, which do still occur too.

30 Ivana Resetar Culo, 'Violence against Children and Integrated Child Protection Systems in the European Union' (2019) 35 *Pravni Vjesnik* 33, 34.

31 UNICEF (n 29) 8.

32 CmRC (n 28) paras 3-4.

33 *Ibid.* para 19.

34 *Ibid.* para 22; UNICEF (n 29) 30.

35 WHO (n 10) 12.

36 *Ibid.*

37 CmRC (n 28) para 25.

38 UNICEF (n 29) 60.

39 United Nations Children's Fund, 'Sexual Violence against Children' (UNICEF 2020) <<https://www.unicef.org/protection/sexual-violence-against-children>> accessed 24 June 2021; Chi-Chi Undie, Saiqa Mullick and Ian Askew, 'The Missing 'C': Sexual Violence against Children in Sub-Saharan Africa' (Population Council 23 September 2013) <<https://www.unicef-irc.org/article/987-the-missing-c-sexual-violence-against-children-in-sub-saharan-africa.html>> accessed 14 June 2021.

40 *Ibid.*; UNICEF (n 29) 61.

41 *Ibid.*

42 UNICEF (n 29) 4.

violence; placement in solitary confinement, isolation or degrading and humiliating conditions of detention; and psychological bullying and hazing.⁴³

➤ **Neglect or negligent treatment** also qualifies as VAC.⁴⁴ This is categorised as the failure to meet a child's physical and psychological needs, to protect them from danger, and failure to obtain medical, birth, and other registration services (when a caregiver has the means, knowledge, and access to such services).⁴⁵ It includes (but is not limited to) physical neglect, psychological or emotional neglect, neglect of a child's physical or mental health (including the withholding of essential medical care), educational neglect (such as failure to comply with school attendance rules), and abandonment.

➤ When discussing these various manifestations, socially, culturally, and traditionally accepted **harmful practices** also form a unique category of VAC.⁴⁶ These include, female genital mutilation (FGM) and breast ironing, subject girls to deliberate pain and disfigurement.⁴⁷ Harmful practices that include uvulectomy, scarifying, branding, and tattooing can affect both girls and boys.⁴⁸ On the other hand, harmful practices can also indirectly lead to forms of VAC. Child marriage not only undermines the autonomy and freedom of choice of the child,⁴⁹ it also limits opportunities for formal education and may place them in social isolation.⁵⁰ In addition, in many cases, these marriages are regarded as girls giving their consent to sexual relations with their husbands.⁵¹ Combined with the unequal power balance between the girl and her husband, a situation of danger materialises and the risk of sexual violence (and other forms of VAC) is heightened.⁵²

These forms of VAC can interact, overlap, and co-occur with one another. For instance, a child that faces physical abuse at home is likely to experience emotional and psychological harm from the suspense of waiting for the next time they will be physically hurt.

These main types of VAC can interact to shape specific forms of violence too. For instance, intimate partner violence (IPV) can include sexual, psychological, and physical violence. IPV is prevalent amongst adolescent teens, and also commonly occurs against girls subjected to early and forced marriages.⁵³ Bullying is another prevalent form of VAC, which is characterised as unwanted aggressive behaviour in the form of physical or psychological and social harm, whether in person or online.⁵⁴ Moreover, the maltreatment of a child involves all the above mentioned different types of VAC that are enacted by parents, caregivers, and those in positions of authority in a child's life, such as teachers.⁵⁵

It must be borne in mind that VAC does not only occur in domestic or care settings like the home, orphanages, and schools. It occurs in other locales not strictly limited to the home or other care settings. Community-based violence occurs both in and out of the work setting (whether legal or illegal work) and across many industries and locations, such as in agriculture, tourism, construction, domestic service, fishing, and forced-begging operations.⁵⁶ These tend to be severe forms of VAC, such as exploiting the child for forced labour and slavery, debt bondage and domestic servitude, use in armed conflict, trafficking, and sexual exploitation.⁵⁷ Often away from parents and caregivers in these situations, children are "left to navigate challenges without assistance" or guidance.⁵⁸

⁴³ CmRC (n 28) paras 4, 21; Todres (n 1) 217.

⁴⁴ Ibid. para. 4.

⁴⁵ Ibid. para 20.

⁴⁶ Ibid. para 29.

⁴⁷ Pinheiro (n 3) 60. NB: FGM can manifest in many forms, some of which are more severe and extreme than others.

⁴⁸ Ibid.

⁴⁹ Brenda Bartelink, Elisabeth le Roux and Wouter Levinga, 'Harmful Traditional Practices in the Context of Faith: A Literature Review' (University of Groningen 2017) 14 <https://pure.rug.nl/ws/portalfiles/portal/56871524/Literature_Review_DFID_.pdf> accessed 29 June 2021.

⁵⁰ Pinheiro (n 3) 57.

⁵¹ Ibid.

⁵² Pinheiro (n 3) 57-58; Mariam Ouattara, Purna Sen and Marilyn Thomson, 'Forced Marriage, Forced Sex: The Perils of Childhood for Girls' (2010) 6 Gender and Development 27, 30-31. There are many other types of harmful practises that exist and are beyond the scope of this brochure, which deals more with the maltreatment of the child. It should be noted, however, that since harmful practices are a unique and pressing category of VAC, there is a plethora of evidence-based handbooks and guidelines that serve to specifically address this phenomenon, which is recommended to be consulted.

⁵³ WHO (n 116) 14.

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Todres (n 1) 218.

⁵⁷ Ibid.

⁵⁸ Ibid.



When we speak of VAC, the topic of structural violence is unavoidable. Many of these forms of VAC, whether they are dependent on the locales in which they occur and/or the acts through or against which they are perpetrated, are rooted in deeper structural and systemic issues common to all societies.⁵⁹ Structural violence is not the violence we directly see and respond to. It is defined as a violence of inequality, injustice, and inequity,⁶⁰ which is fixed in “ubiquitous social structures”⁶¹ and results in avoidable death, injury, and illness.⁶²

These constructs are organised societal arrangements and are based on multiple indicators, such as political, economic, cultural, legal, racial, and religious relationships and groupings, and can serve as a bias towards how we as individuals behave in the social system.⁶³ A regular experience to many of us, they have been normalised in

our communities and societies, and have been enforced by our institutions.⁶⁴ Some examples include the patriarchy, apartheid regimes, caste systems, slavery, colonialism, imperialism, poverty, and discrimination based on, for example, race, gender, sexual orientation, religion, ethnicity, and social status.⁶⁵

It is important to highlight structural violence because these rooted and harmful foundations replenish and reproduce all other forms of violence.⁶⁶ Because they act to specifically marginalise certain individuals, groups, and communities, individuals become stripped off certain or whole capabilities, rights, and agency, thus directly assaulting their dignity, and sustaining inequalities.⁶⁷ The choreographed plight of unequal access to society’s resources, including basic necessities, education, legal standing, political power, and/or opportunities in life, logically makes individuals (although not all) resort or expose themselves to other forms of violence.⁶⁸ This cycle spans across generations.

For example, poverty is proven to be a root driver of violence as it creates instability, insecurity, and deprives individuals of the most basic needs required for full development and even survival.⁶⁹ As a result, it heightens vulnerability and pressures children and their families, leading directly to an increased risk of violence.⁷⁰ Individuals may either themselves or make their children pursue riskier and exploitative jobs, and/or early and forced child marriages, which predisposes them and their children to a risk of multiple forms of violence, whether in a domestic setting or within the community. Not only does this marginalisation act as a barrier against a child’s access to multiple rights, but most of these rights are only safeguarded through the rights of their parents, who also face the brunt of marginalisation.⁷¹

⁵⁹ Ibid. 219.

⁶⁰ Barbara Rylko-Bauer and Paul Farmer, ‘Structural Violence, Poverty, and Social Suffering’ in David Brady and Linda M. Burton (eds) *The Oxford Handbook of the Social Science of Poverty* (Oxford University Press 2016) 47.

⁶¹ Deborah DuNann Winter and Dana C. Leighton, ‘Structural Violence Introduction’ in Daniel J. Christie, Richard V. Wagner and Deorah DuNann Winter (eds) *Peace, Conflict and Violence* (Prentice Hall 2001) 99-101.

⁶² Ibid.

⁶³ Barbara Rylko-Bauer and Paul Farmer (n 60) 47.

⁶⁴ Deborah Dunann Winter and Dana C. Leighton (n 62) 100.

⁶⁵ Rylko-Bauer and Farmer (n 60) 47.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Winter and Leighton (n 64) 99-100.

⁶⁹ See Todres (n 1) 219; Nicola Balvin and Daniel J. Christie, *Children and Peace – From Research to Action* (Springer 2020) 145; Layla Ismayilova and others, ‘Maltreatment and Mental Health Outcomes among Ultra-Poor Children in Burkina Faso: A Latent Class Analysis’ (2020) 11 *PLoS One* 3 <<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0164790>> accessed 18 April 2021.

⁷⁰ Ibid.

⁷¹ Todres (n 1) 220.



Inasmuch as poverty is a root cause of violence, violence is simultaneously identified as a root cause of poverty because of the harmful structures it upholds and the social suffering it creates.⁷² The **bystander effect** can also be observed throughout this entire cycle. As violence terrorises bystanders, they are less inclined and are “unwilling or unable to confront social injustice”.⁷³ Thus, because violence reproduces and reinforces a climate of greater structural inequalities and inequities, the cycle is intergenerationally upheld.⁷⁴

There are many more forms of structural violence and VAC that can be discussed from multiple perspectives, and there is a plethora of studies that analyse each one of these. Yet, it is beyond the scope of this brochure to discuss and analyse them all. However, it is necessary to address the certain risk factors and vulnerabilities which predisposes some children and groups to some forms of violence more often than others, which can also be dependent on pre-existing structural inequities.

1.3 WHO IS AT RISK OF VAC?

VAC occurs in all settings and across all boundaries, including nationality, social class, race, ethnicity, age, wealth, gender, and sexual orientation. However, some children are more susceptible to certain forms of VAC than others. As UNICEF’s 2014 ‘Hidden in Plain Sight’ report demonstrates, children are exposed to different risks of various forms of violence during all stages of the journey of childhood; from the prenatal period and birth to adolescence.

Even before birth, a foetus or unborn child can be exposed to a risk of VAC. In the **prenatal phase**, if a pregnant woman is exposed to violence and abuse, this may increase cortisol levels. The stress of violence on a pregnant mother can lead to other consequences such as failure to obtain adequate nutritional intake, which can affect foetal development and growth,⁷⁵ and can even continue in later life as it is linked to the subsequent development of adult diseases.⁷⁶ Other potential consequences resulting from the stress of violence and/or abuse include low birth weight, miscarriage, stillbirth and complications during childbirth.⁷⁷

During **early childhood**, infants and young children are more at risk of VAC perpetrated by parents and caregivers. This is usually correlated to their dependency on their parents and caregivers, and because their social interactions are primarily limited to the home space.⁷⁸ Thus, the risk of domestic violence during this stage is heightened. Children do not have to be direct victims either; they are particularly sensitive to their surroundings and can suffer as a result of witnessing (domestic) violence, thus becoming inadvertently hurt.⁷⁹ Research demonstrates that prolonged exposure to violence in early childhood can increase toxic stress levels, causing cognitive developmental issues and delay. This can also increase the potential of developing stress-related health issues in later life, such as heart disease, substance abuse, and depression.⁸⁰

⁷² United Nations Special Representative for the Secretary General on Violence against Children and others, *Why Children’s Protection from Violence Must be at the Heart of the Post-2015 Development Agenda* (United Nations 2015) 6-7 <https://violenceagainstchildren.un.org/sites/violenceagainstchildren.un.org/files/documents/publications/4_why_childrens_protection_post_2015_development.pdf> accessed 7 May 2021.

⁷³ Winter and Leighton (n 61) 100.

⁷⁴ UNSRSGVAC (n 72) 7; Todres (n 1) 219-220; Rylko-Bauer and Farmer (n 60) 47-48.

⁷⁵ UNICEF (n 29) 12; Megan R Gunnar and Ronald G Barr, ‘Stress, Early Brain Development, and Behaviour’ (1998) 11 *Infants and Young Children* 1, 5-6.

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

THE LIFECYCLE OF VIOLENCE

Sources: See page 117

INTERGENERATION, INTERPERSONAL AND SELF-DIRECTED IMPACT IN ADULT LIFE

- Adults who experienced four or more forms of VAC are 7-8 times more likely to be involved in interpersonal violence and 30 times more likely to attempt suicide
- Adolescent survivors of sexual VAC are 3-5 times more likely to become revictimised
- Mothers who were exposed to physical abuse as children and IPV, have a significant greater risk of maltreating their own children

PRENATAL STAGE

Violence against a pregnant mother:

- May increase cortisol levels, which may lead to poor foetal development and adult diseases in later life
- May also increase the likelihood of poor nutritional intake, which may lead to low birth weight, miscarriage, and stillbirth

EARLY CHILDHOOD

- Most at risk of VAC perpetrated by parents/ caregivers.

Prolonged exposure can:

- Increase toxic stress and disrupt the development of the brain
- Increase the risk of later health problems in adulthood such as heart disease, substance abuse and depression

LIFECYCLE OF VIOLENCE



MIDDLE CHILDHOOD

- Most at risk of exposure to interpersonal violence
- Most likely to experience violent and corporal punishment

ADOLESCENCE

- Most at risk of VAC stemming from gender identity, sexuality and sexual orientation factors
- Girls at greater risk of sexual violence and forced/early marriage
- More likely to adopt risk behaviours, which may increase risk of VAC

In **middle childhood**, which includes children between the ages of six and twelve years old, the risk of interpersonal violence is heightened. Violent and corporal punishment are more common amongst this age-group, which is likely linked to new-found independence and influence from peers.⁸¹ Moreover, more interactions between peers, links to a risk of new forms of violence in a child's life, such as (sexual) harassment and bullying.⁸²

In the **adolescence period of childhood** marked by the important transitional period of puberty, teenage boys and girls are most at risk of violence that relates to gender, sexual orientation, and identity.⁸³ As an example, girls are most at risk of experiencing sexual violence and victimisation, whether in an intimate partner relationship or not. Furthermore, attention must be given to the issue of early and forced marriages, which makes girls susceptible to contracting sexually-transmitted infections or diseases (STI/D), and as well as sexual violence, a greater exposure to emotional and physical violence.⁸⁴ In this stage, adolescents that are LGBTQIAP+⁸⁵ and/or that do not identify as their assigned at birth gender, are disproportionately vulnerable and at greater risk of becoming targets of violence based on their sexuality and/or gender.⁸⁶ Moreover, youth violence is concentrated amongst this age group and beyond it into early adulthood.⁸⁷ Adopting high-risk behaviours, such as alcohol and drug abuse and unsafe and unprotected sex is also linked to the transition of puberty. This may increase the risk and vulnerability of becoming both victim to and/or perpetrator of violence.⁸⁸

It is also important to address, however, that whilst certain age groups within childhood are indeed more at risk to certain forms of violence than others, socioecological, situational, and individual contexts must always be accounted for as we cannot view risk factors in isolation. **Structural violence**, which is **reinforced and aided by our formal**

institutions at the societal level, are definitive drivers of VAC. However, there are even more **complex and ever-changing risks at the community, interpersonal, and individual socio-ecological levels** that can be motivated by and feed these same structural drivers.⁸⁹

In the most simplified of examples, when taking a closer inspection again at the issue of poverty, certain risk factors on each level can be interconnected. At the societal level, poverty is a structural violence that can be reinforced institutionally, for instance, via austerity measures and absence of poverty alleviation in legislation, policies, and social norms. This also translates directly to how impoverished children can be treated and/or affected on a community, interpersonal, and individual level. With unequal access to society's resources, riskier factors and behaviour are heightened, which not only, for example, exposes a child to an age-group based risk of VAC, but also vulnerable to other (potentially extreme) forms of VAC unique to that child or group of children.⁹⁰

The situation of children living or working on the street is just one example of where we can observe polyvictimisation of VAC stemming from an accumulation of interconnected risk factors. These are rooted in the same social issues and have evidently engaged at all four levels: societal, community, interpersonal and individual. Surviving on the streets usually without the love, companionship, and care of family, and without necessities such as access to food, water, education, and medical services, means these children are often abused and become victims of daily VAC.⁹¹

One study that assessed the vulnerabilities and risk factors of children living on the streets of the city of Rajshahi in Bangladesh, found that extreme poverty and starvation in the community drove children between the ages of seven

⁸¹ Ibid. 13; Tracy L Dietz, 'Disciplining Children: Characteristics Associated with the Use of Corporal Punishment' (2000) 24 *Child Abuse and Neglect* 1529, 1535-1536.

⁸² Ibid.

⁸³ Ibid.

⁸⁴ Ibid; Minh Thi Hong Le and Others, 'Early Marriage and Intimate Partner Violence Among Adolescents and Young Adults in Viet Nam' (2014) 29 *Journal of Interpersonal Violence* 889, 896-887.

⁸⁵ The lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual/aromantic, and pansexual communities.

⁸⁶ UNICEF (n 29) 13; United Nation's Children's Fund, 'Research on the Sexual Exploitation of Boys: Findings, Ethical Considerations and Methodological Challenges' (UNICEF 2020) 7 <<https://data.unicef.org/resources/sexual-exploitation-boys-findings-ethical-methodological-challenges/>> accessed 15 October 2021; Anthony R D'Augelli, Neil Pilkington and Scott Heschberger, 'Incidence and Mental Health Impact of Sexual Orientation Victimization of Lesbian, Gay, and Bisexual Youths in High School' (2002) 17 *School Psychology Quarterly* 148, 149-150, 155-156; See also Karen Blondeel and Others, 'Violence Motivated by Perception of Sexual Orientation and Gender Identity: A Systematic Review' (2018) 96 *Bulletin of the World Health Organisation* 29.

⁸⁷ WHO (n 10) 14.

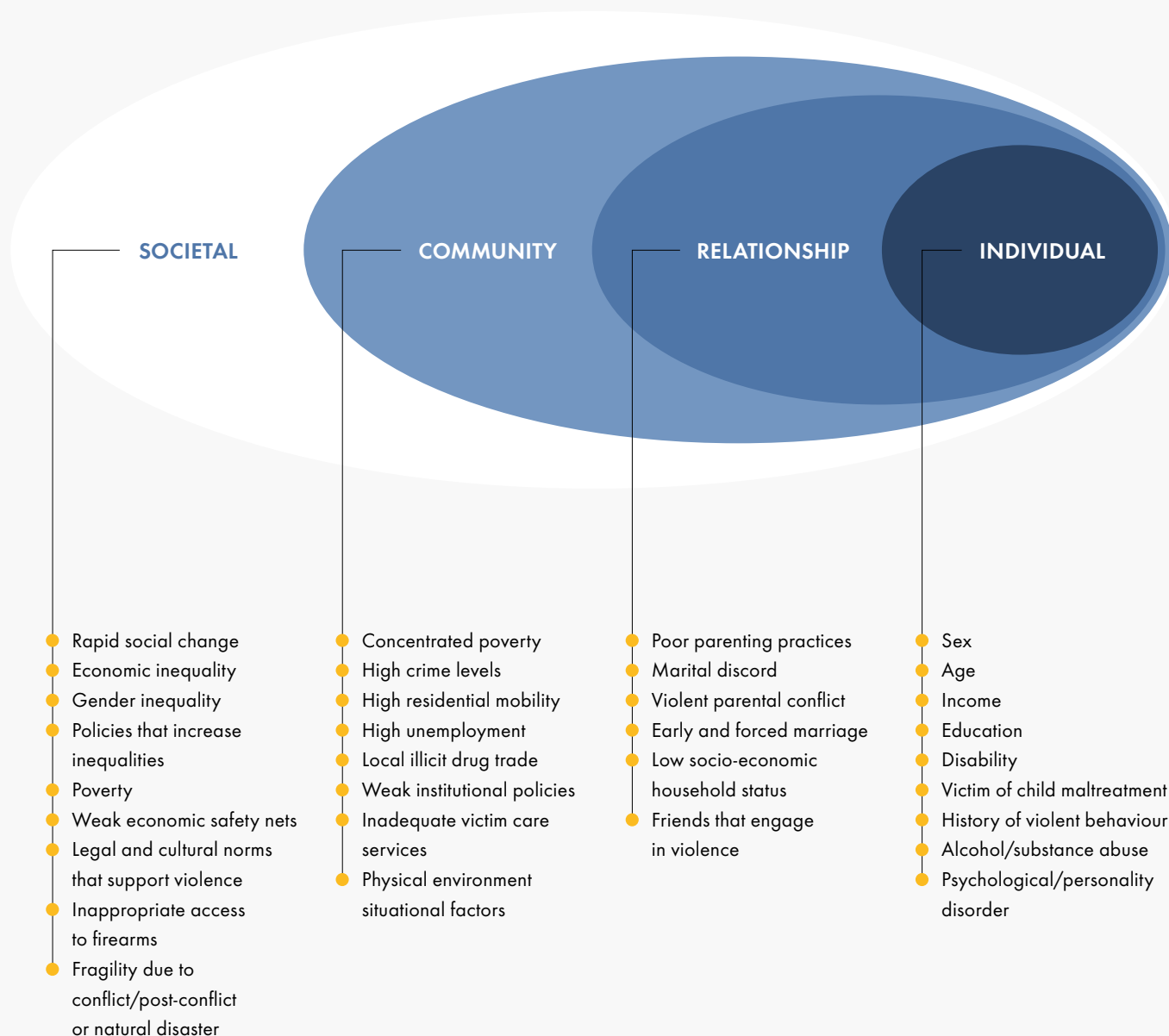
⁸⁸ UNICEF (n 29) 13.

⁸⁹ M Catherine Maternowska and Deborah Fry, 'The Multi-Country Study on the Drivers of Violence Affecting Children: An Overview' (2018) 13 *Vulnerable Children and Youth Studies* 12, 15; M Catherine Maternowska and Others, 'Beyond Risk Factors: Structural Drivers of Violence Affecting Children' in Nicola Balving and Daniel J Christie (eds) *Children and Peace* (Springer 2020) 141, 148; WHO (n 10) 16; Tia Palermo and others, 'Risk Factors for Childhood Violence and Polyvictimisation: A Cross-Country Analysis from Three Regions' (2018) 88 *Child Abuse and Neglect* 348, 357.

⁹⁰ Maternowska and Fry (n 89) 15.

⁹¹ Md Ataul Gani Osmani and Md Elias Hossain, 'Examining the Factors and Vulnerabilities of the Streets in Rajshahi City of Bangladesh' (2020) 15 *Vulnerable Children and Youth Studies* 279, 279.

THE SOCIO-ECOLOGICAL MODEL



and fourteen to leave home for the streets.⁹² In many instances, these children were also exposed to fractured lives at home with many complexities, such as low societal values and norms.⁹³

At the interpersonal and individual levels, family conflicts (including violence and neglect), changes in family structure (including the death of a parent and/or remarriage resulting in abandonment or discrimination), and being a victim to physical abuse, punishment, harassment, and rebuke by parents, were reported by some children as reasons that drove them to leave home and onto the streets.⁹⁴

For their survival, their vulnerabilities and risk of VAC were heightened even further, as some sought risky and informal jobs. These varied between the sexes, but the most common work for both included domestic help, factory labour, luggage bearing, garbage scavenging, and restaurant work.⁹⁵ Maltreatment, harassment, and beating were observed at these jobs. Girls faced the common issue of maltreatment at work due to unequal societal rules. Girls working in domestic work suffered the most from this, where they commonly experienced sexual harassment and fondling by the male persons of the household.⁹⁶ Sex work was also prominent amongst girls, leading to direct VAC in the form of sexual violence.⁹⁷

This is just one example of how risk factors engage with one another at all levels. Even here, however, we can already observe that not all these children's lives carry the same vulnerabilities and risks of VAC, even though, categorically, they are all vulnerable by virtue of their situation. It is also important to remember that VAC and its risk factors occur in all settings and not just in its most extreme forms. This includes in high-income and industrialised states. These consequences of VAC are monumental and have been observed on a global scale.

1.4 THE CONSEQUENCES OF VAC

The many forms of VAC, the risk factors, and its intergenerational effects rooted in deep structural problems, have many consequences that uphold and aid the vicious cycle of violence. VAC has persistently proven to result in devastating, complex, long-lasting, adverse, and multidimensional consequences, and this is backed by a plethora of evidence-based studies. However, it is important to keep in mind that not all cases of VAC and its many different forms, result in the same consequences. Again, there are many subjective factors and variables that need to be considered, such as age, sex, gender, socio-economic background, and frequency of abuse. This section highlights only a *small and general* fraction of these consequences.

In cases involving physical maltreatment, abuse, and violence, **VAC has a direct detrimental impact on a child's physical health.** These physical effects can range from non-fatal injuries, fractures, broken bones, lacerations, and disability.⁹⁸ In the most harrowing of instances, VAC can even threaten or cost children's lives.⁹⁹

Unsurprisingly, sexual violence committed against children bears a multitude of far-reaching consequences that can hinder all aspects of a child's development.¹⁰⁰ As well as the psychological trauma that results in an array mental health issues¹⁰¹ (see next paragraph below), there are **reproductive health consequences** especially associated in particular with sexual violence. For instance, there is an increased risk of contracting human immunodeficiency virus (HIV/AIDS), other STDS and STIs, unwanted and early pregnancies, and various physical traumas and injuries to the underdeveloped reproductive organs.¹⁰² Prolonged labour and stillbirth are common in women with FGM too.¹⁰³

⁹² Ibid. 282.

⁹³ Ibid.

⁹⁴ Ibid. 283.

⁹⁵ Ibid.

⁹⁶ Ibid. 284.

⁹⁷ Ibid.

⁹⁸ UNICEF (n 29) 31.

⁹⁹ Ibid.

¹⁰⁰ Ibid. 62.

¹⁰¹ Elizabeth Oddone Paolucci, Mark L Genius and Claudio Violato, 'A Meta-Analysis of the Published Research on the Effects of Child Sexual Abuse' (2001) 135 *The Journal of Psychology* 17, 31.

¹⁰² Todres (n 1) 220; Pinheiro (n 3) 15-16.

¹⁰³ Pinheiro (n 3) 60.

This direct or indirect exposure to VAC (whether in a physical, sexual, mental, or negligent form) can also lead to an array of short-term and long-term **psychological consequences**. For instance, one study found that children with both experience of being witness and victim to physical violence have a four times greater risk of having mental health problems than those children who have not experienced VAC.¹⁰⁴ Moreover, children that have experienced some form of recurring emotional violence often **grow up to feel deficient in some way**.¹⁰⁵ In children who have experienced **sexual violence**, studies have found that its links to **mental disorders, such as obsessive compulsive disorders, eating disorders, and personality disorders**.¹⁰⁶ Other psychological consequences resulting from VAC can range anywhere from **post-traumatic stress disorder, anxiety, depression, dissociation low self-esteem, insecurity, isolation, internalisation, long-term psychiatric and personality disorders** that extend to adulthood, and **self-directed suicidal behaviour and self-harm**.¹⁰⁷

Educational consequences also stem from VAC. For instance, a study from 2018 demonstrates that children who had experienced some form of childhood violence, abuse, and/or neglect, were **13% more likely to not graduate from school**.¹⁰⁸ Those who experienced frequent **bullying by peers, were twice as likely to skip school than their non-bullied peers**.¹⁰⁹ Moreover, **girls who had experienced sexual violence were approximately three times more at risk of being absent from school**.¹¹⁰

Maltreatment against a child has also been shown to **impair cognitive brain development and can lead to delayed development caused by numerous factors,**

such as from toxic stress due to higher cortisol levels.¹¹¹ Many studies have consistently found this can result in **lower school achievements at school than their non-maltreated peers from the same socio-economic background**.¹¹² Often, it is also observed that maltreated and neglected children are referred to **special education or retention at school**.¹¹³ Moreover, psychosocial and educational performance consequences correlate with the level of victimisation a child experiences. In one study, **youth that had become polyvictimised from multiple VAC experiences**, emerged as those with the **most significant psychological and social difficulties at school and academic performance problems**.¹¹⁴

Evidence also demonstrates that the impacts of VAC can also extend to and appear decades later, into adult life.¹¹⁵ **Acute and long-term health consequences** are caused by both direct and indirect **communicable and non-communicable diseases**, with some correlated with adopting high-risk behaviour as a coping mechanism.¹¹⁶ For instance, violence is strongly associated with **adopting risky behaviour, such as alcohol and drug abuse, and smoking**, which in turn causes several key-risk noncommunicable diseases. These include (inter alia) cancer, chronic lung disease, heart disease, liver disease, stroke, and diabetes.¹¹⁷

National development is also gravely affected by the **economic consequences** of VAC. For instance, in South Africa in the year 2015, the estimated economic value of 'disability-adjusted life years' (DALYs),¹¹⁸ or otherwise years lost in life due to non-fatal VAC incidents or incidents that have resulted in long-term consequences, such as poor health, disability or premature death,¹¹⁹ was esti-

¹⁰⁴ Noora Ellonen and others, 'Exposure to Parental Violence and Outcomes of Child Psychosocial Adjustment' (2013) 28 *Violence and Victims* 3, 9.

¹⁰⁵ UNICEF (n 29) 56.

¹⁰⁶ Gavin Andrews and others, 'Child Sexual Abuse' in Majid Ezzati and others (eds) *Comparative Quantification of Health Risks* (World Health Organisation 2004) 1884.

¹⁰⁷ UNICEF (n 29) 31, 56, 62; Candice Feiring, Charles M Cleland and Valerie A Simon, 'Childhood Sexual Abuse, Stigmatisation, Internalising Symptoms and the Development of Sexual Difficulties and Dating Aggression' (2009) 77 *Journal of Consulting and Clinical Psychology* 127, 128, 134.

¹⁰⁸ WHO (n 15) 17; Deborah Fry and others, 'The Relationships between Violence in Childhood and Educational Outcomes: A Global Systematic Review and Meta-Analysis' (2018) 75 *Child Abuse and Neglect* 6, 21.

¹⁰⁹ WHO (n 15) 17.

¹¹⁰ Ibid; United Nations Educational, Scientific and Cultural Organisation, 'Behind the Numbers: Ending School Violence and Bullying' (UNESCO 2019) 31-33 <<https://www.unicef.org/media/66496/file/Behind-the-Numbers.pdf>> accessed 16 June 2021.

¹¹¹ Danya Glaser, 'The Effects of Maltreatment on the Developing Brain' (2014) 82 *Medico-Legal Journal* 97, 106-107.

¹¹² Barbara Lowenthal, 'Child Maltreatment: Effects on Development and Learning' in Diane Rothenberg (ed) *Issues in Early Childhood Education: Curriculum, Teacher Education, and Dissemination of Information* (Early Childhood and Parenting Collaborative 2002) 367.

¹¹³ Ibid, 368.

¹¹⁴ Melissa K Holt, David Finkelhor and Glenda Kaufman Kantor, 'Multiple Victimization Experiences of Urban Elementary School Students: Associations with Psychosocial Functioning and Academic Performance' (2007) 31 *Child Abuse and Neglect* 503, 512.

¹¹⁵ Mercy and others (n 6) 76.

¹¹⁶ WHO (n 10) 11, 13; Vincent J Felitti and others, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study' (1998) 14 *American Journal of Preventative Medicine* 245, 249-250; Ellonen and others (n 104) 9.

¹¹⁷ Ibid, 11; WHO (n 15) 16-17; Mercy and others (n 6) 76.

¹¹⁸ The World Health Organisation coined 'DALY' in 1990, as a useful method to measure the impacts of violence on a person's potential lifespan.

¹¹⁹ UNICEF (n 29) 32.

PSYCHOLOGICAL CONSEQUENCES OF CHILDHOOD VIOLENCE

Sources: See page 117



The estimated costs

of physical, psychological and sexual VAC may be as high as

8%

of the world's GDP



Children who had experienced **some form of violence** were

13%

more likely to not graduate from school.

Children who had experienced **bullying by peers** were

2×

more likely to skip school.

Girls who had experienced **sexual violence** were

3×

more at risk of being absent from school.

mated at **4.3% of the country's gross domestic product (GDP)**.¹²⁰ In one study from 2014, it was estimated that the costs of physical, psychological and sexual VAC could even be **as high as 8%** of the global GDP.¹²¹

Zooming out even further from the cycle, it is important to understand **the interpersonal, intergenerational, and self-directed nature of VAC that can increase the likelihood of violence being perpetrated again, and thus subsequently upholding the vicious cycle**. For instance, and to name just a few findings, individuals who have experienced maltreatment or neglect during childhood are more likely to perpetrate it in adulthood than those who have not; adults who were exposed to four or more adverse childhood experiences (ACEs) (including physical, emotional and sexual abuse) are seven to eight times more likely to be involved in interpersonal violence both as victims or perpetrators, and thirty times more likely to attempt suicide in adulthood.¹²² Some studies have found that female victims of sexual VAC are between three and five times more likely to suffer further sexual assault than those who have not.¹²³ Other studies have found that men who faced physical or sexual violence as children and men who faced multiple types of child maltreatment were more likely to perpetrate violence in adult life.¹²⁴ Moreover, one study found that women who experienced both IPV and childhood physical abuse were significantly more at risk of maltreating their own children.¹²⁵

When discussing these consequences, **the COVID-19 pandemic** and its pathway of repercussions that link to VAC is unavoidable. Lockdown measures and other restrictions imposed during the pandemic have significantly

heightened VAC cases, which also has direct consequences not only for now, but also for future generations. With the closure of schools affecting over 1.5 billion children worldwide,¹²⁶ children have been disrupted in their everyday lives, their routines, their relationships, and their everyday environments.¹²⁷ As a result, we have seen the number of calls to helplines spike on a global scale. Yet, at the same time, restrictions have disrupted ordinary referral and reporting systems to child protection networks.¹²⁸

Furthermore, as demonstrated by a study led by Save the Children, there is a **direct correlation between cases of VAC and income loss, stress and anxiety generated from the pandemic and restriction measures**. Results demonstrate that in households that have suffered **more income loss, there is a higher reporting of violence in the home** by both children and parents.¹²⁹ In fact, nearly one-third (32%) of the households with children monitored in this study reported that violence had occurred in their home, whether in a physical or mental form.¹³⁰ The pandemic may also worsen existing mental health problems and increase cases amongst children, adolescents, and their parents. This may lead to tensions within the family and thus increase the risk of VAC.¹³¹

Lockdown measures have also increased the online presence of and internet use by children for learning activities and socialisation. This has increased the **potential or actual online harms**, such as cyberbullying and (sexual) exploitation, leading to an array of many different consequences, including self-directed harm and exposure to many other forms of (exploitative) violence.¹³²

120 WHO (n 15) 9, 18; Xiangming Fang and others, 'The Economic Burden of Violence against Children in South Africa' (2017) 14 *International Journal of Environmental Research and Public Health* 1431, 1439.

121 Paola Pereznielo and Lara Langston, 'The Costs and Economic Impact of Violence against Children' (ODI 2014) ix <https://www.researchgate.net/publication/266258834_The_costs_and_economic_impact_of_violence_against_children> accessed 13 September 2021.

122 WHO (n 15) 18; Karen Hughes and others, 'The Effect of Multiple Adverse Childhood Experiences on Health: A Systematic Review and Meta-Analysis' (2017) 2 *The Lancet Public Health* e356, e362-363.

123 Ibid. 9, 19; Angel Castro and others, 'Childhood Sexual Abuse, Sexual Behaviour, and Revictimisation in Adolescence and Youth: A Mini Review' (2019) 10 *Frontiers in Psychology* 2 <<https://www.frontiersin.org/articles/10.3389/fpsyg.2019.02018/full>> accessed 21 May 2021.

124 Ibid; Emma Fulu and others, 'Pathways between Childhood Trauma, Intimate Partner Violence, and Harsh Parenting: Findings from the UN Multi-Country Study on Men and Violence in Asia and the Pacific' (2017) 5 *The Lancet Global Health* e512, e519-e520.

125 Ibid; Lynette M Renner and Kristen Shook Slack, 'Intimate Partner Violence and Child Maltreatment: Understanding Intra- and Intergenerational Connections' (2006) 30 *Child Abuse and Neglect* 599, 601.

126 Amiya Bhatia and others, 'COVID-19 Response Measures and Violence against Children' (World Health Organisation 2020) 583 <<https://www.who.int/bulletin/volumes/98/9/20-263467.pdf>> accessed 20 June 2021.

127 UNICEF (n 14).

128 WHO (n 15) xi; UNICEF (n 14).

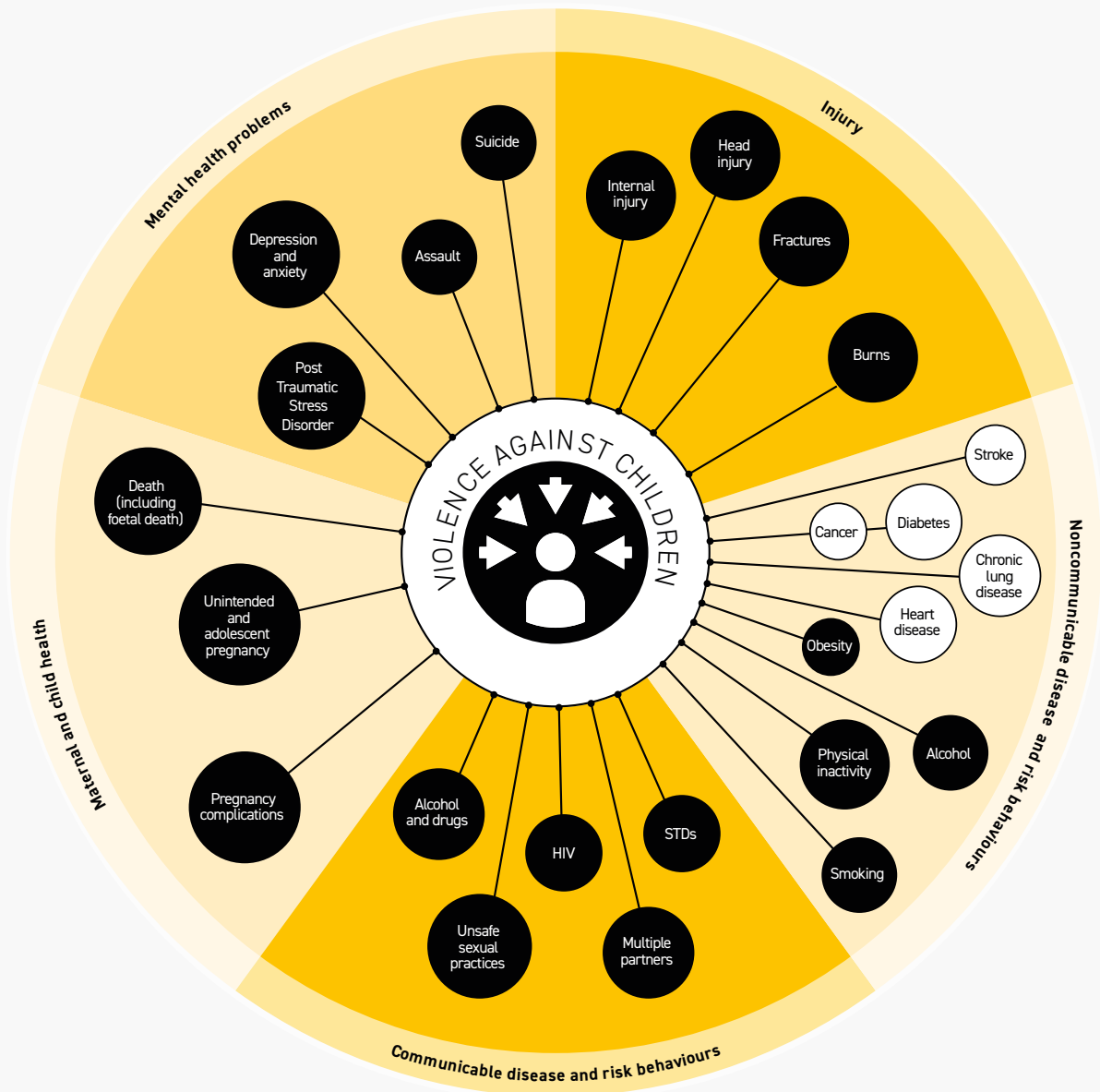
129 Georgina O'Hare, Daniela Ritz and Melissa Burgess, 'The Hidden Impact of COVID-19 - On Child Protection and Wellbeing' (Save the Children International 2020) 23 <https://resourcecentre.savethechildren.net/node/18174/pdf/the_hidden_impact_of_covid-19_on_child_protection_and_wellbeing.pdf> accessed 21 May 2021.

130 Ibid. 7.

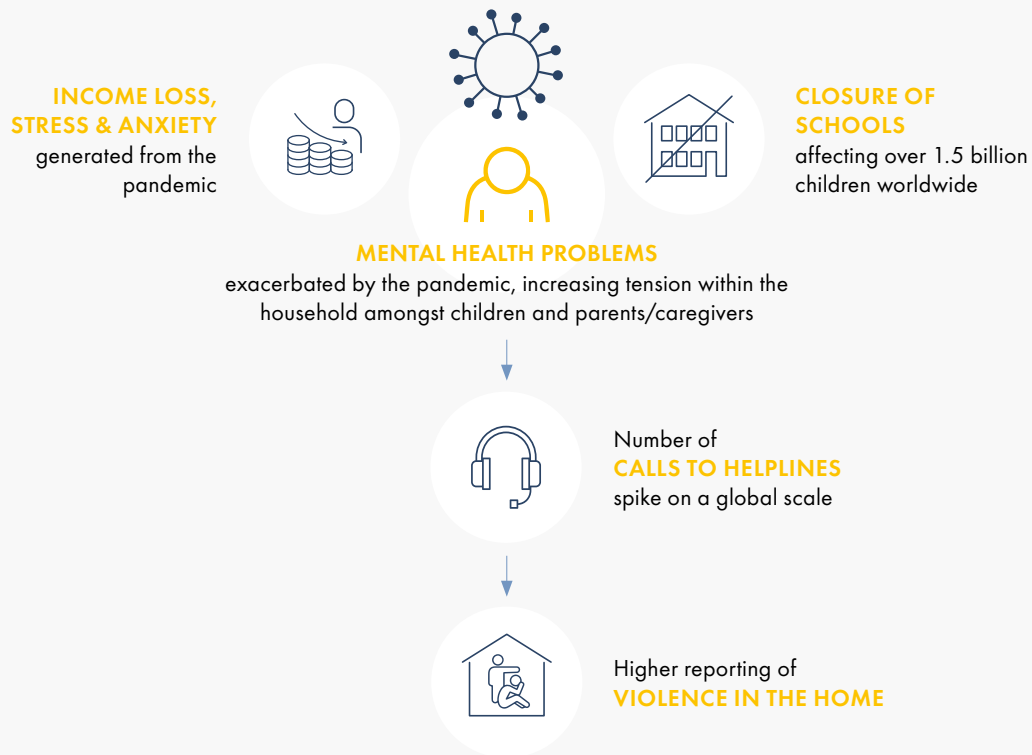
131 Noemi Pereda and Diego A Diaz-Faes, 'Family Violence against Children in the Wake of COVID-19 Pandemic: A Review of Current Perspectives and Risk Factors' (2020) 14 *Child and Adolescent Psychiatry and Mental Health* 4 <<https://capmh.biomedcentral.com/track/pdf/10.1186/s13034-020-00347-1.pdf>> accessed 22 May 2021.

132 O'Hare, Ritz and Burgess (n 129) 47-48.

POTENTIAL HEALTH CONSEQUENCES OF VIOLENCE AGAINST CHILDREN



COVID-19 AND ITS LOCKDOWN MEASURES



The exact magnitude of the COVID-19 pandemic is still, for many reasons, largely unknown.¹³³ There are many more concerns of well-being that are associated with the pandemic, such as disability status and violent parenting and disrupted child-parent relationships that are linked to VAC.¹³⁴ Generally, however, it has been predicted that the consequences of the pandemic, both in direct cases, and for future incidents driven by COVID-exacerbated economic inequalities and structural issues, may take years to overcome and are expected to put VAC incidents up to (and even beyond) pre-lockdown levels.¹³⁵

It should be noted that what has been discussed depicts only a general and small fraction of the results yielded over multiple studies that have, for decades, analysed the impacts of VAC. However, from this information alone, it

can be easily gauged that, at all levels, VAC is an epidemic that reproduces and causes continuing detrimental consequences, negatively impacting individuals, interpersonal relationships, the community, society, and even entire states. Even so, and despite these persistent findings, there is still a wide-scale acceptance of VAC in many of its forms.

¹³³ UNDESA (n 16) 57.

¹³⁴ O'Hare, Ritz and Burgess (n 129) 8.

¹³⁵ WHO (n 15) xi.

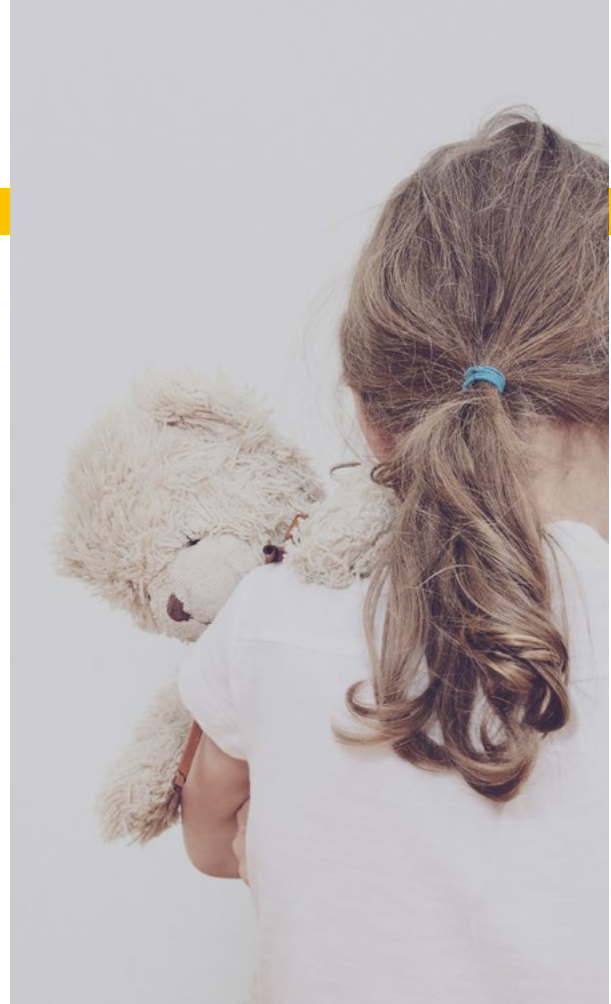
1.5 SOCIAL JUSTIFICATION, ACCEPTANCE & TOLERANCE OF VAC & ASSOCIATED STIGMATISATIONS

Despite the monumental consequences of VAC, in many of our societies the maltreatment of the child is still supported and even encouraged by cultural and/or social acceptance and by fostering attitudes of tolerance.¹³⁶ Alarming, not only is this a social practice, but in many jurisdictions VAC also remains legal in some of its forms.¹³⁷

Corporal punishment is a prime example of this. For instance, in the UK, VAC as a form of discipline by parents in the home settings (subject to certain limitations) is still embedded in cultural norms and this is reflected in its common law too.¹³⁸ In the USA, corporal punishment also remains legal in public school settings across nineteen of its states,¹³⁹ and legal in private school settings across all but two of its states.¹⁴⁰

In fact, as of 2021, currently only sixty-two countries worldwide have absolutely prohibited corporal punishment in all settings.¹⁴¹ Whilst this does reflect progress in the efforts that have been made over the last forty years to commit to a full prohibition, in reality, only 13% of the world's population of children live in countries where the law recognises their right to equal protection from assault – as it does for adults.¹⁴²

This acceptance may be due to the public and private divide that has resulted in enduring cultural views that are accepting of VAC,¹⁴³ meaning that, for many children,



the home is not the safe place it should be.¹⁴⁴ Of course, the right to a private life is deeply embedded in our societies, and whilst this right should not be interfered with by states, this often acts to disadvantage children who are exposed to VAC at home, heightening their vulnerability and limiting access to remedies.¹⁴⁵

Other harmful acts, such as forced and early child marriages, also relay this message of acceptance and are based on numerous social justifications. Mostly affecting girls, early marriage may be arranged and/or forced for reasons such as honouring the family, religious motivations, and salvaging sexual purity, or for economic reasons, such as security, dowry costs and wealth gains for families.¹⁴⁶

Beyond practices, harmful beliefs also tolerate or exacerbate trauma caused by VAC. The virgin cleansing myth

¹³⁶ Todres (n 1) 228.

¹³⁷ Ibid.

¹³⁸ Ibid.

¹³⁹ Elizabeth T Gershoff and Sarah A Font, 'Corporal Punishment in U.S. Public Schools: Prevalence, Disparities in Use, and Status in State and Federal Policy' (2016) 30 Social Policy Report 3 <<https://srcd.onlinelibrary.wiley.com/doi/epdf/10.1002/j.2379-3988.2016.tb00086.x>> accessed 6 July 2021.

¹⁴⁰ Elizabeth Breshears, 'Is it Time for a US Policy to Ban Corporal Punishment of Schoolchildren?' (2014) 23 International Journal of Education Reform 2, 7.

¹⁴¹ 'Prohibiting All Corporal Punishment of Children: Laying the Foundations for Non-Violent Childhoods' (End Violence against Children April 2021) 8, 11 <<https://www.end-violence.org/sites/default/files/paragraphs/download/Prohibiting%20all%20corporal%20punishment%20of%20children%20laying%20the%20foundations%20for%20nonviolent%20childhoods.pdf>> accessed 30 April 2021.

¹⁴² Ibid. Forty years ago, Sweden was the only one country in the world had completely outlawed corporal punishment in all settings.

¹⁴³ Todres (n 1) 229.

¹⁴⁴ Ibid.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid. 57.



The commitment to women and girls who suffer from discrimination, harmful practices and violence and to girls and adolescents who demand equal access to quality education, protection and healthcare remains paramount. Gender equality is a critical aspect of each of the 17 SDGs. Target 5.2 calls to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. Not only is the One-Stop Centre model an essential part of a well-functioning child protection system but they have proven to serve an important point of contact for especially young and vulnerable female survivors of violence.

María Fernanda Espinosa Garcés, President of the United Nations General Assembly for the 73rd Session, Councillor of the World Future Council

derived from ethnomedical practice, where child rape is performed in the belief that it will cure HIV/AIDs, alarmingly and dangerously exists in some societies too and is *prima facie* VAC.¹⁴⁷

Harmful stigmatisation in highly traditional societies can result in exacerbated trauma for victims, which is particularly prominent in cases of sexual violence. This stigma shifts blame onto the victim for reasons such as wearing inappropriate clothing according to cultural standards; for a girl being out of the house alone at night; or in the instance a boy having been sexually abused, a stigma associated with homosexuality that exists in some societies.¹⁴⁸

By accepting this stigmatisation, society fails to outright condone the *actual* act of sexual violence by the perpetrator. As victims are perceived as immoral,¹⁴⁹ not only is stigmatisation directly damaging to their dignity, causing internalised trauma and further victimisation, it also encourages a **culture of silence** where they may be deterred from reporting their abuse because of the reputation they fear they may face.¹⁵⁰

Lastly, it is worth mentioning that this tolerance of VAC can even extend to *after* these acts have been perpetrated, which can be extremely damaging to the welfare of the child, preventing an appropriate response to their needs as victims, and failing to condone perpetrated acts of VAC. In some societies, the preferred way of settling an incident and seeking justice from a case of VAC is through informal private arrangements. Observed grounds include salvaging the family dynamic, particularly when the perpetrator is the breadwinner of the family.¹⁵¹ In such instances, lengthy prison sentences can affect the economic survival of poor families when the perpetrator is prosecuted and incarcerated.¹⁵² Informal mechanisms may also be used where the perpetrator has close relations with the family of the victim. This may manifest in financial payments as a means of resolving conflict, and, in some extreme in-

stances, marriage between the perpetrator and victim has been documented. This has usually been conducted on the grounds of avoiding shame and the associated (harmful) stigma associated with the victim.¹⁵³

These examples are evidence of just a few ways VAC transpires through accepted social norms. Whilst some forms are more extreme than others, there is no doubt that, even with the efforts that have been made in our recent decades, widespread tolerance still exists on a global scale through entrenched practices and beliefs that encroach on the respect for the child's dignity.¹⁵⁴

¹⁴⁷ Suzanne Leclerc-Madlala, 'On the Virgin Cleansing Myth: Gendered Bodies, AIDs and Ethnomedicine' (2002) 1 African Journal of AIDS Research 87, 89-90, 92; Jill Keesbury and Ian Askew, 'Comprehensive Responses to Gender-Based Violence in Low-Resource Settings: Lessons Learned from Implementation' (Population Council 2010) 10 <https://knowledgecommons.popcouncil.org/departments_sbsr-rh/95/> accessed 5 May 2021; Linda Richter and others, 'Reported Physical and Sexual Abuse in Childhood and Adult HIV Risk Behaviour in Three African Countries: Findings from Project Accept' (2014) 18 AIDS and Behaviour 381, 387.

¹⁴⁸ Yabwile Mulambia and others, 'Are One-Stop Centres an Appropriate Model to Deliver Services to Sexually Abused Children in Urban Malawi?' (2018) 18 BioMed Central Paediatrics 5 <<https://bmcpediatr.biomedcentral.com/track/pdf/10.1186/s12887-018-1121-z.pdf>> accessed 16 May 2021.

¹⁴⁹ Ibid. 4.

¹⁵⁰ Keesbury and Askew (n 147) 10.

¹⁵¹ Ibid. 28.

¹⁵² Ibid; Janice A Dyre, 'The Silent Victims of Domestic Violence: Children Forgotten by the Judicial System' (1998) 34 Gonzaga Law Review 229, 233.

¹⁵³ Shelley Lees and Karen Devries, 'Local Narratives of Sexual and Other Violence against Children and Young People in Zanzibar' (2017) 20 Culture, Health and Sexuality 99, 109.

¹⁵⁴ Todres (n 1) 230.

CHAPTER CONCLUSION

VAC is a common occurrence for many children. It penetrates all levels of our societies, targeting children of all socio-economic backgrounds, ethnicity, race, religion, sexual orientation, gender, and sex. However, when we speak of VAC it is important to acknowledge that children are not one homogenous group. A common misperception is that children are merely a categorisation of passing beings. This incorrect perception fails to consider that their experiences as individuals, in childhood and the personhood they possess, makes them unique subjects with inherent human dignity. For these exact reasons, not one experience a child victim of VAC endures, is the same experience as another victim, which also explains why the risk factors of VAC are influenced by multiple and continually shaping elements. Certain children are more at risk to certain forms of VAC than others. These are not only determined by individual risk factors, but can be driven by deeply embedded systemic and structural root drivers that are present in all our societies. These existing structures of inequities and inequalities create the perfect environment for fostering the reproduction of VAC, not only in present time, but also across future generations. With both short-term and long-term physical, mental, health, educational, and economical consequences, the burden of this vicious cycle carries a monumental cost at all levels. Yet, despite these consequences, social acceptance and entrenched practices tolerating some forms of VAC continue to take place. Nevertheless, the international community has not been silent upon the matter. Whilst there is recognition that not enough has been done to respond adequately to VAC, the existing legal framework and the goals we have committed ourselves to are important steps in the right direction.

CHAPTER 2

The background of the top half of the page features a large, semi-transparent United Nations emblem. The emblem consists of a world map centered on the Atlantic Ocean, surrounded by a laurel wreath. The map and wreath are rendered in a dark blue color against a lighter blue background.

THE LEGAL FRAMEWORK FOR THE PROHIBITION OF VIOLENCE AGAINST CHILDREN

The various forms, consequences, and the burdens resulting directly from VAC are monumental and affect us at every level of our societies. Nevertheless, the legal frameworks at the international, regional, and national levels are not silent on the matter. As previously mentioned, by the year 2030, in their commitments to the SDGs, states have agreed to ending all forms of VAC including the abuse, (sexual) exploitation, trafficking, and torture committed against any child, in both the public and private domains.¹⁵⁵ In addition to these promising commitments, however, exists a body of human rights law that addresses legal obligations for protecting children from VAC based on a respect for their inherent human dignity.

¹⁵⁵ UNDESA (n 12) SDG 5.2, 16.2.

2.1 MAPPING OUT THE LAW: THE PROHIBITION OF VAC AND THE OBLIGATIONS TO PREVENT AND RESPOND

The United Nations Convention on the Rights of the Child (CRC)¹⁵⁶ is clear and outright in its prohibition of VAC, in whichever form it may manifest.¹⁵⁷ This is articulated in Art. 19 CRC,¹⁵⁸ which provides the following general prohibition that:

1. States Parties shall take **all appropriate legislative, administrative, social and educational measures to protect** the child from **all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse**, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such **protective measures should**, as appropriate, **include effective procedures for the establishment of social programmes** to provide necessary support for the child and for those who have the care of the child, **as well as for other forms of prevention** and for **identification, reporting, referral, investigation, treatment and follow-up** of instances of child maltreatment described heretofore, and, as appropriate, for **judicial involvement**.¹⁵⁹

Not only are states required to adopt all appropriate and effective legislative measures and policies that prohibit VAC, but the prohibition requires the implementation of administrative, social, and educational measures for the protection of children against *all* forms of violence. In doing so, these measures must contribute to and implement an integrated, cohesive, interdisciplinary, and coordinated system.¹⁶⁰

Adopting legislation and policy plays an important and decisive role in shaping prevention and response to VAC,¹⁶¹ yet, this is not merely enough to fulfil the right to be free from VAC.¹⁶² Paragraph two further outlines the protective interventions that must be implemented to fulfil this prohibition and incorporated into an integrated and holistic system.¹⁶³ Such interventions include establishing programmes that aim to advance the social conditions for children, their parents, and their caregivers, as well as other prevention mechanisms. **Prevention is at the forefront of this prohibition, as “prevention of children’s rights violations is the ultimate goal of children’s rights law”.**¹⁶⁴

Notwithstanding this goal, states are positively obligated to respond appropriately to VAC by **identifying** and acting upon a case, **referring** the child to **necessary support and treatment services** that include **follow-up support** and the **involvement of the judiciary** when necessary so as to ensure that VAC does **not reoccur**.¹⁶⁵ This aspect is supported by Art. 39 CRC,¹⁶⁶ which compels states to take every necessary “*appropriate measure to promote physical recovery[.]... psychological recovery and social reintegration of a child victim*”¹⁶⁷ after VAC and other forms of exploitation, including torture and cruel, inhuman, or degrading treatment (CIDT).¹⁶⁸

Importantly, these mechanisms need to be cohesive. In its General Comment on the right of the child to be free from

¹⁵⁶ Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC).

¹⁵⁷ Todres (n 1) 221; Susan H Bitensky, ‘The Mother of All Human Rights: The Child’s Right to be Free of Corporate Punishment as Hard International Law’ (2010) 36 Ohio Northern University Law Review 701, 715.

¹⁵⁸ Ibid. art 19.

¹⁵⁹ Ibid.

¹⁶⁰ CmRC (n 28) para 39.

¹⁶¹ Jaap E Doek, ‘Child Abuse and Neglect: Article 19 CRC’ (1994) 2 International Journal of Children’s Rights 88, 91.

¹⁶² Todres (n 1) 222.

¹⁶³ CmRC (n 28) para 39; See also Child Rights International Network, ‘Article 19: Protection from Abuse and Neglect’ (Child Rights International Network, 2018) <<https://archive.crin.org/en/home/rights/convention/articles/article-19-protection-abuse-and-neglect.html>> accessed 19 June 2021.

¹⁶⁴ Todres (n 1) 222.

¹⁶⁵ Ibid.; CmRC (n 28) para 37; CRC (n 156) art 19(2).

¹⁶⁶ Ibid. 222-223; CRC (n 156) art 39.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.



all forms of violence, the CmRC expresses that isolated mechanisms that are not or insufficiently integrated into a holistic system will have a limited and unsustainable effect.¹⁶⁹ It is a violation of the rights of the child when institutional systems on any level in the domestic jurisdiction “lack effective means of implementation of [the] obligations”¹⁷⁰ that may cause direct or indirect harm to the child. This includes the insufficient provision of the resources necessary for the capacity to identify, prevent, and react to VAC, including the means to **monitor and evaluate these national mechanisms in order to improve on any observed shortcomings.**¹⁷¹

Further, there is **no leeway** for discretion in safeguarding this prohibition.¹⁷² The prohibition of VAC and the right of a child to be protected from it, is interpreted as a **civil right**, thus **imposing immediate and unqualified obligations on states** akin to the prohibition of CIDT.¹⁷³ Taking into consideration the best interests of the child, the prohibition thus leaves no room for justifying any practice of violence, whether in a legally or socially accepted manner.¹⁷⁴

Not only is this right embedded at the international level, it has also been echoed across the **regional levels**. The Council of Europe’s (CoE) European Court of Human Rights (ECtHR) has interpreted acts of VAC under its pro-

¹⁶⁹ CmRC (n 28) para 39.

¹⁷⁰ Ibid. para 32.

¹⁷¹ Ibid.

¹⁷² Ibid. para 37.

¹⁷³ Ibid. para 65; Todres (n 1) 222; Joan E Durrant, Ashley Stewart-Tufescu and Tracie O Afifi, ‘Recognising the Child’s Rights to Protection from Physical Violence: An Update on Progress and a Call to Action’ (2020) 110 Child Abuse and Neglect 2 <<https://www.sciencedirect.com/science/article/abs/pii/S0145213419304739?via%3Dihub>> accessed 30 June 2021.

¹⁷⁴ CmRC (n 28) para 61; United Nations Committee on the Rights of the Child, ‘General Comment No 8: The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment’ (2006) UN Doc CRC/C/GC/8 para 18; Gerrison Lansdown, ‘Children’s Rights and Domestic Violence’ (2000) 9 Child Abuse Review 416, 421.



hibition of CIDT (Art. 3 ECHR)¹⁷⁵ on several occasions,¹⁷⁶ making it clear that, as a fundamental value intrinsic to any democratic society, the prohibition of torture and CIDT is absolute and requires extra “effective protection [and deterrence], in particular, [for] children...[which] include[s] reasonable steps to prevent ill treatment of which the authorities had or ought to have had knowledge”.¹⁷⁷ The African Union’s (AU) African Charter on the Rights and Welfare of the Child (ACRWC)¹⁷⁸ also expressly prohibits all forms of child abuse and torture against the child enshrined in Art. 16 ACRWC,¹⁷⁹ which follows a similar prohibition to the CRC.¹⁸⁰ In the Inter-American system,

Art. 19 ACHR¹⁸¹ on the rights of the child explicitly safeguards the child’s right to measures of protection. This includes the positive obligation to protect the child from mistreatment, reinforced in the Inter-American Court on Human Rights’ Advisory Opinion on the Juridical Condition and Human Rights of the Child.¹⁸² Moreover, in Asia, regional developments have also incorporated protections. For instance, the South Asian Association for Regional Cooperation (SAARC) has adopted the SAARC Social Charter, which includes recognition of a respect for the human dignity of the child and affords legal protection against violence.¹⁸³

¹⁷⁵ Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) [ECHR] 3 September 1953 005 art 3.

¹⁷⁶ See for example *Z and Others v The United Kingdom* [GC] ECHR 2001-V 1; *E and Others v The United Kingdom* App no 33218/96 [ECiHR, 26 November 2002]; *Talpis v Italy* App no 41237/14 [ECiHR, 2 March 2017]; *D.M.D. v Romania* App no 23022/13 [ECiHR, 3 October 2017]; *Association Innocence en Danger and Association Enfance et Partage v France* App nos 15343/15 and 16806/15 [ECiHR, 4 June 2020]; *Tyrer v United Kingdom* (1978) Series A no 26; *O’Keefe v Ireland* [GC] ECHR 2014-1 155; *M.G.C. v Romania* App no 61495/11 [ECiHR, 15 March 2016].

¹⁷⁷ See above *Z and Others v UK* para 73.

¹⁷⁸ African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) OAU Doc CAB/LEG/24.9/49 (ACRWC).

¹⁷⁹ *Ibid.* art 16 ; See also African Committee of Experts on the Rights and Welfare of the Child, ‘General Comment No 5 on State Party Obligations under the African Charter on the Rights and Welfare of the Child (Article 1) and Systems Strengthening for Child Protection’ (2018) <https://violenceagainchildren.un.org/sites/violenceagainchildren.un.org/files/regions/acerwc_general_comment_no_5_2018.pdf> accessed 27 April 2021.

¹⁸⁰ CRC (n 156) art 19; Todres (n 1) 222.

¹⁸¹ American Convention on Human Rights (adopted 22 November 1969, entered into force 18 July 1978) 1144 UNTS 123 (ACHR) art 19.

¹⁸² *Judicial Condition and Human Rights of the Child*, Advisory Opinion OC-17 Inter-American Court of Human Rights Series A (28 August 2003) para 87.

¹⁸³ Michael D A Freeman, ‘Upholding the Dignity and Best Interest of Children: International Law and the Corporal Punishment of Children’ (2010) 73 *Law and Contemporary Problems* 211, 250; South Asian Association for Regional Cooperation Social Charter (signed 4 January 2004) <<https://www.saarc-sec.org/SAARC-Charter/5/>> accessed 31 July 2021.

Whilst it is beyond the scope of this brochure to analyse every issue-specific legal prohibition and the obligations stemming from them, it is worth mentioning that this body of human rights law stretches beyond a general prohibition. Specific topics and forms of violence have been codified across various legally binding treaties. As well as the CRC's Optional Protocols on the Involvement of Children in Armed Conflict,¹⁸⁴ and on the Sale of Children, Child Prostitution, and Child Pornography,¹⁸⁵ other forms of exploitative VAC have been covered. For instance, child labour has been addressed specifically in the International Labour Organisation's (ILO) Convention No. 182 on the Worst Forms of Child Labour.¹⁸⁶ Additionally, structural violence issues such as poverty and discrimination, have been frequent and vital topics in the discourse of the various human rights institutions and bodies, which have continually urged states to seek alleviation and reduction strategies.¹⁸⁷

One vital point that cannot be ignored when discussing the prohibition of VAC, is the need to adopt a **rights-based approach** to child protection. This means that within a CPS, “**a paradigm shift towards respecting and promoting the human dignity and the physical and psychological integrity of children as rights-bearing individuals rather than perceiving them primarily as “victims”**”¹⁸⁸ is required of states.¹⁸⁹ As rights holders, **children need to be recognised, respected, and protected as individuals with valuable and unique characteristics**, – just as individual adults are perceived.¹⁹⁰ This approach is guided by a respect for the **core principles of dignity, the best interests of the child, non-discrimination, life, survival, well-being and development, participation, interdependence and**

indivisibility of rights, and transparency and accountability.¹⁹¹

Grounding prevention and responses to VAC by utilising a rights-based approach, allows for these principles, all other human rights norms, social justice, and equity, to be transferred to the relevant domains, systems, public policies, and programmes within a CPS.¹⁹² As a consequence, duty bearers (such as the government, and even caregivers, parents, and community members) need to acknowledge that **children's rights are holistic**, and thus a holistic perspective is necessary to safeguarding the prohibition of VAC.¹⁹³ **Safeguarding the right to be free from violence cannot be realised without fulfilling, respecting, and furthering these core principles and all other rights of the child, of which the fulfilment of such rights are threatened by VAC.**¹⁹⁴

¹⁸⁴ Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (adopted 25 May 2000, entered into force 12 February 2002) 2173 UNTS 222 (OP-AC).

¹⁸⁵ Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child pornography (adopted 25 May 2000, entered into force 18 January 2002) 2173 UNTS 227 (OP-SC).

¹⁸⁶ International Labour Organisation Convention (No 182) Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour (adopted 17 June 1999, entered into force 19 November 2000) (ILO C182); See also other issue-specific treaties such as Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) 25 October 2007 ETS 201; Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children (adopted 14 November 2000, entered into force 25 December 2003) 2237 UNTS 319.

¹⁸⁷ Todres (n 1) 224; CmRC (n 28) 12, 46; See for example United Nations Committee on the Elimination of Discrimination against Women, 'Joint General Recommendation No 31 on the Elimination of Discrimination against Women' and United Nations Committee on the Rights of the Child 'General Comment No 18 on Harmful Practices' (2014) UN Doc CEDAW/C/GC/31-CRC/C/GC/18 paras 9, 17; United Nations Committee on the Rights of the Child, 'General Comment No 7: Implementing Child Rights in Early Childhood' (2005) UN Doc CRC/C/GC/7/Rev.1 paras 8, 26, 36.

¹⁸⁸ CmRC (n 28) para 3(b).

¹⁸⁹ Jaap E Doek and Kimberly Svevo-Cianci, 'The Child's Right to Freedom from Violence: The UN Convention on the Rights of the child and UNCRC General Comment 13' in John R Conte (ed) *Child Abuse and Neglect Worldwide*, vol 1 (Praeger 2014) 218-219

¹⁹⁰ CmRC (n 28) para 3(c).

¹⁹¹ United Nations Children's Fund UK, 'Child Rights Partners: Putting Children's Rights at the Heart of Public Service' (UNICEF 2014) 6 <https://www.unicef.org.uk/child-rights-partners/wp-content/uploads/sites/3/2016/11/Unicef-UK_CRP-information-booklet_14.11.16.pdf> accessed 16 July 2021.

¹⁹² Charles Oberg and others, 'Violence Against Children: Recognition, Rights, Responses' (2021) 68 *Paediatric Clinics of North America* 357, 358.

¹⁹³ Doek and Svevo-Cianci (n 189) 219.

¹⁹⁴ CmRC (n 28) paras 11(d), 59; Oberg and others (n 192) 359.

2.2 DESIGNING A SOCIETY INTOLERANT OF VAC AND ELEVATING A RESPECT FOR THE DIGNITY OF THE CHILD

Despite the existence of the SDGs¹⁹⁵ and the vast legal framework that not only protects the child from violence but requires the recognition of their inherent dignity, the ever-present existence of VAC is still a harrowing issue. As protection mechanisms have inadequately addressed VAC, children are still waiting for their “full recognition of respect for their human dignity and physical integrity”.¹⁹⁶ As mentioned in the previous chapter, we know this because VAC not only remains tolerated and socially accepted in certain societies but is legal in some forms too.¹⁹⁷

Instead of perceiving children as equals, when we allow for and tolerate the perpetration of VAC, there is an underlying assumption that children are viewed as inferior to adults simply due to a lack of experience, maturity, and capacity.¹⁹⁸ This notion that dignity is an attribute that must be earned, as opposed to being inherent to every individual simply by virtue of *being human*, is a common and major obstacle reflected across many of our societies.¹⁹⁹ Such acts are not only transcribed through law but also exist in social and community structures.²⁰⁰ The legality of corporal punishment in many jurisdictions encapsulates this perfectly,²⁰¹ as do many other harmful practices (see section 1.5).

These reinforcements naturally act as a major barrier to the holistic realisation of children’s rights, which is why many children around the world struggle to or do not benefit from their protected human rights,²⁰² and vice versa. However, it is impossible to define any human being, including a



To confront and, eventually, eliminate VAC requires more than good law. Law is critical, but we also must address the root causes of VAC. That means addressing with cultural humility adult attitudes and behaviors that contribute to, or foster tolerance of, VAC in every country. More broadly, it means creating genuine partnerships with young people, their families, and their communities to build rights-respecting societies in which the dignity of every child is recognized, and the rights and well-being of all children are secured.

Jonathan Todres,
Distinguished University Professor & Professor
of Law, Georgia State University

child, without recourse to their dignity – the special worth imbued within them through being human.²⁰³

Because the CmRC obliges states to shift this paradigm so that full recognition of a child’s personhood is the new norm,²⁰⁴ there are two important considerations requisite to fulfilling respect for the child and elevating their dignity, that are necessary in order to improve responses to VAC.

Firstly, the **political will that prioritises eliminating VAC and reshapes society’s attitudes to and tolerance of childhood violence, must change to one that instead respects children.**²⁰⁵ As we know, the way in which VAC transpires, right down to the interpersonal relationships and individual levels, is often swayed by the decisions and structures embedded in the community, societal, and institutional levels (and vice versa). States and those that represent them must lead by example by ceasing themselves to participate in acts that, directly or indirect-

¹⁹⁵ SDGs (n 12).

¹⁹⁶ Pinheiro (n 3) 5.

¹⁹⁷ Todres (n 1) 228.

¹⁹⁸ K A Polonko and L X Lombardo, ‘Human Dignity and Children: Operationalising a Human Rights Concept’ (2014) 18 *Global Bioethics* 17, 20.

¹⁹⁹ *Ibid.* 21.

²⁰⁰ *Ibid.*

²⁰¹ Todres (n 1) 229.

²⁰² Doek and Svevo-Cianci (n 189) 224.

²⁰³ Freeman (n 183) 215.

²⁰⁴ CmRC (n 28) para 3(b).

²⁰⁵ Doek and Svevo-Vianci (n 189) 224-225.

ly, constitute or tolerate VAC.²⁰⁶ Implementing a national strategy to combat VAC is a sensible starting point. This includes improving the overall understanding (on all socio-ecological levels) of childhood violence, its complexities unique to each individual child, and its (major) consequences.²⁰⁷

Second, **ensuring the right to a child's participation is necessary to acknowledging their full personhood.** In the past, children have often been considered “the passive recipients of culture, rather than active participants in it”.²⁰⁸ Yet, this perception is faulty. As the CmRC has expressed, there is no age limitation for a child to be able to express themselves: evidence stemming from research has demonstrated that a child is capable of forming their own views from the youngest of ages, even though they may not be able to express these verbally.²⁰⁹

Age discrimination is the main factor that inhibits this very right to expression and participation. Yet, this is only an issue because it presents a challenge to the already established attitudes and ideals popular culture has shaped of children over generations as *dependent beings*.²¹⁰ **Yet, the right to participate does not imply that the family of the child is any less important. Rather, it is an acknowledgment of the child as a person with individual and inherent dignity, and equal and inalienable rights.**²¹¹ Every child who is capable of forming their own views, has the right to express themselves by participating in any decision-making process that affects them.²¹²

In a CPS, **participation yields major benefits** for individuals and society.²¹³ In cases of VAC, participation gives the child the opportunity to communicate their own understandings and convey their unique, complex, and differing

needs. This pathway to participation must be provided in a considerate practice and manner that promotes the best interests of the child.²¹⁴ This is crucial because participation assists agents of child protection to improve responses.²¹⁵ **A better understanding of the wants, needs, thoughts, and feelings of the child will place them at the centre of protection and assist adults in making better-informed decisions.**²¹⁶

Participation in cases of protection, however, should not be construed as language that overrides all other rights and must be interpreted with caution,²¹⁷ as an over-emphasis of a protectionist approach can lead to an adult's use of a child's rights for their own self-interest and agenda.²¹⁸ By example, in some instances, it has been observed that children themselves have agreed to their own marriages for the purpose of improving their own and their family's social and economic living situations. By relying on the right to participation and protection, parents can strategically make use of their child's marriage as a protective measure for their own lives and security.²¹⁹ Child participation in this instance does not work to improve responses for protection, and nor does it value the dignity of the child.²²⁰

Accordingly, whilst participation is crucial to recognising the child's dignity in VAC responses, safeguarding this right needs to be interpreted with comprehensive and contextualised research and understanding of the targeted community.²²¹ When this is done appropriately, combined with the political will and commitment to shifting attitudes away from an acceptance of VAC, these two imperatives will react to elevate a respect for the human dignity of the child to improve responses to and eliminate VAC.

²⁰⁶ Todres (n 1) 226.

²⁰⁷ Ibid.

²⁰⁸ Nicola Taylor, Pauline Tap and Mark Henaghan, 'Respecting Children's Participation in Family Law Proceedings' (2007) 15 *International Journal of Children's Rights* 61, 62; Allison James and Alan Prout, 'Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood' in Julia Brannen and Margaret O'Brien (eds) *Children in Families: Research and Policy* (2nd edn, Routledge 1996) 41.

²⁰⁹ United Nations Committee on the Rights of the Child, 'General Comment No 12: The Rights of the Child to be Heard' (2009) UN Doc CRC/C/GC/12 para 21.

²¹⁰ Tara M Collins, 'A Child's Right to Participate: Implications for International Protection' (2016) 21 *The International Journal of Human Rights* 14, 7.

²¹¹ Todres (n 1) 227.

²¹² CRC (n 156) art 12.

²¹³ Polonko and Lombardo (n 198) 21.

²¹⁴ CmRC (n 209) para 21.

²¹⁵ Collins (n 210) 20.

²¹⁶ Thoko Kaime, 'Children's Rights and the Environment' in Ursula Kilkelly and Ton Liefgaard (eds) *The International Human Rights of Children* (Springer 2019) 580.

²¹⁷ Collins (n 210) 17-18.

²¹⁸ Ibid; Kristin Chenney, 'Malik and his Three Mothers: AIDS Orphans' Survival Strategies and How Children's Rights Translations Hinder Them' in Karl Hanson (ed) *Reconceptualising Children's Rights in International Development* (Cambridge University Press 2012) 163.

²¹⁹ Ibid. 17.

²²⁰ Ibid. 18.

²²¹ Ibid.

CHAPTER CONCLUSION

The international law dealing with VAC is a vast and detailed framework that not only addresses the general and absolute prohibition of VAC in all its forms, but also contains legally binding issue-specific prohibitions. States are not only required to implement legislative, administrative, social, and educational measures, but also implement protective interventions. Importantly, a CPS must contain integrated, multisectoral, interdisciplinary, and interagency responses and prevention that adopt a child's rights-based approach to VAC. Instead of perceiving children as dependent and passive objects that need the assistance of adults,²²² they are recognised as individuals with full personhood. By nature they are entitled to the full realisation of all their non-negotiable rights inherent to them because they are rights bearing individuals.²²³ In every aspect of a CPS protecting children from VAC, this approach is imperative and should act to holistically realise all children's rights. Duty-bearers are responsible for protecting, respecting and fulfilling their obligations so that children can claim these rights.²²⁴ Yet, despite these comprehensive obligations encumbered upon states, it is indisputable that child protection responses have been inadequate. Girls and boys are still being subjected to many forms of VAC in their everyday lives, and this is tolerated on different levels. To fulfil the prohibition of VAC, elevating respect for the dignity of the child is a prerequisite necessity, and there are two main factors that need to be met. First, political will that prioritises eliminating VAC in all its forms placed on the national agenda is a sensible starting point, as institutional decisions will determine the way in which children are perceived and treated at all other levels. Second, child participation is crucial. Children have the right to participate in any issue that affects them, meaning that agents in all sectors can make better informed decisions that meet the exact needs of child victims of violence in a holistic manner and in line with *their* best interests.

²²² CmRC (n 28) para 59.

²²³ *Ibid.*

²²⁴ *Ibid.*

CHAPTER 3

A HOLISTIC CHILD PROTECTION SYSTEM & THE ONE-STOP CENTRE MODEL

A child's rights-based approach to VAC, requires states to incorporate protective and preventative mechanisms and interventions into their national jurisdictions.²²⁵ To do so, the implementation of a holistic CPS is necessary. This requires the provision of measures to be “comprehensive and integrated ... across the full range of stages...”²²⁶ of support, prevention, identification, reporting, referral, investigation, and (where necessary) judicial action.²²⁷ Accordingly, collaboration that is cohesive, multidisciplinary, multisectoral and interagency is requisite for a holistic CPS that requires whole systems strengthening.

²²⁵ CmRC (n 28) paras 11(d), 59. The CRC's holistic approach to securing a prohibition of VAC is based on the Convention's overall perspective to securing children's rights to survival, development, dignity, well-being, health, development, participation, and non-discrimination. The fulfilment of these rights are all threatened by VAC.

²²⁶ *Ibid.* para 45.

²²⁷ CRC (n 156) art 19(2).

3.1 SHIFTING FROM THEMATIC RESPONSES TO A SYSTEMS STRENGTHENED CPS

In acknowledging that our systems require far more comprehensive efforts to ensure that the legal obligation for the prohibition of VAC and the SDG targets are met, CPSs that follow a **systems approach** have been endorsed by many international stakeholders.²²⁸ In his recommendation to the international community in the 2006 *World Report on Violence Against Children*,²²⁹ Paulo Sérgio Pinheiro recommended that “...**all States develop a multi-faceted and systematic framework to respond to violence against children which is integrated into national planning processes.**”²³⁰ This approach has been promoted by NGOs, such as Save the Children, and some UN agencies and bodies such as UNICEF and the High Commissioner for Refugees (UNHCR).²³¹

Our past efforts in protection have often focused on thematic and issue-specific groups, such as children living and working on the street, trafficking, child labour, children in armed conflict and other man-made or naturally occurring emergencies.²³² Whilst this approach has undoubtedly contributed to our understanding of how CPSs can work and how we can further our systems, they have resulted in the **fragmentation of services.**²³³

As we know, children face multiple issues at the same time. They are complex, have individual needs, and their situations can uniquely differ based on multiple factors that occur in their individual lives. Factors such as gender, economic and wealth class, family life, race, ethnic group, and sexual orientation are amongst just some of these



There is an urgent need for leadership to push back on the culture of (sexualized) violence in the home and in public spaces, especially against girls and boys. Although over the last years, there is growing recognition about violence against girls and boys being wrong, there is still a wall of silence that needs to be torn down. We need to strengthen our child protection systems and include intervention tools, like the One-Stop Centre model, to offer immediate support and to ease prosecution. Besides changing mindsets; the adoption of legislation to criminalize violence against girls, boys and young women; and strong commitment to building strong child protection systems are key.

Dr. Hafsat Abiola-Costello
Executive President of Women in Africa Initiative (WIA), Councillor at the World Future Council

general traits affecting children in different ways and at different levels.

When we consider again the context of children living and working on the street, certainly they do not *all* these children face the *same* experiences. There are multiple issues that may simultaneously and uniquely occur in each and every one of their lives. Fragmented services and child protection responses that only resolve one of their issues may leave their other problems untouched.²³⁴ This may be the case when a girl, for instance, has been subjected to abuse by her family, lives on the streets, has sought work in a domestic help setting, *and* faces sexual harassment at her workplace.²³⁵ When services merely target the issue of street living in her life, they fail to address all the other

²²⁸ Desai (n 24) 44.

²²⁹ Pinheiro (n 3).

²³⁰ Ibid. 18.

²³¹ Fred Wulczyn and others, 'Adapting a Systems Approach to Child Protection: Key Concepts and Considerations' (UNICEF 2010) 1 <<https://resourcecentre.savethechildren.net/node/2778/pdf/2778.pdf>> accessed 31 May 2021

²³² Ibid. 1, 6.

²³³ Gabriella Oloffson and others, 'Child Protection Initiative - Building Rights-Based National Child Protection Systems: A Concept Paper to Support Save the Children's Work' (Save the Children 2010) 5 <<https://resourcecentre.savethechildren.net/node/3250/pdf/3250.pdf>> accessed 5 May 2021.

²³⁴ Ibid.

²³⁵ Ibid.

issues she faces, such as child labour, domestic abuse, and sexual violence.

This fragmentation of services will fail to provide an effective, comprehensive, and sustainable long-term solution.²³⁶ Nor does it guarantee that *all* children with unique and complex issues who experience or are at risk of different forms of VAC, are protected.²³⁷

Specific responses, however, are not meaningless. In times of emergency, prompt and short-term protection services are necessary to hastily address the immediate needs of the vulnerable groups of children affected.²³⁸ As Save the Children stipulates, “the detection of high-risk groups of children, or patterns of grave violations, in combination with limited time, access and resources, may require short-term narrow focus on specific children or issues...”.²³⁹ However, this may be at the expense of strengthening protection systems for *all* vulnerable children.²⁴⁰

However, existing emergency response mechanisms need not be eliminated.²⁴¹ Whilst utilising these existing frameworks and structures, it is important that steps are taken to build and reinforce components of a greater and overarching CPS at the same time.²⁴² To do this, **adopting a systems approach** becomes necessary.

As children are unique and have different experiences, responding to every child requires synchronising every element of a CPS in order to avoid gaps that are often felt in isolated responses.²⁴³ Rather than viewing individual issues separately, a systems approach is one that **“strengthen[s] the protective nature of the environment around children and [places them at the heart of it],... in order to ensure their well-being and fulfil their rights to protection from abuse, neglect, exploitation and other**

forms of violence.”²⁴⁴ The systems approach thus seeks to address the lack of coherent multisectoral policy and programming agenda for child protection, any weak national and subnational coordination, unclear responsibilities and accountabilities for all actors and agents involved, and under-resourcing in child protection.²⁴⁵

This approach views a CPS holistically. **It captures *all* categories of children**, guaranteeing equal access to the services they require.²⁴⁶ This is due to its **flexible, robust, and cohesive nature**, as it implements measures, mechanisms, and interventions at a wide range. These are implemented to meet all different contexts and situations a child may face, whilst simultaneously addressing, promoting, and advocating for the interests of the particularly marginalised groups of children.²⁴⁷

Importantly, **a successful systems approach to a CPS is one that adopts a broad social welfare perspective.** It seeks to address and recognise the impact of not only the deeply embedded root causes of VAC, and the other stigmas and hidden issues, but also violations that are deemed socially accepted, such as corporal punishment.²⁴⁸

Achieving this system **requires collaboration amongst stakeholders.** A systems approach is a multisectoral, interdisciplinary, and interagency coordination of cohesive interventions and mechanisms, placed across all layers of protection to mitigate the harms of VAC.²⁴⁹ It should begin with prevention but also incorporate adequate response services.²⁵⁰

Thus, this approach does **not only** involve specialist child protection competencies and disciplines within the child protection sector. A holistic approach requires coordination with the **social welfare, education, judiciary, health,**

²³⁶ Ibid; Wulczyn and others (n 231) 6; CmRC (n 28) para 39.

²³⁷ Ibid. 6.

²³⁸ Ibid.

²³⁹ Ibid.

²⁴⁰ Ibid.

²⁴¹ Bill Forbes and others, ‘A Systems Approach to Child Protection’ (World Vision International 2011) 2 <https://www.wvi.org/sites/default/files/Systems_Approach_to_Child_Protection.pdf> accessed 28 July 2021.

²⁴² Oloffson and others (n 233) 6.

²⁴³ Desai (n 24) 44.

²⁴⁴ Forbes and others (n 241) 2; Wulczyn and others (n 231) 6; Terre des Hommes, ‘Enhancing Child Protection Systems’ (Terre des Hommes 2011) 8 <https://www.tdh.ch/sites/default/files/1511bcf6-f0e5-495d-ada6-74261c45b798_tdh_reinforcement_syteme_protection_enfance_en_light_original_0.pdf> accessed 31 May 2021.

²⁴⁵ WFC (n 20) 3.

²⁴⁶ Forbes and others (n 241) 2.

²⁴⁷ Ibid. For example, children living and working on the street, children who have been trafficked, children in armed conflict, the sale of children etc.

²⁴⁸ Oloffson and others (n 233) 6.

²⁴⁹ Ibid. 5; Forbes and others (n 241) 2; Oberg and others (n 192) 364-365.

²⁵⁰ Ibid. Oloffson and others. 8.



and law enforcement sectors.²⁵¹ Thus, there are **many actors** involved in this CPS, including the government (and its various bodies), civil society, parents, families, caregivers, and other community structures.²⁵²

This highly interactive environment **contains sets of both formal and informal structures.**²⁵³ The incorporation of legislation, policies, norms, and values are sensible starting points. Equally important is the inclusion of mechanisms that target community engagement, education, and parent and caregiver support.²⁵⁴

Needless to say, not all societies function in the same way. For instance, in some places formal mechanisms may not be as pertinent as the informal structures in place at the community or family level that already have organically served to protect children.²⁵⁵ **The systems approach analyses these functions and bolsters their mechanisms, as opposed to being prescriptive of new functions.**²⁵⁶

These structures are not only made more efficient through the coordination of sectors, but also **maximises scarce resources and strive to eliminate the possibility of duplication in overlapping mechanisms.**²⁵⁷

By bolstering existing structures, the system **harmoniously and continuously works to identify new issues and addresses gaps in an ongoing fashion.**²⁵⁸ Thus, at every step, it affirms the role of parents and caregivers who are first responsible for the care and protection of children; it affirms the state's responsibilities to respect, protect, and fulfil their human rights obligations towards children; and it aims to strengthen the protective environment around children.²⁵⁹

Yet, to have a successfully functioning systems approach requires meticulous and thoughtful planning, and this comprises of several components.

²⁵¹ Ibid.

²⁵² Forbes and others (n 241) 2; Oberg and others (n 192) 364-365.

²⁵³ Oloffson and others (n 233) 7; Wulczyn and others (n 231) 18.

²⁵⁴ See the WHO INSPIRE (n 10) for more in-depth strategies necessary in a CPS.

²⁵⁵ Wulczyn and others (n 231) 18; Desai (n 24) 45.

²⁵⁶ Wulczyn and others (n 231) 18.

²⁵⁷ Desai (n 24) 45; Child Protection Working Group, 'Strengthening National Child Protection Systems in Emergencies Through Community-Based Mechanisms' (Save the Children 2010) 24-26 <<https://resourcecentre.savethechildren.net/node/3292/pdf/3292.pdf>> accessed 14 August 2021.

²⁵⁸ Ibid.

²⁵⁹ Bill Forbes and others (n 241) 2.

3.2 WHAT CONSTITUTES A SYSTEMS APPROACH & HOLISTIC CPS?

Although there is no such universal consensus as to what constitutes a CPS,²⁶⁰ according to Save the Children, CPSs are best “characterised by specific sets of functions, structures and capacities, and their local characteristics are determined by their socio-cultural, historical, and political context[s].”²⁶¹ These structures are **both formal and informal**, and are implemented at different levels. They address risk factors, prevent occurrences, and reduce vulnerabilities, whilst strengthening interlinked mechanisms to improve the resilience of children, their families, and even the communities and the government.²⁶²

Accordingly, a systems approach to a CPS requires several key components to effectively respond to VAC.²⁶³ This system **begins with a comprehensive regulatory framework consisting of legislation** (and the policies, standards, and norms that may emanate from this).²⁶⁴ This determines the system’s structures, its mandate, and its functions serving to prohibit, prevent, and mitigate the effects of all forms of VAC in all settings.²⁶⁵ This framework establishes a basis for accountability. The state is responsible for ensuring these rules and that the structures that emanate from them, are effectively implemented and monitored.²⁶⁶ Even as a fixed component, the way in which these rules are enforced depends on the decisions and choices affecting their implementation, which are further dependent on specific contexts of the national jurisdiction. From this perspective, they capture both structure and

flexibility, which is vital to securing a systems approach and its diversities.²⁶⁷

A **national strategy** or plan of action should accompany this regulatory framework. This sets out collective goals and strategies of action towards ending VAC.²⁶⁸ This is crucial so that “actors within the system are joined together through sense of a common purpose.”²⁶⁹ They are accompanied by legitimate and realistic targets to be met within a time frame and should include goals engaging *all* sectors that impact the protection of children.²⁷⁰

Cooperation, coordination, and collaboration at all levels amongst different disciplinaries, sectors, and actors should be realised by a central **national coordinating agency** that serves to implement the national strategy.²⁷¹ In doing so, it brings together different governmental departments at all levels as well as civil society.²⁷² This mechanism can also be supported by informal multistakeholder networks designed to interlink initiatives, strategies and the various actors that are involved.²⁷³

A **committed workforce**, which is strengthened to provide adequate, skilled, and stable services is equally necessary.²⁷⁴ This workforce, consisting not only of professionals specialised in working with children, but also other professionals that engage directly with children, must be trained to work with children and adhere to a respect for their dignity and their rights. Professionals should work under a clear mandate that highlights their competencies. Moreover, the training of informal actors, such as community figures and groups, is equally pertinent for enhancing protection.²⁷⁵

²⁶⁰ Ibid.

²⁶¹ Save the Children, ‘Strengthening Child Protection Systems’ (Save the Children UK 2019) 12 <https://resourcecentre.savethechildren.net/node/16321/pdf/strengthening_child_protection_systems.pdf> accessed 8 August 2021.

²⁶² Ibid.

²⁶³ Kimberly A Svevo-Cianci, Stuart N Hart and Claude Rubinson, ‘Protecting Children from Violence and Maltreatment: A Qualitative Comparative Analysis Assessing the Implementation of UN CRC Article 19’ (2010) 34 Child Abuse and Neglect 45, 54.

²⁶⁴ Save the Children (n 261) 13; Wulczyn and others (n 231) 21.

²⁶⁵ Forbes and others (n 241) 4.

²⁶⁶ Wulczyn and others (n 231) 21; Save the Children (n 261) 13.

²⁶⁷ Ibid. Wulczyn and others. 21.

²⁶⁸ Save the Children (n 261) 13.

²⁶⁹ Wulczyn and others (n 231) 18.

²⁷⁰ Save the Children (n 261) 13.

²⁷¹ Ibid.

²⁷² Oloffson and others (n 233) 4.

²⁷³ Forbes and others (n 241) 7.

²⁷⁴ Oloffson and others (n 233) 4, 7; Save the Children (n 261) 13.

²⁷⁵ Ibid; Forbes and others (n 241) 6.

THE 11 COMPONENTS OF A CHILD PROTECTION SYSTEM



Inspired by Save the Children's guide on "Strengthening Child Protection Systems: Guidance for Country Offices," available at https://resourcecentre.savethechildren.net/pdf/strengthening_child_protection_system

A range of child-friendly preventative and response services is required. This must target all levels, all disciplines, and all sectors that are involved in the protection of children.²⁷⁶ Furthermore, this includes supporting and strengthening informal mechanisms.

Existing prevention and response mechanisms must be supported and strengthened. A holistic CPS takes every level of protection into consideration, including informal structures that may exist in the community or family life. As these structures usually act as first respondents to protecting children, recognising issues, and immediately responding, they are paramount to their well-being. Thus, it is crucial they are supported. Responsibility should also be afforded to the local government for ensuring accessible, child-friendly, and preventative and support services.²⁷⁷

Changing attitudes and practices that foster a climate for VAC is a fundamental requisite to respecting the dignity of children that forms a vital component of a functioning CPS. Governments should undertake all possible efforts to raise awareness of the prohibition of VAC in its entirety and change any attitudes that tolerate violence perpetrated against any child, – both against girls and boys. An aware public will be more involved in the efforts to prevent violence and respond to child protection issues in communities and the wider society.²⁷⁸

The adequate allocation of resources is another integral ingredient in a systems CPS. This should be at *all* levels, including within the child's community.²⁷⁹ Thus, resource allocation requires collaboration with and advocacy from the respective national ministry of finance and external donors to increase budgets for VAC.²⁸⁰

Lastly, a CPS requires a **data collection system** that is centralised, ensures the regulation of information on the prevalence of VAC, as well as the effectiveness of strategies by identifying potential shortcomings.²⁸¹ This system monitoring all prevention and response mechanisms at every level will serve to identify, analyse, and evaluate lessons learnt and any gaps that need to be addressed for future prevention and response.²⁸²

Together, these components, guided by the core principles of the rights of the child (including their right to participation – see previous chapter), will synergise to form a functioning and strengthened CPS. These elements do not function independently or stand alone.²⁸³ Rather, they are integral segments that synergise to form a whole.

An in-depth discussion on best practice methods that may be implemented to contribute to this systems approach is outside the scope of this brochure. However, for further guidance, the Global Partnership to End Violence Against Children (End Violence)²⁸⁴ has adopted the World Health Organisation's (WHO) **INSPIRE Seven Strategies**. This framework identifies evidence-based strategies that have proven successful in reducing VAC, and includes the implementation and enforcement of laws, norms and values, safe environments, parent and caregiver support, income and economic strengthening, response and support services, and education and life skills.²⁸⁵ Detailed approaches and programmes within these strategies and global best practices have been highlighted.²⁸⁶ It is recommended that policymakers and other stakeholders look to INSPIRE and its handbook for implementation for the best available methods that support systems strengthening CPS.²⁸⁷

²⁷⁶ Ibid.

²⁷⁷ Ibid.

²⁷⁸ Save the Children (n 261) 13.

²⁷⁹ Oloffson and others (n 233) 7.

²⁸⁰ Save the Children (n 261) 13.

²⁸¹ Oloffson and others (n 233) 7.

²⁸² Save the Children (n 261) 13.

²⁸³ Ibid.

²⁸⁴ The partnership is led by UNICEF and involves 420 other global partners.

²⁸⁵ United Nations Children's Fund, 'INSPIRE: Seven Strategies for Ending Violence Against Children' (UNICEF) <<https://www.unicef.org/documents/inspire-seven-strategies-ending-violence-against-children>> accessed 12 September 2021.

²⁸⁶ WHO (n 10) 8; Save the Children (n 261) 12; Desai (n 24) 59-60; World Health Organisation and Others, 'INSPIRE Handbook: Action for Implementing the Seven Strategies for Ending Violence Against Children' (World Health Organisation 2018) 16 <<https://www.who.int/publications/i/item/inspire-handbook-action-for-implementing-the-seven-strategies-for-ending-violence-against-children>> accessed 5 August 2021. The implementation handbook offers a handful of considerations necessary for INSPIRE's implementation, such as cost estimations, impact and sustainability considerations, and child participation.

²⁸⁷ Ibid.

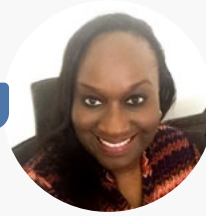
3.3 THE ONE-STOP CENTRE MODEL AS A CHILD PROTECTION INTERVENTION TOOL

The **One-Stop Centre (OSC)** model is a global best practice intervention tool that utilises multisectoral, inter-agency, and interdisciplinary coordination in the provision of comprehensive and cohesive services for survivors of VAC. The model first emerged in Malaysia in 1994 as a government-led response to GBV, primarily targeted at abused women seeking immediate help.²⁸⁸ These centres were designed based on a Canadian model.²⁸⁹ Shortly after, many other states within the region began to replicate their own OSCs based on the Malaysian model. Today OSCs and similar mechanisms have been adopted on a global scale²⁹⁰ and are not only used to respond to violence against women (VAW) but also to VAC.

The concept of an OSC is rather simple. An **OSC is an umbrella institution for services required to respond to the immediate and long-term needs of survivors of VAC.** With services physically located under one roof, an OSC provides easy and speedy access to the most essential services required.²⁹¹ They are a central contact point for both children and their families affected by violence.

Too often, response services have been sporadically spaced across multiple and different institutions. In these scenarios, survivors of violence have had to travel to different departments and buildings to receive all the appropriate and necessary services they require.²⁹² Already faced with the unfair burden of trauma, survivors must retell their distressing experiences at every contact point

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When it comes to One-Stop Centres, if you 'build them', survivors will be more likely to come when they have warm, accompanied referrals to ensure they are efficiently connected to care.

Chi-Chi Undie, Senior Associate of the Population Council's Reproductive Health Programme.

of service they receive, which can cause or increase the likelihood of retraumatisation and revictimisation. This is only exacerbated when the services are not provided in a child-friendly and sensitive manner by trained professionals competent in dealing with cases of child abuse, violence, and neglect.

With all services located in one department, it is **the main goal of an OSC to prevent the retraumatisation and revictimisation of survivors of VAC.**²⁹³ In low and middle-income resource settings, OSCs are usually best integrated into existing healthcare centres that already have existing infrastructure and capacity. In higher resource settings, stand-alone OSCs are more possible if resources for infrastructure and capacity are adequately provided for. Nonetheless, in whichever way OSCs may be integrated and institutionalised into national systems, it is requisite that all centres offer a safe, secure, comfortable, and child-friendly environment, with services provided by trained professionals capable of dealing with children and cases of VAC.²⁹⁴ These services should operate based on mandated protocols dictating the procedures and responsibilities of each actor and agency at the centre. Ideally, **four essential pillars of service** should be provided at OSCs.²⁹⁵

²⁸⁸ McKeon, Garcia-Moreno and Colombini (n 21) 2; Keng Sheng Chew, Noredelina M Noor and Ida Zarina Zaini, 'Knowledge, Attitude and Practice Among Healthcare Staffs in the Emergency Department, Hospital Universiti Sains Malaysia towards Rape Victims in One Stop Crisis Center (OSCC)' (2015) 70 *Medical Journal of Malaysia* 162, 162.

²⁸⁹ Manuela Colombini, Susannah Mayhew and Charlotte Watts, 'Health Sector Responses to Intimate Partner Violence in Low-and Middle-Income Settings: A Review of Current Models, Challenges and Opportunities' (2008) 86 *Bulletin of the World Health Organisation* 635, 637.

²⁹⁰ 'Ending Violence against Women: Study of the Secretary-General' (United Nations 2006) 116 <<https://www.unwomen.org/en/digital-library/publications/2006/1/ending-violence-against-women-from-words-to-action-study-of-the-secretary-general>> accessed 15 July 2021.

²⁹¹ Rachel Jewkes and others, 'What Works to Prevent Violence Against Women and Girls - Evidence Reviews' (What Works 2015) 28 <<https://www.whatworks.co.za/resources/evidence-reviews/item/4-effectiveness-of-interventions-to-prevent-violence-against-women-and-girls>> accessed 9 April 2021

²⁹² For instance, a girl who has been sexually violated may first have to travel to the emergency department of a hospital to receive immediate medical attention, and shortly after have to travel and retell this same experience at the police department when filing a report against her perpetrator.

²⁹³ McKeon, Garcia-Moreno and Colombini (n 21) 2.

²⁹⁴ World Future Council, 'Ghana on its Way to its Enhanced Child Protection System for Survivors of Child Violence' (World Future Council 6 December 2018) <<https://www.worldfuturecouncil.org/ghana-child-protection-workshop-2018/>> accessed 4 April 2021

²⁹⁵ Ibid.

THE IDEAL ONE STOP CENTRE MODEL

Fast and easy support for Survivors of Child Violence
- all under one roof



"One-Stop Centre" at a local hospital

Survivors report case
in a secure, comfortable
and confidential
environment



Legal Personell

gathers and secures all evidence
needed to aid prosecution



Social Welfare

personell offers psycho-social
emergency help



Police

provides medical exams form,
gathers information, prepares
arrest and prosecution



Medical Team

makes medical examinations
and gathers evidence



➤ **Social and psychological Services:**

A social worker is usually the initial contact point for a child survivor of VAC and their non-offending family, though this can vary from country to country depending on the domestic systems in place. Social workers are tasked with the initial exploratory assessment of the child and determining if VAC has been perpetrated. If VAC has been determined, the social worker will initiate a referral to the services next required for the child. Highly competent mental health staff that are professionally trained in dealing with children are equally important in the provision of psychosocial services. They are tasked with both the immediate screening of the child, including for crisis support and long-term therapeutic services to improve the resilience of the child survivor. Importantly, the accounts collected by the social worker should serve as the main document detailing the experiences of the survivor. A child should **not** be required to repeat their experiences to other services at the OSC after this initial contact point. Repetition of experiences would defy the purpose of an OSC for preventing retraumatisation. It should be the duty of the initial screening team to transfer the account of the child's experience(s) to the rest of the team, whether through documentation, recordings, or through live hearings from another room within the centre.

➤ **Medical services:**

A medical team, which should consist of an in-house doctor, nurses, and other medical assistants, evaluates the child's health. Where necessary, they may administer and prescribe tests, treatment, and medicine such as post-exposure prophylaxes (PEP) and anti-contraceptives. In the case of a medical emergency, referrals are immediately made to emergency services. Another vital component of the medical service pillar is to carry out medico-legal reports and collect the forensic evidence necessary for filing a police report against an accused perpetrator, which is indispensable in instances of sexual violence.

➤ **Law enforcement services:**

Police officers also form an integral part of an OSC. It is their duty to provide an accessible reporting service to survivors and their families. The law enforcement agent should be well equipped and trained in dealing with cases in a child-sensitive, warm, and friendly manner. Where necessary, the agent initiates a criminal investigation, gathers any forensic evidence through a forensic interview, and, where required, prepares for the arrest and prosecution of the perpetrator.



👉 Legal aid services:

The legal system is often an overtly complex mechanism to navigate. Thus, the legal team at the OSC guide the child and their non-offending family in the appropriate legal direction that may be pursued. These services may be provided by legal counsel, advocates, advisers, and aids that assist in determining the child's legal position and rights (including for civil compensation). A qualified advocate may also represent the child survivor in a court of law should a case be prosecuted. The legal team also gathers the necessary evidence to assist in the prosecution of the perpetrator.

Importantly, it should be noted that **OSCs make up just one element of a national CPS**. Although these centres can be designed to respond to the needs of survivors of VAC appropriately and effectively, they cannot exist as isolated intervention tools. Without the other key components within a CPS, the relevance of OSCs is diminished. If there are no prevention mechanisms designed to hinder the prevalence of VAC, then the implementation of OSCs serves little purpose and can inadequately pursue the legal obligations that emanate from a child's rights-

based approach. These centres must be designed within a cohesive and all-embracing system that challenges VAC and its perhaps tolerated status quo in the first place.

The operation of OSCs would not be possible without actors from multiple disciplines, different sectors of our societies, and the agencies involved that coordinate to provide the very best services for child survivors. To ensure this synergised response, the government, its relevant child protection coordinating agency, and ministries may be involved in the accountability for the coordination of centres and the provision of agencies and employees.²⁹⁶

These considerations only give a brief insight into the ideal components of an OSC. However, there are many ways these centres can and have been incorporated into national jurisdictions. **This model is not a one-size-fits-all mechanism and may function differently in different societies.**

²⁹⁶ WFC (n 294).

CHAPTER CONCLUSION

The CPS is both an intricate and intrinsic system required by the legal obligations for protecting the rights of the child. In the past, thematic and issue-specific forms of VAC were the focal point for responses. Although these assisted in achieving a greater understanding of specific issues in children's lives, these isolated measures are unsustainable, often leading to gaps in the provision of child protection services that address *all* the challenges in children's lives. Within the last decade, however, there have been calls to reform our CPSs by adopting a systems approach designed to strengthen and support formal and informal mechanisms of child protection. Targeting both prevention and response, a systems approach opts to provide a child with a safe and secure environment, viewing all components of a CPS holistically and adopting a broad child welfare perspective. It synergises all components to form a greater and overarching system. Rather than viewing individual issues, a systems CPS continually captures *every* issue that arises. Fostering this approach is rooted in multisectoral, interdisciplinary, and interagency collaboration that target every socio-ecological level of society. Over the last few decades and across many states, the OSC model has emerged as a best practice intervention tool for responding to VAC within a greater CPS. Grounded upon multisectoral, multidisciplinary, and interagency collaborations, these centres usually provide four coordinated and essential services of psychosocial, medical, legal, and law enforcement care, which occur under *one roof*. By preventing child survivors from seeking services under fragmented and different institutions, the goal of the OSC is to prevent retraumatisation and revictimisation and improve the resilience of child survivors.

CHAPTER 4

A globe of the Earth is shown, focusing on the Americas. The globe is held by two hands, one on the left and one on the right. The text 'COUNTRY CASE STUDIES OF ONE-STOP CENTRES AROUND THE WORLD' is overlaid in white, bold, sans-serif font across the center of the globe. The background is a dark blue gradient with faint, circular patterns.

COUNTRY CASE STUDIES OF ONE-STOP CENTRES AROUND THE WORLD

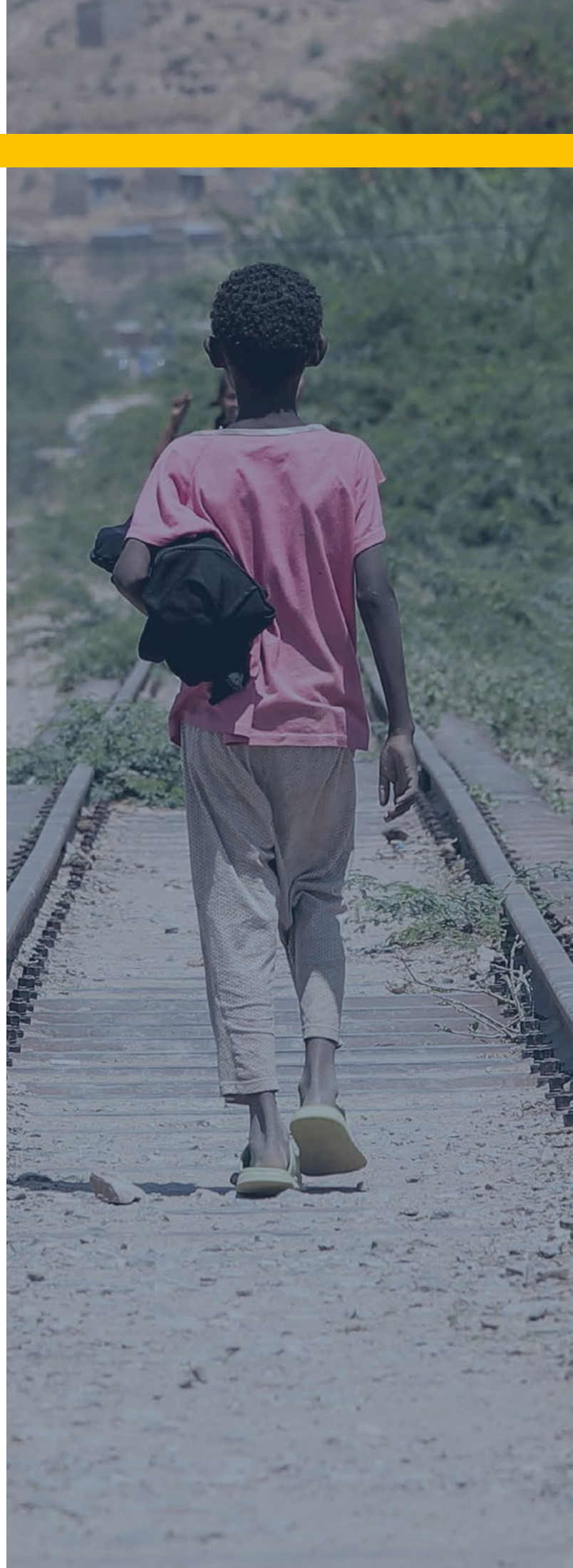
Throughout the world, OSCs have been implemented across many different national contexts. As there have been no uniform nor harmonised global standards, these centres have manifested in different ways and bear unique characteristics. There is no one-size-fits-all OSC, as the approach caters to fit unique and different contexts. For instance, some centres focus on issue-specific forms of VAC, such as GBV or sexual violence, other are family-oriented and provide services not only for the children but also the whole family too, and some centres are targeted predominantly at women but also provide access to child survivors of VAC. Importantly, whilst the term ‘OSC’ can be considered an umbrella concept, all centres studied in this brochure have envisioned a multidisciplinary response to VAC. As such, with the aim of preventing retraumatisation and revictimisation, they have engaged in coordinated services from sectors such as social welfare, child protection, medicine, psychological therapy, law enforcement, and the judiciary. It is worth noting that beyond this context of country studies, many other OSCs exist that respond to violence. However, the OSCs in this brochure have been selected as they explicitly target child survivors of VAC in their mandates and have been evaluated to some degree. As this model has been commonly implemented across many African and Asian countries, the majority of the studies in this chapter stem from these two continents, although, similar approaches have also been identified in other regions, and these are also highlighted. Additionally, it is worth bearing in mind that countries that have not implemented OSCs do have other child protection interventions in place.

4.1 OSCs IN AFRICA



In Africa, there are initiatives that are working in dealing and responding to violence against children such as the One-Stop Centre model, which have been successfully implemented in countries such as Zanzibar and are also being attempted in other countries. It is an initiative we really need in African countries, even the ones that would be considered to have relatively good facilities, such as in South Africa where the model already exists. The problem [for victims] is that in most African countries, we have police stations in one place and the next available hospital that has the capacity to do assessments necessary to provide the essential services responding to a child that is a victim of violence, that is too far away. This OSC model is the only way of ensuring a child-friendly response to VAC, because it has all the medical, psychological, legal and law enforcement services under one roof, thereby easing access for victims, and preventing retraumatisation as they do not have to go to different institutions just to seek these necessary services.

Dr. Nkatha Murungi, Assistant Director of the Centre for Human Rights and Senior Lecturer at the Faculty of Law at the University of Pretoria, Councillor of the World Future Council



THE CASE OF KENYA

BACKGROUND

Exposure to VAC in Kenya is exceedingly high over a lifetime exposure.²⁹⁷ As a 2019 survey recorded, **15.6% of females and 6.4% of males** aged between eighteen and twenty-four disclosed that they had experienced some form of **sexual violence** prior to turning eighteen.²⁹⁸ In the **last twelve months** of this survey being conducted, **as high as 13.5% of females and 2.4% of males** aged between **thirteen and seventeen** reported to having **experienced sexual violence**.²⁹⁹ Instances of physical violence are even higher, with more than **one in three females (36.8%) and two in five males (40.5%)** aged between **thirteen and seventeen**, disclosing that they had **experienced some form of physical violence within the last twelve months**.³⁰⁰

Nevertheless, Kenya has not remained silent on this epidemic against children. Through establishing OSCs, it is among the countries identified at the forefront of responding to VAC and GBV.³⁰¹ The first ever OSC model was established in 2001 in Nairobi's Women's Hospital, a private for-profit healthcare facility.³⁰² Since then, over twenty more OSCs have been implemented within the country. Most of these centres were established in the wake of the 2007-2008 post-election period, which erupted in violence and sparked a major humanitarian crisis.³⁰³ Today, with the support of various stakeholders, OSCs have been incorporated into several other healthcare facilities and independent centres.³⁰⁴

CHARACTERISTICS OF ONE-STOP CENTRES IN KENYA

A System of Different Types of OSCs Managed by Different Stakeholders:

In Kenya, OSCs have been implemented in different ways. Health facility-based centres may be managed by public healthcare (and are therefore government owned), private healthcare initiatives, and/or run by/supported by non-state agencies. Stand-alone centres also exist, and are mostly NGO-run.³⁰⁵ There is some degree of ministry oversight by the Ministry of Health, along with its partners (including NGOs), which have implemented standard operating guidelines on the provision of services for survivors of VAC and (S)GBV.³⁰⁶

The provision of **OSC services rather refers to a system with referral networks rather than a single physical entity or mechanism**.³⁰⁷ For instance, clinical health and psychological needs may be addressed under one roof in healthcare systems, and judicial and legal services may be incorporated later. In stand-alone OSCs, one will often find that legal and psychological services may be provided, but referrals may be made for medical care.³⁰⁸ As these OSCs target responses to survivors of VAC and GBV, they are designed for both children *and* women and men.

Even within hospital-based facilities, OSCs bear differences from centre to centre. For instance, Kenyatta National Hospital's OSC, the Gender-Based Violence Recovery Centre, only operates weekdays from 8a.m. to 5p.m. Situated in the Mental Health Department, it offers a full range of psychosocial services (including trauma counselling, safe house referral, and survivors' groups).³⁰⁹ For medical services, survivors are referred within the hospital. On the other hand, the OSC in the Moi Teaching and

²⁹⁷ Jill Keesbury and Others, 'A Review and Evaluation of Multi-Sectoral Response Services ["One-Stop Centers"] For Gender-Based Violence in Kenya and Zambia' (The Population Council 2012) vi <https://knowledgecommons.popcouncil.org/departments_sbsr-rh/9/> accessed 15 May 2021.

²⁹⁸ Ministry of Labour and Social Protection, 'Violence Against Children Survey Report' (Republic of Kenya 2019) 31 <[https://www.unicef.org/kenya/media/1516/file/2019%20Violence%20Against%20Children%20Survey%20\(VACS\)%20.pdf](https://www.unicef.org/kenya/media/1516/file/2019%20Violence%20Against%20Children%20Survey%20(VACS)%20.pdf)> accessed 3 September 2021.

²⁹⁹ Ibid. 35.

³⁰⁰ Ibid. 39.

³⁰¹ Keesbury and others (n 297) vii.

³⁰² Ibid. 11.

³⁰³ Ibid.

³⁰⁴ Ibid.

³⁰⁵ Kizzie Shako and Myrna Kalsi, 'Forensic Observations and Recommendations on Sexual and Gender Based Violence in Kenya' (2019) 1 *Forensic Science International: Synergy* 185, 189.

³⁰⁶ Ibid.

³⁰⁷ Keesbury and Others (n 297) 1.

³⁰⁸ Ibid.

³⁰⁹ Ibid. 7-8.

Referral Hospital (MTRH), namely the Centre for Assault Recovery Eldoret, operates twenty-four hours a day and seven-days a week, offering a full range of medical and psychosocial services. For police and legal assistance, both centres refer their clients to legal aid NGOs and the police.³¹⁰ Whilst both centres are managed by the hospitals, they are supported by national and international partners (such as Liverpool VCT, Coalition on Violence against Women, USAID, and the German Development Corporation).³¹¹

Stand-alone OSCs also exist in Kenya. These include *Medicins Sans Frontieres* (MSF)'s SGBV Clinic, which has been operating in eastern Nairobi since 2008. Since 2011, the clinic has offered care seven-days a week and twenty-four hours a day. The centre provides services to all victims of sexual and GBV and has a specialised paediatric room for children. All survivors undergo clinical and psychological assessment, HIV and pregnancy testing (if required), testing for other infections and diseases, and forensic evidence collection.³¹²

SUCCESSSES & SHORTCOMINGS OF KENYA'S OSCS

In a country that has experienced a major humanitarian crisis and where VAC (and other forms of violence) is endemic, the implementation of OSCs has proven to be beneficial. Over the years, there have been some vital lessons learnt from the successes and shortcomings observed that are useful inputs in understanding what contributes to a well-functioning OSC. It should be duly noted that these factors do not necessarily represent OSCs in Kenya today, but rather are crucial observations that have occurred since their implementation and have contributed to better understanding of OSCs. The successes identified include:

➤ There has been a successful prosecution of cases due to the **effective link with the criminal justice system present in some OSCs**. These centres collected and stored

forensic evidence and issued medical report forms. The medico-legal services combined with coordinated links to the criminal justice sector plausibly enhances the likelihood of prosecuting court cases.³¹³ Additionally, some OSC forensic doctors also give statements in Court.³¹⁴

➤ **Written protocols containing specialised guidelines for examining and treating infants and children** exist at the facility level in some OSCs.³¹⁵

➤ **Guidelines exist at the national level.** For instance, the Reproductive and Maternal Health Services Unit and development partners at the Ministry of Health have developed procedures such as the National Standard Operating Procedures for the Management of Sexual Violence against Children.³¹⁶

➤ **Healthcare facility set-ups of OSCs** were found to **not be administratively heavy** because of their integration within existing institutional and operational set-ups of hospitals.³¹⁷

Despite these successes, some notable challenges, shortcomings, and weaknesses identified include:

➤ The **reliance on and sustainability of funding mechanisms** for OSCs is a major challenge. Because a significant proportion of the services provided are funded by donors,³¹⁸ this has been unsustainable due to the sporadic nature of donations.

➤ Several **human resource capacity** shortcomings have previously been identified. For instance, legal services had been provided pro bono or by NGOs and funded by donors. Additionally, medical staff at public healthcare facilities had previously struggled with workload and multitasking roles due to staff shortages. Moreover, of those that were available to provide services for OSCs, some had insufficient technical and cross-cutting knowledge for pro-

³¹⁰ Ibid. 6.

³¹¹ Ibid.

³¹² V Baurd and Others, 'Characteristics, Medical Management and Outcomes of Survivors of Sexual Gender-Based Violence Nairobi, Kenya' (2013) 3 *Public Health Action* 109, 109.

³¹³ Ibid. 110; Keesbury and Others [n 297] 19-20.

³¹⁴ Ibid.

³¹⁵ Ibid. 14.

³¹⁶ Shako and Kalsi [n 305] 189.

³¹⁷ Ibid. 26.

³¹⁸ National Gender and Equality Commission, 'Gender-Based Violence in Kenya: The Cost of Providing Services' (NGEC 2016) 36 <<https://www.ngeckeny.org/Downloads/GBV%20Costing%20Study-THE%20COST%20of%20PROVIDING%20SERVICES.pdf>> accessed 12 July 2021.

vision of services.³¹⁹ Additionally, training of services providers had been hampered due to lack of funding.³²⁰

➤ **Not all OSCs have had strong links to the criminal justice system.** In a review of Kenyatta National Hospital's OSC, of the 194 cases referred within the time frame of the review, not one case resulted in the perpetrator ever being arrested and nor had any perpetrator been prosecuted.³²¹ This may be because **well-managed forensic evidence collection** has been problematic in Kenya. A bulk of laws (both domestic and international) and policies guiding service providers in the administration of justice do exist. Even so, there have been gaps in police, medical, and laboratory science agencies in their practice of evidence collection.³²²

➤ Previous evaluations have identified that at some OSCs, **only survivors of sexual violence received free services**, leaving survivors of other forms of violence to settle their own fees.³²³

➤ According to one article from 2019, some centres had not provided a full range of services under one roof, which may be an indication of a holistic and multidisciplinary approach lacking.³²⁴ For instance, some have offered a full range of psychological services yet lacked the provision of comprehensive clinical services (such as the provision of paediatric PEP and medico-legal forensic examinations).³²⁵ On the other hand, some OSCs provided a full range of clinical services, yet lacked psychological services and staff to provide them.³²⁶

➤ An external factor that has challenged OSCs is the **culture of silence**. In Kenya, not only has this practice been extremely detrimental to the survivor's needs, but has played a significant role in further weakening the chances of perpetrator prosecution. Survivors have often been silenced by societal pressures and sometimes have been

made to resolve cases through community leaders. This has been especially apparent when the perpetrator has been a family member.³²⁷

➤ **Poor follow-up services** for medical interventions that required repeated visits (such as vaccination plans) have previously been another observed barrier at some OSCs.³²⁸

➤ Whilst some OSCs in Kenya have child-specialised rooms to assess children, in one review, a **major gap** identified was a **lack of integrated child-focused social welfare and child protection services**. These aspects are an integral part of any OSC model that deals with VAC, not only for short-term protection assessment, but also for the prevention of the reoccurrence of VAC in the long run.³²⁹

➤ **Limited opening hour times** in some OSCs, has been a major weakness in the access to services. This is particularly concerning as some forms of violence (especially GBV) are more likely to be perpetrated at night.



319 Shako and Kalsi (n 305) 189.

320 Ibid. 37-38.

321 Keesbury and Others (n 297) 19; See also Chi-Chi Undie and Others, 'Routine Screening for Intimate Partner Violence in Public Healthcare Settings in Kenya: An Assessment of Acceptability' (Population Council 2012) 13 <https://knowledgecommons.popcouncil.org/departments_sbsr-rh/165/> accessed 22 July 2021.

322 Shako and Kalsi (n 305) 189

323 Keesbury and Others (n 297) 17.

324 Shako and Kalsi (n 305) 189.

325 Keesbury and Others (n 297) 14.

326 Megan L Ranney and Others, 'A Novel ED-Based Sexual Assault Centre in Western Kenya: Description of Patients and Analysis of Treatment Patterns' (2011) 28 *Emergency Medicine Journal* 927, 929; McKeon and Others (n 21) 12.

327 Keesbury and Others (297) 21. In this evaluation of MTRH's OSC, it was found that less than half (44%) of the survivors seeking services received counselling. This was largely due to there being only one counsellor available during standard business hours (throughout the duration of this study)

328 Baurd and Others (n 312) 111.

329 Keesbury and Others (n 297) 29.

THE CASE OF MALAWI

BACKGROUND

In 2005, the results of a study interviewing 4412 school children revealed the harrowing public health crisis of child sexual abuse in Malawi. Almost a quarter (23.8 %) of these students had been forced to have sex against their own will.³³⁰ A further study conducted in 2013 on violence against children and young women found that **37.7% of girls and 9.8% of boys** aged between eighteen and twenty-four, said their **first sexual experience before the age of eighteen was unwanted**.³³¹ The results were just as alarming for physical violence. **64.5% of boys and 42.4% of girls reported to having experienced physical abuse prior to the age of eighteen**.³³²

In the past, there was a serious lack of coordinated and multisectoral services responding to cases of VAC. For instance, it was found in one report regarding sexual assault survivors, that of those that had formally reported their cases, only 10% received any form of professional assistance and service.³³³ Additionally, when parents brought their children to the police, they would often be subject to forensic interviews by untrained professionals. One study even found that at hospitals, as little as 24% of the doctors could correctly interpret genital findings.³³⁴ The required services were generally spread across different institutional bodies and there were different departments for different checks, even for services provided by the same institutions. These poor links between each sector resulted in poor case management and were often lost at the follow-up services.³³⁵

In response to this absence of coordinated services, in 2010, Queen Elizabeth Central Hospital in Blantyre became home to the first ever OSC in Malawi. The centre was tasked with holistically responding to sexual and physical violence perpetrated against children, *as well as* women and men,³³⁶ although the focus of the centres is primarily on children affected by violence.³³⁷

Known locally as ‘**Chikwanekane**’ meaning ‘everything under one roof’, since its implementation in Blantyre, the model has been scaled up and rolled out throughout Malawi. Today, OSCs have been implemented not only in other tertiary hospitals but also in secondary district hospitals.³³⁸ According to a 2018 article, Malawi is now home to twenty-eight Chikwanekane OSCs.³³⁹

CHARACTERISTICS OF CHIKWANEKANE ONE-STOP CENTRES IN MALAWI

A Multidisciplinary Team Providing Holistic Services in Accordance with National Guidelines:

Based in healthcare centres, the Chikwanekane OSC multidisciplinary team comprises paediatricians, nurses, social workers, police victim support officers and volunteer counsellors. The team’s aim for collaboration is to respond and provide the best support for child survivors of VAC.³⁴⁰ Procedures, referrals, reporting, and evaluation by the team are conducted in accordance with the *Guidelines for the Provision of Comprehensive Services for Survivors of Physical and Sexual Violence* implemented by the Ministry of Health in 2012. Children and women are the target of these guidelines, although the definition of victim/survivor acknowledges that men (and boys) can also become victims to physical and sexual violence.³⁴¹

³³⁰ Patrick Burton, *Suffering at School: Results of the Malawi Gender-Based Violence in Schools Survey* (Institute of Security Studies Pretoria 2005) 23.

³³¹ The Ministry of Gender, Children, Disability and Social Welfare, ‘Report: Violence against Children and Young Women in Malawi: Findings from a National Survey 2013’ (Government of Malawi 2014) 67 <<https://evaw-global-database.unwomen.org/-/media/files/un%20women/vaw/full%20text/africa/malawi%20violence%20against%20children%20survey%202013.pdf?vs=1244>> accessed 20 August 2021.

³³² *Ibid.* 83.

³³³ Mulambia and Others (n 148) 1.

³³⁴ *Ibid.*; Aaron J Miller and Kristin Barlup Toombs, ‘Educating Physicians Internationally in the Diagnosis of Child Sexual Abuse: Evaluation of a Brief Educational Intervention in Malawi’ (2014) 23 *Journal of Child Sexual Abuse* 247, 251.

³³⁵ *Ibid.*; See also Emily Chesshyre and Elizabeth Molyneux, ‘Presentation of Child Sexual Abuse Cases to Queen Elizabeth Central Hospital Following the Establishment of an HIC Post-Exposure Prophylaxis’ (2009) 21 *Malawi Medical Journal* 54, 56.

³³⁶ *Ibid.*; Lignet M Chepuka, ‘Perceptions, Experiences and Health Sector Responses to Intimate Partner Violence in Malawi: The Centrality Context’ (DPhil, University of Liverpool 2013) 87, 90.

³³⁷ *Ibid.* Chepuka. 90.

³³⁸ *Ibid.*

³³⁹ Mulambia and Others (n 148) 1.

³⁴⁰ *Ibid.* 2.

³⁴¹ Madison Mellish, Susan Settergren and Henry Sapuwa, *Gender-Based Violence in Malawi: A Literature Review to Inform the National Response* (Health Policy Project, Futures Group 2015) 45.

Children are usually referred to the centres via Victim Support Units, which fall under the direction of the national police. They may also access the centres via paediatric referrals within healthcare centres.³⁴² However, self-referral is allowed, promoted, and welcomed.³⁴³

Within the OSCs, a medical examination for the child is administered by experienced doctors, who also have the capacity to file forensic medico-legal reports for investigation and prosecution.³⁴⁴ Medical professionals provide PEP within seventy-two hours, with follow-up support at months three and six after the incident and screening for HIV is performed too. STI/D management is offered when necessary.³⁴⁵

Social workers and counsellors provide safety and support for victims, respectively. Counsellors offer the longest period of support and may arrange to see survivors and their non-offending families weekly, as required.³⁴⁶ The social welfare workers focus on (protection) assessment, case planning, and case management.³⁴⁷ The welfare and protection of the child is assessed both at the centres and at a three-month follow-up support at the child's home. The police victim support officers, jointly carry out an investigation. They also focus on other matters such as referrals and safety planning.³⁴⁸

Whilst legal services do not appear to be a direct service provided within the OSC, professionals in the court system collaborate directly with the police and social welfare services of the OSC. They coordinate for the further development of safety plans and the prosecution of cases.³⁴⁹ With the aim of achieving justice and increasing prosecution, the coordination of comprehensive services at the OSCs allows evidence to be collected expediently for this investigation.³⁵⁰

COORDINATION AND EXTERNAL SUPPORT

In addition to the government, establishing the OSC model was supported and funded by international stakeholders, including UNICEF and the United Nation's Population Fund (UNFPA), as well as with assistance from the UK's Department for International Development.³⁵¹ At the government level, the Ministry of Health, in recognition of its duty of care to children and women, has assumed responsibility of the OSC mandate.³⁵² Additionally, the Ministries of Gender, Children, Disabilities and Social Welfare, of Home Affairs and Internal Security, and of Justice and Constitutional Affairs are consulted for their sectoral support.³⁵³

SUCCESSSES & SHORTCOMINGS OF THE CHIKWANEKANE OSCS

The Chikwanekane OSC model has proven itself to be a fundamental step in overcoming the crisis of VAC in Malawi. For instance, establishing the OSC at the Queen Elizabeth Central Hospital has been associated with nearly tripling the number of child survivors of sexual abuse receiving services each year.³⁵⁴ Over the years, there have been some vital successes and shortcomings that are useful inputs in understanding what contributes to a well-functioning OSC. It should be noted that these factors do not necessarily represent the climate of OSCs in Malawi today, but rather are observations that have occurred since the implementation of OSCs. Some successes and strengths identified include:

- HIV testing and PEP at the OSCs has been deemed central in the effective **prevention of the virus**. In a country with a high prevalence of HIV (10%), this could save healthcare costs, prevent the uncertainty of stigma, and, most importantly, save lives.³⁵⁵ The fear of HIV was

³⁴² Chepuka (n 336) 246.

³⁴³ Mulambia and Others (n 148) 2.

³⁴⁴ Chepuka (n 336) 90.

³⁴⁵ Mulambia and Others (n 148) 2.

³⁴⁶ Ibid.

³⁴⁷ Brendan Ross, Karen Smith Rotabi and Nankali Maksud, 'From the Evidence of Violence Against Children to a Prevention-Oriented Response in Malawi: Planning for Social Services with a Public Health Model for Social Work Engagement' (2015) 2 *Global Social Welfare* 147, 153.

³⁴⁸ Ibid; Mulambia and Others (n 148) 2.

³⁴⁹ Ibid.

³⁵⁰ Chepuka (n 336) 90.

³⁵¹ Ross, Rotabi and Maksud (n 347) 152.

³⁵² Chepuka (n 336) 90.

³⁵³ Ross, Rotabi and Maksud (n 347) 152.

³⁵⁴ Mulambia and Others (n 148) 4.

³⁵⁵ Ibid.

also cited as the strongest motivator for seeking OSC services (76%) in one study. As a result, high amounts of cases arrive in time for HIV testing and PEP, which is also encouraging for the overall awareness of OSCs.³⁵⁶

▶ The OSC mandate supported by the Ministry of Health demonstrates **strong political will** and **commitment** from the top level in duty of care. This acts as a fundamental enabler for fostering and developing a cultural attitude towards an intolerance of VAC.

▶ OSCs have significantly **accelerated the handling of VAC and GBV cases**, including increased arrests, investigations, and the prosecution of suspected perpetrators.³⁵⁷

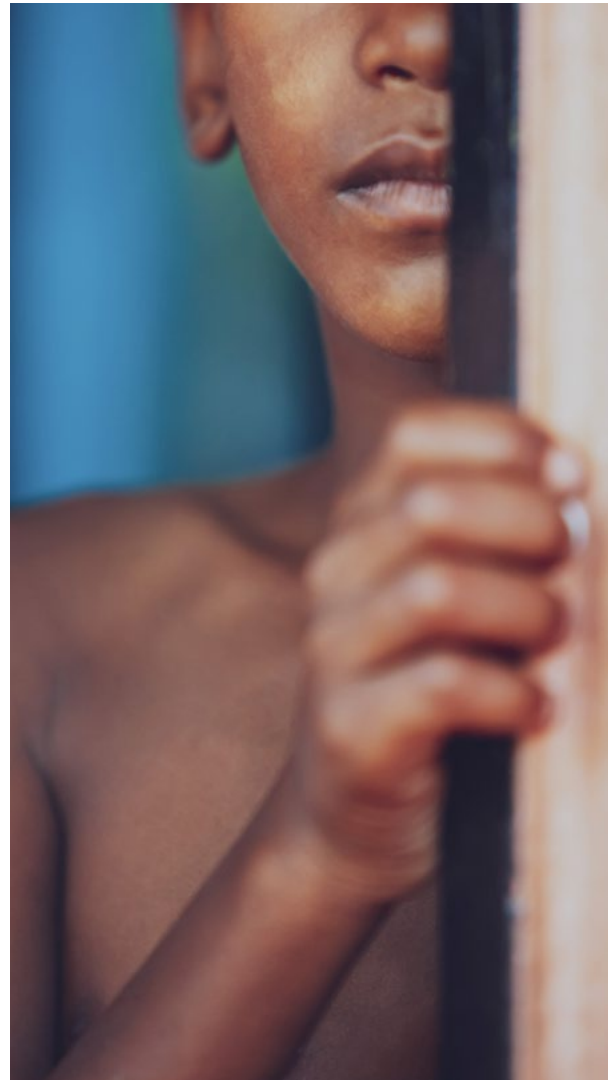
Whilst OSCs in Malawi have significant benefits, there are some weaknesses and barriers that have been identified. These include:

▶ In one review, it was identified that many of those that sought help from OSCs received the immediate services they needed at presentation. However, **follow-up support by social welfare was hindered because of a lack of funding**.³⁵⁸

▶ A culture of **mistrust in the police** has been observed as a barrier to OSCs. There are concerns about the level of corruption and negligence in the police, which has affected client satisfaction with OSC services.³⁵⁹

▶ Implementation of OSCs as a comprehensive and holistic response to VAC requires capacity and duly trained professionals and personnel. In Malawi, this has been identified as a challenge due to **significant gaps in knowledge and in the provision of care**.³⁶⁰ Additionally, a **lack of proper infrastructure** has previously been identified as problematic for the scale-up of OSCs, as service providers are geographically distant from each other.³⁶¹

▶ One review identified a **lower societal prioritisation and understanding of social work** in comparison to legal



work, clinical response services, and/or policing impacts the work of social workers and their important functions at the OSCs. In Malawi, the case management process is a significant role specifically carried out by social workers. Yet, because their roles are perceived as having lower value, the early identification of VAC, referral to OSCs, and after-care have been poorly implemented and understood as a result.³⁶²

³⁵⁶ Ibid.

³⁵⁷ National Gender and Equality Commission (n 318) 13.

³⁵⁸ Ibid.

³⁵⁹ Ibid. 4.

³⁶⁰ Chepuka (n 336) 240.

³⁶¹ Chepuka (n 336) 241; Lignet Chepuka and Others, 'Assessment of the Capacity of the Health sector to Respond to Violence against Women and Children in Malawi' (UNICEF 2011) 42 <<http://www.ndr.mw:8080/xmlui/bitstream/handle/123456789/1365/Assessment%20of%20the%20Capacity%20of%20the%20Health%20Sector%20to%20Respond%20to%20Violence%20against%20Women%20and%20Children%20in%20Malawi.pdf?sequence=1>> accessed 3 August 2021.

³⁶² Ross, Rotabi and Maksud (n 347) 153.

➤ Some accounts have identified **negative attitudes in service providers** due to a combination of lack of awareness on the implications of violence and cultural perceptions. This has been further fostered by an overall culture of placing physical issues above psychological/emotional/social responses within the healthcare system.³⁶³

➤ **The social stigma attached to sexual violence that is prominent in Malawi** has posed a major external barrier to OSCs. Often, sexual abuse is misinterpreted as consensual, particularly if the child involved is older. The adolescent child (usually a girl) is perceived to society as being immoral rather than a victim, which has encouraged a culture of silence. Consequently, this stigma deters survivors of sexual VAC and/or their non-offending parents or caregivers from seeking support at the OSCs.³⁶⁴ Moreover, in a country where **homosexuality remains illegal too, boys have also been affected by this stigma**, thus limiting their willingness to disclose their experiences. This may explain why, even with high rates of sexual violence found to be perpetrated against boys, a high proportion of OSC users have been girls.³⁶⁵

➤ **Potential disruption of family relationships** has previously been identified as another external barrier deterring individuals from seeking OSC services. Some parents reported that they chose to neglect the welfare of the child and refrain from seeking assistance in order to save their marriage, which is particularly the case when the **perpetrator is the breadwinner**.³⁶⁶

THE CASE OF RWANDA

BACKGROUND

Rwanda is a prime example of an African state where **OSCs have been implemented, evaluated, and scaled up on a national basis**. This process began in 2008. In taking a crucial step to reconstruct the country and in striving to overcome its legacy, Rwanda volunteered to become one of the first of eight pilot states for the UN's Delivering as One initiative (One UN). The purpose of this project was to develop approaches to enhance coherence, efficiency, and effectiveness of the UN system at the country level.³⁶⁷

As part of this initiative, the Rwandan National Police and the government set up a joint intervention with the One UN Rwanda agencies including UNICEF, UNWomen and the United Nations Population Fund (UNFPA),³⁶⁸ for the prevention of and response to VAC and GBV. In addition to this partnership, and policies to progressively eradicate VAC and GBV, the government has implemented, strengthened, and revised legislation relating to protecting children from violence.³⁶⁹

Whilst there is strong political commitment to protecting children from violence, VAC remains a persistent problem in Rwanda. In the latest survey on VAC conducted by the government between 2015-2016, the **prevalence of physical violence** inflicted upon boys before the age of eighteen was as high as **59.5%**, with **37.2%** in girls.³⁷⁰ Moreover, **23.9%** of girls surveyed **reported to have experienced being sexually abuse before the age of eighteen**, with **9.6% for boys** reported. Additionally, **12% of girls and 5% of boys aged** between thirteen and seventeen

³⁶³ Chepuka and Others (n 361) 42.

³⁶⁴ Mulambia and Others (n 148) 4.

³⁶⁵ Ibid.

³⁶⁶ Ibid.

³⁶⁷ 'Delivering as One' (United Nations) <<https://www.un.org/en/ga/deliveringasone/>> accessed 20 August 2021.

³⁶⁸ RAD Consult, 'Report of the Final Evaluation of the Project for the National Scale Up of the Isange One Stop Center Model in Rwanda' (Republic of Rwanda and United Nations Rwanda December 2016) 5 <<https://gate.unwomen.org/EvaluationDocument/Download?evaluationDocumentID=9065>> accessed 30 May 2021.

³⁶⁹ Rwanda Ministry of Health, 'Violence Against Children and Youth Survey: Findings from a National Survey 2015-2016' (Republic of Rwanda 2018) 22 <[https://www.unicef.org/rwanda/media/181/file/Violence%20against%20Children%20and%20Youth%20Survey%20\(2015-16\).pdf](https://www.unicef.org/rwanda/media/181/file/Violence%20against%20Children%20and%20Youth%20Survey%20(2015-16).pdf)> accessed 16 May 2021; 'Policy Brief: Update of Rwanda's Gender-Based Violence Policy' (Care December 2019) 2-4 <https://www.careneland.org/wp-content/uploads/2019/12/GBV-Policy-Revision-Briefing_-_Rwanda_clean.pdf> accessed 25 May 2021.

³⁷⁰ Ibid. 8.

reported to having been **sexually abused within the last twelve months** of taking the survey.³⁷¹

Nevertheless, the government-backed responses to VAC have proven vital to addressing this epidemic. In May 2009, the partnership between One UN and the government designed an interdisciplinary programme that created the first ever holistic hub – an integral part of the response.³⁷² **The Isange One-Stop Centre (IOSC)**, located inside the Kicyiru Police Hospital in Kigali, was established.³⁷³ “Isange” meaning “*to feel at home*” in Kinyarwanda, and bears an important message. The name was specifically chosen to help victims of VAC and GBV realise that they are welcome to seek refuge and support at the centres.³⁷⁴

The centres utilise a multisectoral team approach to respond to and provide follow-up support for children and women and men who are survivors of physical, sexual, and/or emotional VAC and/or GBV, whether occurring in the family or the community at large.³⁷⁵ The team involves the coordination of the medical, psychosocial, law enforcement, and judicial sectors.³⁷⁶

Today, the IOSC has **scaled up** to include a **total of forty-four centres** that are **located in every district** of Rwanda.³⁷⁷ As part of its development agenda to transform Rwanda into a middle-income country, this number is expected to increase to an estimated total of 500 centres through the decentralisation of healthcare centres.³⁷⁸

CHARACTERISTICS OF THE ISANGE ONE-STOP CENTRES IN RWANDA

A Multidisciplinary Provision of Services in Accordance with Protocol:

The IOSCs utilise a multidisciplinary investigative and intervention team approach, which “adapts evidence-based, international best practice protocols for working with victims of GBV and child abuse”.³⁷⁹ In 2015, the Ministry of Health also implemented its own *Protocol for Multidisciplinary Treatment of Victims of Gender-Based Violence and Child Abuse*, which determines the roles and responsibilities of the members of the IOSC team.³⁸⁰

A Multidisciplinary Team:

Based in **healthcare centres**, IOSCs provide **free-of-charge** holistic services **under one roof, twenty-four hours a day and seven days a week**. In the provision of services, the team aims to **prevent retraumatisation and revictimisation**, and **improve the resilience** of child survivors of abuse.³⁸¹ Each IOSC multidisciplinary team consists of **social workers, psychologists, medical doctors (including gynaecologists), investigators and a Judicial Police Officer (JPO)**. Together, the team provides an array of services. Medical services, including collecting forensic evidence, health evaluations and treatment, and the provision of emergency contraceptives, PEP and STI/D care. Psychosocial counselling, legal care, temporary safe shelter, social reintegration, and follow-up support services are also provided.³⁸²

Working with Children and a Children’s Room:

IOSCs offer services not only to children but *also* to women and men survivors of violence. However, children

³⁷¹ Ibid.

³⁷² Sophie Cousins, ‘Isange One Stop Centre: Sanctuary from Violence in Rwanda’ (2019) 6 *The Lancet* e12, e12.

³⁷³ Tania Bernath and Liberata Gahongayire, ‘Final Evaluation of the Rwandan Government and ONE UN ISANGE One Stop Centre – Final Report’ (2013) 8 <https://www.dol.gov/sites/dolgov/files/ILAB/evaluation_type/final_evaluation/Rwanda_REACH_feval.pdf> accessed 5 April 2021

³⁷⁴ ‘Rwanda’s Holistic Approach to Tackling the Different Faces of Gender-Based Violence’ (United Nations Rwanda, 30 August 2019) <<https://rwanda.un.org/en/15872-rwandas-holistic-approach-tackling-different-faces-gender-based-violence-gbv>> accessed 17 April 2021.

³⁷⁵ Bernath and Gahongayire (n373) 12.

³⁷⁶ Ibid.

³⁷⁷ Cousins (n 372) e12.

³⁷⁸ Care (n 369) 4; Gender Monitoring Office, ‘The State of Gender Equality in Rwanda: From Transition to Transformation’ (Republic of Rwanda 2019) 9 <http://gmo.gov.rw/fileadmin/user_upload/Researches%20and%20Assessments/State%20of%20Gender%20Equality%20in%20Rwanda.pdf> accessed 27 August 2021.

³⁷⁹ Bernath and Gahongayire (n 373) 12.

³⁸⁰ Government of Rwanda Ministry of Health, *Protocol on Multidisciplinary Treatment of Victims of Gender-Based Violence and Child Abuse* (April 2015).

³⁸¹ RAD Consult (n 368) 6.

³⁸² Ibid. 6, 17; Cousins (n 372) e12.

have access to services provided by individuals that are specifically trained to work with them.³⁸³ There is a designated room for children with cartooned-painted walls and toys to play with. The aim is to create a comfortable and safe environment for children.³⁸⁴ Social workers and psychologists work first with children first at the centres, often interacting with them through play to make them feel comfortable and encourage them to open up. They are then referred on to the next services at the centre, usually the JPO who files a police report.³⁸⁵

Management, Support and Coordination:

The Ministry of Gender and Family Promotion is the *overall national coordinator*.³⁸⁶ The Ministry of Health and the police jointly coordinate the *implementation* of IOSCs,³⁸⁷ and the Ministry of Justice is consulted in the coordination of legal sector services. A *Steering Committee*, consisting of the implementing partners and donors, meets four times per year for management oversight.³⁸⁸ A *Technical Committee* consists of the coordinator of the IOCS, the GBV coordinator of the Ministry of Health, and the technical gender, child, and human rights staff of UNICEF, UNWomen, and UNFPA. The Technical Committee meets on a regular basis for meetings concerning the IOSC programme. Every six months, it submits a progress and financial report to the Steering Committee.³⁸⁹

Strong Links to the Police and Community Policing Structures:

Although the IOSC is embedded within the health system, the police play a central and leading role. As every victim that seeks services at the centre is seen by the Judicial Police Officer, their cases are immediately investigated and referred to the National Public Prosecution Authority if required.³⁹⁰ The JPO is linked to the police's Gender Desk, and a high proportion of cases are referred from the Gender Desk in instances of GBV.³⁹¹ This strong policing



In response to GBV and child abuse, Isange OSCs have had a positive impact: cases of women and children who are victims of violence have been reported. The assembly of the 4 services (legal, medical, psychological, and safe room) has been beneficial in preserving the safety and health of the victims with the necessary discretion [and] without hindering the possibilities of going to work when one is employed especially. The good thing is that the community policing volunteers in the communities, [first] give advice to the families that manifest conflict behaviours. In case of a lack of positive change, these volunteers can denounce the violence in the neighbourhood by calling for help to the police hotline that is created for this purpose...

Liberata Gahongayire, Researcher in
Genocide Studies and PhD Candidate
at the Université libre de Bruxelles

structure between the JPO and the police puts the IOSCs at a distinctive advantage when compared to other interventions.³⁹²

Funding:

Initially, funding was heavily reliant on the One UN partnership agencies. In the initial year of IOSC implementation, UNICEF in particular provided the most funding and training for the centre's operations.³⁹³ However, the government has attempted to phase out international aid and with an increased allocation of its own budget for the IOSCs and responses to VAC. Today, whilst there is still

³⁸³ Bernath and Gahongayire (n 373) 25.

³⁸⁴ Cousins (n 372) e12.

³⁸⁵ Bernath and Gahongayire (n 373) 25.

³⁸⁶ RAD Consult (n 368) 33.

³⁸⁷ Ibid. 23.

³⁸⁸ Ibid. 33.

³⁸⁹ Bernath and Gahongayire (n 373) 37-38.

³⁹⁰ Ibid. 8.

³⁹¹ Ibid. The Gender Desk is a specifically established office within the Rwandan National Police which coordinates issues related to GBV.

³⁹² Ibid. 22.

³⁹³ Ibid. 13-14, 41.

financial support from foreign donors, the Ministry of Health predominantly funds the centres.³⁹⁴

Data Collection:

Each member of the multidisciplinary team at the IOSC is involved in the data collection process. This begins when the child enters the centre. The social worker, who sees the child first, collects their basic information, and then escorts the child to the other service providers who obtain further information.³⁹⁵ Data management has improved over the last decade, with policies and data capturing processes in place. Since 2013, there has been active work on streamlining the quality of the data collected and management through a database.³⁹⁶ Today, the IOSCs utilise the Health Management Information System to collect and manage information.³⁹⁷

Awareness-Raising:

Awareness-raising forms another component of the IOSC programme too. Across the country, there have been campaigns on television and radio platforms and through existing community structures, to disseminate the message of the centres. A toll-free line is also available at all times for individuals who require help.³⁹⁸

SUCCESSES & SHORTCOMINGS OF THE IOSCS

The implementation and scale-up of the IOSCs has resulted in some major progress towards Rwanda's goals of eliminating VAC and GBV. The centres have become a recognised international model, with some other states looking into how it can be replicated into their own jurisdictions.³⁹⁹ Since implementation over the years, there have been some crucial successes and shortcomings that are useful inputs in understanding what contributes to a well-functioning OSC. Although it should be noted that these factors do not necessarily represent the climate of

IOSCs in Rwanda today, and are rather crucial observations that have occurred since implementation. Some strengths and enablers identified include:

- There has been an **increase in the number of survivors accessing IOSC services per cases of VAC**, and there has been an **increase in the number of cases prosecuted in the courts**.⁴⁰⁰
- A **free-of-charge** provision of services has enabled the accessibility to the OSC.
- **Medico-legal forensic capacity** has been identified to exceed any other intervention within the country. For the National Public Prosecution Authority, a medical report is the most important document that provides evidence in successfully prosecuting a case. As the most professional and timely reports are reported to have come from the IOSC, the authority has expressed support for the centres and often refers survivors there.⁴⁰¹
- **Strong links with policing structures** has placed the centres at a comparative advantage in the likelihood of preserving the chain of evidence. This begins from the time the survivor visits the IOSC since there is an immediate investigation by the JPO.⁴⁰² The centres also benefit greatly from **awareness-raising carried out by community policing structures**.⁴⁰³
- **Strong political commitment** to eliminating VAC **has been recognised through law and policy** and recognises that the IOSC fills the role of good practice in VAC responses. This attitude is further reflected in centres being prioritised for improvement, scale-up, and capacity strengthening based on evaluations.⁴⁰⁴
- Implementing the *Protocol for Multidisciplinary Treatment of Victims of Gender-Based Violence and Child Abuse* has delineated clearer responsibilities and

³⁹⁴ Shegufia Shefa Sikder and Others, "Mapping the Health Systems Response to Violence against Women" (2021) 4, 7 <https://www.researchgate.net/publication/349579262_Mapping_the_health_systems_response_to_violence_against_women> accessed 7 June 2021.

³⁹⁵ Bernath and Gahongayire (n 373) 36-37.

³⁹⁶ Sikder and Others (n 394) 4-5, 7.

³⁹⁷ RAD Consult (n 368) 28.

³⁹⁸ Cousins (n 372) e12.

³⁹⁹ Ibid.

⁴⁰⁰ RAD Consult (n 368) 24, 26.

⁴⁰¹ Bernath and Gahongayire (n 373) 8, 23-24.

⁴⁰² Ibid. 22.

⁴⁰³ Ibid.

⁴⁰⁴ Ibid. 42; RAD Consult (n 368) 40.



competencies of service providers at the centres for treating victims. This has enabled a smooth professional coordination between sectors.⁴⁰⁵

Although the implementation of IOSCs has been paramount in the progress towards eliminating VAC, there are some shortcomings, weaknesses, and barriers identified. These include:

➤ **Poor follow-up services** were previously identified as a weakness of the IOSCs and had particular implications for **children who had faced an on-going risk in their communities**. The lack of follow-up support was reportedly due to insufficient time and/or limited resources. This led to a reliance on inadequate and untrained community child protection, GBV committees, and other community policing structures for follow-up. In some cases, this resulted in putting child survivors at even further risk of violence and/or stigmatisation in their own homes and communities.⁴⁰⁶ In cases of VAC, it is critical that a child

who is at significant risk is **linked to the existing social services and the wider CPS**. Thus, follow-up procedures that seek to find a long-term solution are indispensable for protecting children from (further) violence.⁴⁰⁷ It should be noted, however, since this evaluation Rwanda has actively enhanced awareness and knowledge of VAC and GBV. For instance, a two-month countrywide campaign was utilised to address how community members can participate in preventing, detecting and responding to incidents of VAC.⁴⁰⁸

➤ **Victims not returning for follow-up** support has previously been identified as a shortcoming, and the result of an array of factors. This has included a lack of economic means to travel to the IOSCs, pressures from an existing culture of silence, and cultural custom that does not prioritise mental health assistance.⁴⁰⁹

➤ Despite **awareness-raising** efforts, some evaluations have identified them as **inconsistent and not adequately sustained**.⁴¹⁰ Although there have been successful and active campaigns to increase awareness and understanding of the grave individual, interpersonal, communal, and societal consequences of VAC and GBV, 84% of the respondents in one survey did not even know about the existence of the IOSCs.⁴¹¹

➤ Despite the provision of the legal aid component envisioned in the design of the IOSC programme, **access to legal services has been challenging**. According to some evaluations, legal aid is unavailable on a consistent basis.⁴¹² However, it is worth noting that external stakeholders, such as the International Justice Mission, have supported this missing component. Cases have been referred to the NGO from the IOSC.⁴¹³

➤ The Protocol for Multidisciplinary Treatment of Victims of Gender-Based Violence and Child Abuse requires that every effort should be made to limit the number of interviews a survivor experiences. However, in practice, evidence has suggested that **victims have under-**

⁴⁰⁵ Ibid. RAD Consult. 24, 26.

⁴⁰⁶ Bernath and Gahongayire (n 373) 26.

⁴⁰⁷ Ibid. 8.

⁴⁰⁸ RAD Consult (n 368) 24.

⁴⁰⁹ Bernath and Gahongayire (n 373) 26.

⁴¹⁰ Ibid. 8, 29.

⁴¹¹ RAD Consult (n 368) 29.

⁴¹² Ibid. 30; Bernath and Gahongayire (n 373) 8, 34, 38.

⁴¹³ Ibid. 39. This International Justice Mission also specialises in the prosecution of child sexual assault.

gone multiple different interviews with each different service provider, posing the risk of retraumatisation and revictimisation.⁴¹⁴

➤ **Weak and incoherent coordination management** has previously been identified another weakness of the IOSC programme. For instance, Coordinated Steering Committee meetings are supposed to occur four times per year. Despite this, one evaluation revealed that no reporting links between the IOSCs and the relevant ministries had been made. This issue is heightened at the decentralised level.⁴¹⁵ A lack of coordination can hinder evaluation prospects and cause tensions in professionalism and departments.

➤ The combination of a **strong culture of stigma associated with sexual violence that further encourages a culture of silence**, has previously been recognised as a serious external inhibitor to the IOSC programme, which discouraged some survivors from seeking services at the centres. Adolescent girls have been particularly and disproportionately affected by this stigma. Furthermore, there has been concern about the underreporting of sexual abuse perpetrated against children.⁴¹⁶ There have been several reasons that have deterred survivors from seeking services including: the desire to avoid the dislocation of family relationships (particularly when the perpetrator is family) and avoid a perceived embarrassments and/or awkwardness between family and society, and/or when there is an economic dependence linked to the perpetrator.⁴¹⁷

THE CASE OF SOUTH AFRICA

BACKGROUND

The situation of violence perpetrated against children in South Africa is dire. According to the 2015 Optimus Study on Child Abuse, Violence and Neglect in South Africa, **by the time they reach the ages of between fifteen and seventeen, many young South Africans have already experienced some form of VAC.**⁴¹⁸ Compared to global statistics, South African children are disproportionately affected by violence.⁴¹⁹ For instance, one in five (19.8%) children have reported to experiencing some form of sexual abuse during their lifetimes,⁴²⁰ compared to the global average of 12.7%.⁴²¹ Girls in particular, are more likely to experience forced sexual abuse.⁴²² The statistics for physical abuse were even higher at 34.4%.⁴²³ In cases of emotional violence, 19.6% of girls reported to having experienced some form of emotional abuse compared to 12.6% for boys.⁴²⁴

As South Africa has been a pathfinding country in the End Violence Partnership since 2017, it has made a formal commitment towards ending VAC.⁴²⁵ However, because child abuse is often interlinked with other forms of violence, some responses have been incorporated into the many laws and policies targeting GBV, IPV and VAC. This includes provisions across its criminal law, the Children's Act 38 of 2005, the Domestic Violence Act 116 of 1998, and the Service Charter for Victims of Crime in South Africa of 2004.⁴²⁶ Additionally, the National Strategic Plan on Gender-Based Violence and Femicide (2020) has been imple-

⁴¹⁴ Ibid. 34.

⁴¹⁵ RAD Consult (n 368) 20, 33.

⁴¹⁶ United Nations Committee on the Rights of the Children, 'Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Rwanda*' (2020) CRC/C/RWA/CO/5-6 para 25.

⁴¹⁷ RAD Consult (n 368) 32; Keesbury and Askew (n 147) 10.

⁴¹⁸ Patrick Burton and Others, 'Research Bulletin: The Optimus Study on Child Abuse, Violence and Neglect in South Africa' (Centre for Justice and Crime Prevention 2015) 3 <https://www.saferespaces.org.za/uploads/files/cjcp_ubs_web.pdf> accessed 12 July 2021.

⁴¹⁹ Save the Children South Africa, 'Violence Against Children: The Cost of Inaction to our Society and Economy: Policy Brief' (Save the Children 2017) 1 <https://static.pmg.org.za/180515policy_Brief.pdf> accessed 13 July 2021.

⁴²⁰ Burton and Others (n 418) 3.

⁴²¹ Ibid. 12; Save the Children South Africa (n 419) 1.

⁴²² Ibid. 2.

⁴²³ Ibid. 17.

⁴²⁴ Ibid. 18.

⁴²⁵ 'South Africa' (End Violence Against Children) <<https://www.end-violence.org/impact/countries/south-africa>> accessed 11 July 2021.

⁴²⁶ 'Thuthuzela Care Centres Compliance Audit and Gap Analysis' (Foundation for Professional Development 2016) 33 <<https://shukumisa.org.za/wp-content/uploads/2018/02/PA00MQJ6-1.pdf>> accessed 14 July 2021.

mented.⁴²⁷ This aims to strengthen several government and civil society approaches within a multisectoral strategic framework to realise a South Africa that is free from VAC and GBV.⁴²⁸

Over the last two decades, several government-led OSC responses have been implemented stemming from these various laws, policies, and programmes. The *Thuthuzela Care Centre* (TCC) model was specifically introduced in 1999 as a critical response to the government's anti-rape strategy. Led by the National Prosecuting Authority (NPA), these centres offer a One-Stop Centre approach for survivors (including children) of GBV and sexual violence.⁴²⁹ Today, a total of fifty-five centres have been established across nine provinces throughout South Africa.⁴³⁰

Similarly, in 2011, the Department of Social Development supported by the United Nations Office on Drugs and Crime (UNODC) and the European Union (EU), established *Khuseleka OSCs*.⁴³¹ These centres are designed to treat survivors of a wide range of forms of violence and crime. This includes sexual assault; domestic violence, rape, human trafficking, child abuse, and violence against the elderly and disabled.⁴³² In 2015, the North West Department of Health in collaboration with Medicins Sans Frontieres/Doctors Without Borders (MSF), also launched the one-stop *Kgomotso Care Centre* (KCC) model in response to GBV.⁴³³

CHARACTERISTICS OF ONE-STOP CENTRES IN SOUTH AFRICA

Multidisciplinary Provision of Services and Multisectoral & Interagency Collaboration:

In South Africa, because there are various OSCs under the authority of different government departments, their pro-

vision of multidisciplinary services varies according to the OSC.

The TCCs under the direction of the NPA have three main aims: to reduce revictimisation, to increase conviction rates of perpetrators, and to reduce the lengths of time required to finalise criminal cases of GBV and sexual violence.⁴³⁴ Thus, they function in two areas: immediate services are provided in a centre located in a public healthcare facility, and the legal component is dealt with within the sexual offences court.⁴³⁵ Staff on site include a case manager, victim assistance officer, and site coordinator; counsellors (provided by NGOs or the Department of Social Development); trained detectives and professionally competent officers to take statements, as well as the South African Police Service or emergency medical personnel for victim transportation.⁴³⁶

Upon entering a TCC, survivors are welcomed and comforted by a site coordinator or a nurse. A chain of several services are then provided. Medical examinations are conducted, both for health assessment and for forensic evidence collection. An investigative officer conducts an interview to enquire about the survivor's experience and take their statement. A social worker or nurse provides counselling. Treatment, follow-up support, and medication to prevent STI/Ds and HIV is provided by a nurse. Shelter arrangements may also be made where necessary. Before a case goes to court, consultations with a prosecutor may be made, and court preparation is provided by a victim assistant officer. Throughout the judicial phase, updates of the trial process are provided by a case manager.⁴³⁷

The Department of Social Development's *Khuseleka OSCs* are described as a "twenty-four-hour place of refuge" for survivors of violence and crime (including children).⁴³⁸ The operation of the centres builds upon mul-

⁴²⁷ 'National Strategic Plan on Gender-Based Violence and Femicide' (Republic of South Africa 2020) <https://www.gov.za/sites/default/files/gcis_document/202006/stratplan-gbvs.pdf> accessed 17 July 2021.

⁴²⁸ Ibid.

⁴²⁹ Foundation for Professional Development (n 426) 23; 'Thuthuzela Care Centres' (South African Government 2021) <<https://www.gov.za/TCC>> accessed 20 September 2021.

⁴³⁰ Ibid. 23.

⁴³¹ 'Ending GBV and Post 2015 Application' (Gender Links 2015) 2 <<https://genderlinks.org.za/casestudies/khuseleka-one-stop-centre-2015-05-22/>> accessed 27 September 2021.

⁴³² Miché Roberts, *Policy Brief: Victim-Centred Prosecution Lessons for South Africa* (Institute for Security Studies 2017) 5.

⁴³³ 'South Africa: MSF Commends North West Department of Health's Leadership in Response to Survivors of SGBV' (Medicins Sans Frontieres 2019) <<https://www.msf.org.za/news-and-resources/press-release/south-africa-msf-commends-north-west-department-health-s>> 21 September 2021.

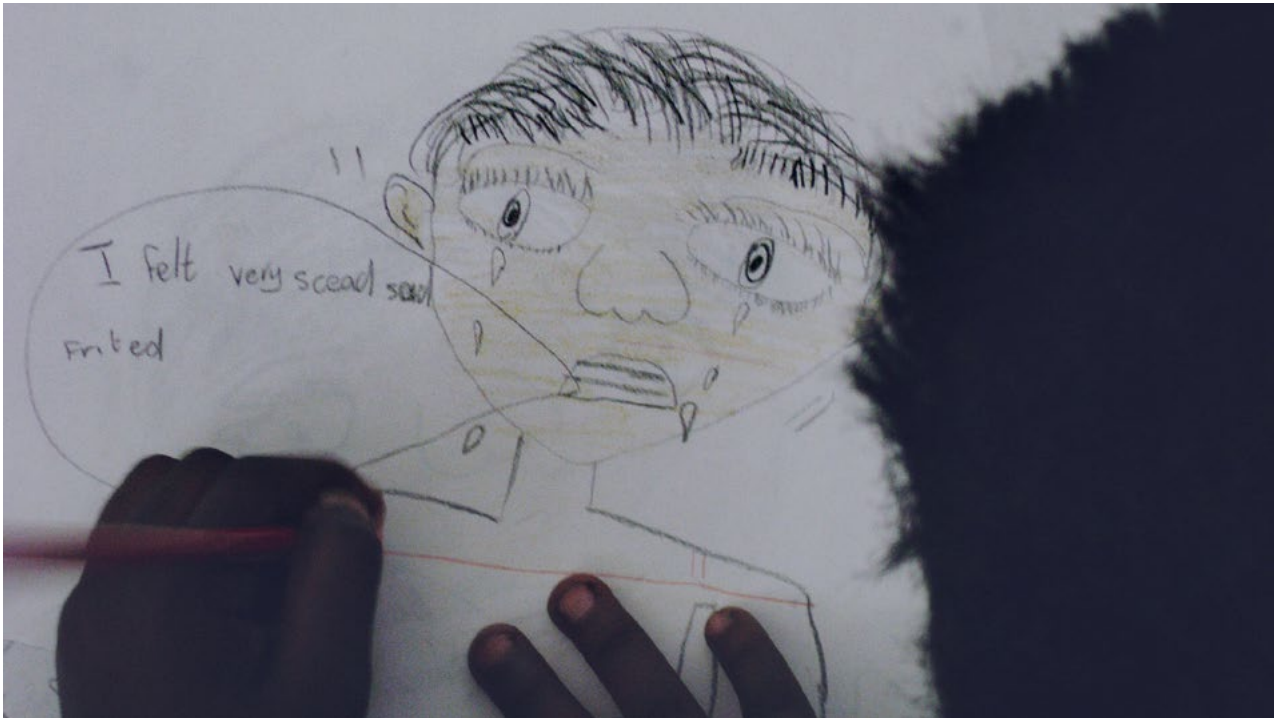
⁴³⁴ Foundation for Professional Development (n 426) 23.

⁴³⁵ Ibid.

⁴³⁶ Lisa Vetten, 'Post Rape Case and the Micro-Politics of Institutions' (Action Aid and Shukumisa 2015) 15 <<https://shukumisa.org.za/wp-content/uploads/2017/09/Thuthuzela-Care-Centres-Shukumisa-Report-2015.pdf>> 19 July 2021.

⁴³⁷ South African Government (n 429).

⁴³⁸ Foundation for Professional Development (n 426) 46.



tisectoral collaboration between numerous state agencies and departments, supported by international agencies, NGOs, and civil society organisations. Each sector offers different services. The Department of Social Development provides shelter, social workers, and care workers. Volunteers provide psychosocial counselling, support, care, and empowerment. The Department of Health is responsible for supporting technical medico-legal services, and examinations, treatment, and forensic documentation. The NPA is also involved in this collaboration, and as is tasked with case preparation for the court process and prosecution. The SAPS registers cases, administers the arrests of perpetrators, and investigates cases for court preparation. Additionally, NGOs and foreign donors support the services, and the technical and financial aspects.⁴³⁹

At the North West Department of Health and MSF's KCCs, emergency medical care and psychosocial support is offered to survivors of GBV. These free services are administered by a team of forensic nurses, registered counsellors, and social workers. The package of care provided by the team includes medical first aid, medical assessment, forensic examination, the administration of PEP and

emergency contraception, vaccinations, and counselling. Linkages and referrals are made for further care if necessary, such as for acute mental health needs, placement at shelters, and access to legal services and counsel.⁴⁴⁰

SUCCESSSES & SHORTCOMINGS OF OSCS IN SOUTH AFRICA

OSCs have made a significant impact over the last two decades of their existence in South Africa. Various assessments have been made and evaluations have identified some key successes and shortcomings. that are useful inputs into understanding what contributes to a well-functioning OSC. However, it should be noted that these factors do not necessarily represent the climate of OSCs in South Africa today. Rather, they are crucial observations that have occurred since their implementation. The successes, strengths, and enablers include the following:

- **Regular coordination meetings in some OSCs have built good relationships** amongst the different disciplines and staff, which has been a key enabler to the functioning of OSCs. These sessions discussed case management and

⁴³⁹ Ibid; Gender Links (n 431) 4-5.

⁴⁴⁰ Ibid; MSF (n 433).

the roles and responsibilities of each member of staff and the agency. This not only enables the operations of OSCs, it also improves the quality of services provided to survivors.⁴⁴¹

➤ As TCCs are under the direction of the NPA as the lead agency, more cases have been prosecuted through these centres, resulting in a **high conviction rate of perpetrators**.⁴⁴²

➤ To avoid patients not returning for follow up support and transportation costs incurred by survivors travelling back to the centres, some OSCs have **administered a full course of treatment upon the survivor's first visit**. This has enabled a more effective way of following through with medical treatment.⁴⁴³

On the other hand, several shortcomings, weaknesses, and barriers have been observed in OSCs throughout South Africa. These include:

➤ Despite children making up 60% of cases at TCCs, one assessment found that **not all centres were child-friendly**. According to an evaluation from 2016, of the fifty-four TCCs surveyed, only twenty-six were considered to be adequately child-friendly. Specifically, there were no child-friendly rooms to wait in, no toys for children to play with, and the interior of some centres were not considered conducive to creating a child-friendly setting and neutral environment.⁴⁴⁴

➤ A major barrier to the sustainability of OSCs in South Africa has been the **heavy reliance on donors for funds**. In some instances, the financial situation had deteriorated to the point that salaries of staff had to be cut, some

services were discontinued, and some centres had to approach donors for emergency funds.⁴⁴⁵

➤ One evaluation identified that at some OSCs, children who presented after hours or children that lived in informal settlements, were significantly less likely to receive psychosocial counselling. These findings were suggestive of **insufficient professional engagement with children and weaknesses in the referral mechanisms** for psychosocial support.⁴⁴⁶

➤ **Poor working relationships** have been identified as another shortcoming throughout the OSCs. For instance, at TCCs, the combination of an NPA-led yet health-care-based setting provoked inherent tensions in the absence of professional coordination and management. Furthermore, the poor transition from an NGO service to a TCC had only further amplified this strain at some centres, which led to the NPA dominating responses, unclear roles, and strained relationships.⁴⁴⁷ However, these tensions have not only been observed in TCCs. For instance, at some Khuseleka OSCs, despite a Memorandum of Understanding in place, inadequate uniformity in communication had hindered the teamwork spirit of staff.⁴⁴⁸

➤ A shortcoming of having different OSC models responding to VAC has meant that that **some services may dominate the focus or there may be a lack of some services**. Different centres may have different arrangements with agencies too. For instance, at some centres, psychosocial services lacked due to the unavailability of social workers.⁴⁴⁹ On the other hand, some centres lacked on-site legal and psychological services.⁴⁵⁰

441 Vetten (n 436) 42.

442 "'We Are With You': The South African Care Centres Providing Hope for Survivors of Sexual Violence' (Reliefweb 2021) <<https://reliefweb.int/report/south-africa/we-are-you-south-african-care-centres-providing-hope-survivors-sexual-violence>> accessed 20 September 2021; Lisa Vetten and Others 'Tracking Justice: The Attrition of Rape Cases through the Criminal Justice System in Gauteng' (Tshwaranang Legal Advocacy Centre, the South African Medical Research Council and the Centre for the Study of Violence and Reconciliation 2008) 19 <https://www.csvr.org.za/docs/tracking_justice.pdf> accessed 16 July 2021.

443 McKeon, Garcia-Moreno and Colombini (n 21) 24.

444 Foundation for Professional Development (n 426) 65.

445 Vetten (n 436) 35.

446 Ibid. 19. This included re-establishing contact with child survivors and their non-offending parents/caregivers for further counselling. For instance, in one evaluation, it was reported that a number of children only received a simple debriefing and were not referred to specialised services required for their psychosocial needs.

447 Ibid. 31-32, 39-40. For instance, in one case, NPA staff assumed ownership of the newly transitioned TCC, dominated response and failed to consider the interests in the public health services.

Additionally, the lack of clear roles assigned to all three sectors only exacerbated the situation in some instances. Some procedures often overlapped too. In some centres, this caused deterioration in relationships between agencies and their staff involved at the TCCs due to confusion of responsibility and accountability for some services. In one centre, a broken-down relationship between the NPA site coordinator and a health worker became so strained that the entire team of healthcare staff removed themselves from site, bringing all their medical equipment with them.

448 Gender Links (n 431) 8.

449 Vetten (n 436) 11, 18. For instance, some TCCs had a fulltime social worker appointed by the Department of Social Development, whereas other relied on NGOs for social support.

450 MSF (n 433).

THE CASE OF ZAMBIA

BACKGROUND

Incidents of VAC in Zambia paints a harrowing picture of reality. The results of a government-led survey from 2014 on VAC confirms the severity of the problem. Of those that were surveyed between the ages of eighteen and twenty-four, females were twice as likely (20.3%) as males (10%) to have experienced childhood sexual abuse. Moreover, of those that had reported experiencing at least one incident of sexual VAC, 66% of females and 78.8% of males reported experiencing it in multiple forms.⁴⁵¹ Additionally, one in four and one in five females and males aged between fifteen and seventeen reported to experiencing some form of physical violence and emotional violence respectively, within the last twelve months.⁴⁵²

Responding to this epidemic, the government has implemented several mechanisms in a bid to eliminate VAC. In general, efforts made towards the elimination of VAC in Zambia have been formally secured in legislation and policy. For instance, in 2015, the government implemented the National Child Policy along with its implementation document, the National Plan of Action for Children. The topic of VAC comes under the chapter of child protection, one of its key pillars. In December of 2020, Zambia also became the thirty-first pathfinding country of the End Violence Partnership.⁴⁵³

In 2006, the first ever OSC in Zambia was also established in the paediatric unit of Lusaka's University Teaching Hospital.⁴⁵⁴ The facility was set up in the department due to

widespread concern about the levels of child sexual abuse cases since these required specialised services.⁴⁵⁵ This OSC was modelled based on similar emerging centres in South Africa.⁴⁵⁶ Although responding to cases of VAC, this OSC was established as part of a wider GBV programme supported by the Centers for Disease Control and Prevention of Zambia. Between 2005-2007, CARE Zambia and its partners also worked on a pilot project geared towards establishing two stand-alone, NGO-driven one-stop Co-ordinated Response Centres in both Lusaka and Chipata. The project was later expanded under the 'A Safer Zambia' project supported by USAID, and from 2007 eight other OSCs were established under this umbrella.⁴⁵⁷

In government-led responses, although there are several policies for child protection and VAC, OSCs have also been incorporated into efforts to specifically combat GBV. The collaboration between the Government of the Republic of Zambia and the United Nations' Joint Programme on GBV, was a four-year multisectoral programme increased the number of hospital-based OSCs too. One further important innovation of the GBV Joint Programme was the introduction of village-based OSCs, which were created in the realisation that it would be too costly to develop and support the target of seventy-two hospital based OSCs within each district.⁴⁵⁸ These centres provide services to survivors of GBV given by trained members of the community.⁴⁵⁹

The various forms of OSCs represent the overall climate of the centres in Zambia responding to GBV. Some were initially established as government, foreign aid, and/or NGO initiatives, or a combination of these, and some are located in health facilities, some are stand-alone, and some are based in community settings. However, in recent years, the government has taken the initiative to integrating all centres into its health system and has assumed ownership.

451 Ministry of Youth, Sport and Child Development and Others, 'Report: Violence Against Children in Zambia Findings from a National Survey, 2014' (Republic of Zambia 2018) 17-18 <<https://www.unicef.org/zambia/sites/unicef.org.zambia/files/2018-11/Binder%20EMAIL%20Thursday%20NEW.pdf>> accessed 10 June 2021.

452 Ibid. 28, 41.

453 'Zambia' [End Violence Against Children] <<https://www.end-violence.org/impact/countries/zambia#collaboration>> accessed 10 June 2021.

454 Keesbury and Others (n 297) 11.

455 Elwyn Chomba and Others, 'Review Article: Integration of Services for Victims of Child Sexual Abuse at the University Teaching Hospital One-Stop Centre' (2010) *Journal of Tropical Medicine* 4 <<https://pubmed.ncbi.nlm.nih.gov/20706671/>> accessed 10 June 2021.

456 Gender in Development Division, 'National Action Plan on Gender-Based Violence 2008-2013' (Government of the Republic of Zambia 2008) 12 <https://endvaw.ca/wp-content/uploads/2015/12/gbv-nap_2008-2013_final.pdf> accessed 11 June 2021.

457 Keesbury and Others (n 297) 11; USAID, 'Gender-Based Violence Programming Evaluation' (USAID 2010) 1 <https://www.betterevaluation.org/sites/default/files/evaluation_services_integrees_vs_care_en_zambia_en.pdf> accessed 9 June 2021.

458 Georgie Zimbizi, Nalukui Milapo and Sara Holsbrink, 'Independent Evaluation of the Government of the Republic of Zambia/United Nations (GRZ/UN) Joint Programme on Gender Based Violence: Final Evaluation Report' (Government of the Republic of Zambia and the United Nations Development Programme 2017) 60 <<http://web.undp/evaluation/evaluations/adr/zambia.shtml>> accessed 10 June 2021

459 Ibid.



In 2018, the former US ambassador to Zambia officially transferred all sixteen USAID-led and funded OSCs to Zambia's Minister of Health.⁴⁶⁰ Moreover, Phase II of the Joint Programme on GBV officially commenced in 2019, which supports the Ministries of Health and of Gender in their implementation and strengthening of hospital and village-based OSCs.⁴⁶¹

CHARACTERISTICS OF ONE-STOP CENTRES IN ZAMBIA

Provision of Multidisciplinary Services:

OSCs were established to bring all the critical services for survivors of GBV (including child survivors) under one roof in a timely and efficient manner. As centres operate from different facilities, they also may also have different features. For example, some do not operate round the clock. Importantly, however, all OSCs in Zambia follow a

National Guideline for the Multidisciplinary Management of Survivors of GBV, which was revised to include extensive provisions for the management of child survivors.⁴⁶² Thus, a typical OSC in Zambia may provide the following services under one roof:

➤ **Police services:** A permanent victim support unit police officer is stationed at the OSC, tasked with filing all cases of violence reported at the OSC. The police officer also collects all necessary evidence, including a forensic medical report, for the preparation of a case submission to the courts.⁴⁶³

➤ **Health services:** Nurses provide services including rapid HIV testing, PEP, emergency contraceptives, and treatment for physical wounds. Doctors at the OSC are tasked with compiling a medical report and taking forensic specimens that are sent to a laboratory for testing.⁴⁶⁴ However, some stand-alone facilities are not equipped to

⁴⁶⁰ Chando Mapoma, 'Zambia's Ministry of Health Integrates U.S.-Funded One-Stop Centres into Fight against Gender-Based Violence' (USAID 2018) <<https://www.usaid.gov/zambia/press-releases/05-15-2018-zambias-ministry-health-integrate-us-funded-antigbvcenters>> accessed 10 June 2021.

⁴⁶¹ Government of the Republic of Zambia and United Nations Zambia, 'Government of the Republic of Zambia (GRZ)-United Nations (UN) Joint Programme on Gender Based Violence Phase II' (GRZ and UN Zambia 2019) 43 <<https://mptf.undp.org/factsheet/fund/JZM10>> accessed 11 June 2021.

⁴⁶² Keesbury and Askew (n 147) 14; Ministry of Community Development and Social Service, 'Research Report: Assessment of Case Management Systems for Improved Access to Basic Social Services for Vulnerable Children and Adolescents in Zambia' (Government of the Republic of Zambia 2019) 59 <https://www.unicef.org/zambia/sites/unicef.org.zambia/files/2020-01/UNICEF%20Case%20Management%20REPORT_0.pdf> accessed 10 June 2021.

⁴⁶³ Zimbizi, Milapo and Holsbrink (n 458) 57.

⁴⁶⁴ Ibid.

provide clinical services, and thus, referrals may be made to hospitals. This is the case for village OSCs.⁴⁶⁵

➤ **Counselling services:** Trained counsellors provide psychosocial support and counselling to survivors, with the aim of improving survivor resilience. Counselling is given to survivors in accordance with their specific needs (and stage of development).⁴⁶⁶

➤ **Paralegal services:** Trained paralegals at the OSCs are tasked with providing legal advice to survivors and/or their parents/caregivers on how to pursue their cases.⁴⁶⁷

➤ **Safe shelter referrals:** As OSCs do not provide temporary shelter, where necessary, OSCs are tasked with ensuring referrals to safe houses, where necessary.⁴⁶⁸

Coordination and Support for OSCs:

The Ministry of Health is accountable for the coordination of OSCs in Zambia,⁴⁶⁹ together with the support of several other stakeholders. The Ministry of Gender is involved in the creation of OSCs at the district and community levels.⁴⁷⁰ Additionally, there are various international and foreign-aid stakeholders still involved in the support of the OSCs. This includes UNICEF, UNFPA, ILO, the United Nations Development Programme (UNDP), and the International Organisation for Migration. Foreign aid and support through GBV programmes are also received from countries including the USA, Sweden, Ireland, the UK, and also the EU.⁴⁷¹

SUCCESSES AND SHORTCOMINGS OF ZAMBIA'S OSCS

Overall, OSCs in Zambia have been an effective and efficient way to offer integrated services to survivors of violence (including for children). Since implementation, some vital successes and shortcomings have been identified over the years, which are useful inputs in understanding

what contributes to a well-functioning OSC. It should be duly noted, however, that these factors do not necessarily represent the climate of OSCs in Zambia today. Rather, they are crucial observations that have occurred since the implementation. Some important successes, strengths, and enablers of the OSC implementation include:

➤ **Hospital-based OSCs** have been able to provide a full range of efficient and comprehensive health, paralegal, and counselling services under one roof.⁴⁷²

➤ **Village-based OSCs have provided an alternative, cost-effective, and first-line of assistance for delivering services to survivors**, utilising existing community structures for counselling, paralegal advice, referrals to specialist services, and awareness raising. As they are located within communities, they are **easily accessible** for child survivors and their families.⁴⁷³

➤ The legitimacy and credibility of village-based OSCs has been secured through a **high level of support from community chiefs and traditional leaders**. This has proven to be immensely beneficial to their success and sustainability. As community leaders are custodians of customs and traditions, they command great respect within the community. Their commitments and dedications to supporting anti-GBV efforts are a prime example of how strong links to community structures can enhance both the prevention of violence and response interventions through OSCs.⁴⁷⁴

➤ **Stand-alone and NGO-led OSCs** have been beneficial for providing services in a more private environment and have been more flexible in the accommodation of emergency transits.⁴⁷⁵

Conversely, some challenges and barriers have been identified in OSCs in Zambia. These include:

⁴⁶⁵ Ibid. 60.

⁴⁶⁶ Ibid. 57.

⁴⁶⁷ Ibid.

⁴⁶⁸ Ibid.

⁴⁶⁹ Ministry of Community Development and Social Service (n 462) 16.

⁴⁷⁰ United Nations Children's Fund, 'Child Protection in Zambia' [UNICEF] <<https://www.unicef.org/zambia/child-protection>> accessed 7 June 2021.

⁴⁷¹ See GRZ and UN Zambia (n 461); See also Mapoma (n 460).

⁴⁷² Zimbizi, Milapo and Holsbrink (n 458) xii.

⁴⁷³ Ibid. xiii.

⁴⁷⁴ Ibid. 81.

⁴⁷⁵ Keesbury and Others (n 297) 12.

There have previously been **concerns over the sustainability** of OSCs in the phasing out of donor driven financing. For instance, whilst the government has planned to incorporate the centres into mainstream case and support services, at the time of evaluation of one assessment in 2017, this had not yet been actualised. In some cases, neither the Ministry of Health nor the hospitals had allocated adequate finance for the centres in their budgets. Thus, without the aid of international and foreign donors, it may be challenging for centres to operate. In the past, the reliance on donations for operations led to some failed or collapsed centres once their projects had elapsed too.⁴⁷⁶

An undersupply of documents related to post-rape care was another identified barrier to the provision of OSC services. For instance, in some cases the unavailability of forms meant that child survivors and their parents/caregivers had to be directed to other departments within the hospital just to open their files to seek services. This hinders the very concept of the 'one-stop' approach, which seeks to prevent retraumatisation.⁴⁷⁷

Although **village-based OSCs** have proven to be cost-effective and accessible, they **have not provided health services on site**. In addition, some centres have been **resource-constrained** and have, therefore, only provided limited services.⁴⁷⁸

As village OSC services are provided by community members, there have been **concerns about professionalism** in adequately detecting, inspecting, and dealing with instances of VAC. Some accounts have found attitudes of harmful cultural stigma amongst staff. Persons with disabilities have been particularly affected by stigma. In some instances, this had detrimentally induced retraumatisation rather than aiding recovery.⁴⁷⁹

Limited resources have been identified as another shortcoming of OSCs in Zambia. As reliance on foreign and international aid is being phased out, budget cuts

have meant that OSCs have faced constraints in transporting sensitive cases to and from facilities,⁴⁸⁰ and have also hindered provision of some services such as prophylaxis treatment.⁴⁸¹

The absence of a national OSC policy framework providing covenant support for OSCs, has previously led to concern over the future accountability and national financial commitments to the OSCs.⁴⁸²



⁴⁷⁶ Zimbizi, Milapo and Holsbrink (n 458) xii, 80-81.

⁴⁷⁷ Nachela Chelwa and Others, 'Enhancing Access to Post-Rape Care for Child Survivors in the Context of Police and Health Services in Zambia: A Feasibility Assessment of a Police Response Model' (Population Council 2017) 13 <https://www.popcouncil.org/uploads/pdfs/2017RH_PoliceResponseGBV-Zambia.pdf> accessed 9 June 2021.

⁴⁷⁸ Georgie Zimbizi, Nalukui Milapo and Sara Holsbrink, 'Independent Evaluation of the Government of the Republic of Zambia/United Nations (GRZ/UN) Joint Programme on Gender Based Violence: Final Evaluation Report' (Government of Zambia and the United Nations Development Programme 2017) xii-xiii <<http://web.undp.org/evaluation/evaluations/adr/zambia.shtml>> accessed 10 June 2021

⁴⁷⁹ Ibid. 74. For instance, in the village-based OSCs, there were accounts detailing that children and women with mental disabilities were physically and verbally abused by village OSC staff during evaluations. When asked about such incidents during a focus group, they appeared to be unaware that their own actions amounted to inflicting violence themselves. This attitude towards persons with disabilities is a greater reflection of the **cultural stigmatisation surrounded by disability** that puts persons with disability at a greater risk of abuse.

⁴⁸⁰ Ministry of Community Development and Social Service (n 469) 29.

⁴⁸¹ Chomba and Others (n 455) 6.

⁴⁸² Zimbizi, Milapo and Holsbrink (n 458) 79; Ministry of Community Development and Social Services (n 469) 29.

THE CASE OF ZANZIBAR

BACKGROUND

Over the last decade, the semi-autonomous island region of Zanzibar has made a paradigm shift in response to cases of VAC. In 2009, Tanzania conducted a national household survey on VAC, the first of its kind in Africa. The results disclosed a shocking revelation: children were enduring serious levels of sexual, physical, and emotional abuse. This signalled a powerful call for action.⁴⁸³

Of those surveyed aged between thirteen and twenty-four, **almost one in ten males (9.3%) and 6% of females** reported to having experienced **at least one form of sexual violence prior to turning the age of eighteen**.⁴⁸⁴ Alarming, **less than half** of both females and males that had been sexually violated **reported telling someone about their experience**. Family, community, and fear of abandonment were amongst the reasons cited as to why children often withheld their experiences.⁴⁸⁵ The percentage of those who sought services for being sexual abused was even lower. **Just 18% of females and 11.4% of males actively sought services**, and of those who did attempt to seek help, **only six in eleven females and males received services**.⁴⁸⁶ The statistics for physical violence were even more disturbing. **Two out of three males (71.1%) and six out of ten females (61.8%) reported having experienced physical violence** in their childhood.⁴⁸⁷ The lack of response from family members, community leaders, and state agencies meant that many of these cases went unreported.⁴⁸⁸

Acting upon these harrowing numbers, in 2011, the Revolutionary Government of Zanzibar adopted the Children's Act. The Act is a **Future Policy Award winning, pioneering, and comprehensive piece of children's rights law**. Prior to its implementation, child-relevant law and the protection of children had been haphazard, with provisions scattered across various pieces of traditional and Islamic legislation that did not necessarily conform to the international and regional legal standards of the rights of the child. The objective of the Children's Act was not only to **effectively outlaw and respond to cases of VAC**, but it has laid down the **foundation for a coordinated CPS, established a child-friendly court, promoted the rights of children**, including for those in conflict with the law, **streamlined child-relevant law**, and conformed to the **obligations under international and regional laws on the rights of the child**.⁴⁸⁹

In the past, protection and response services available to child abuse survivors were also fragmented and uncoordinated.⁴⁹⁰ As many complaints were reported by members of the community regarding the various challenges they faced in responding and reporting to cases of VAC, representatives of the government embarked upon a **study visit to Zambia** where a functioning OSC model had already existed.⁴⁹¹ Taking inspiration from this model, **OSCs were established in Zanzibar** in 2011. These centres were a paramount aspect of operationalising the Children's Act and of formed part of the **national action plan policy to ending VAC**.⁴⁹²

The first ever centre was based in Mnazi Mmoja Hospital in the capital of Stone Town, which opened as part of a **joint collaboration between Save the Children and the Child Protection Unit** (an agency operating under the Ministry of Empowerment, Social Welfare, Youth, Women and Children).⁴⁹³ Encouraged by the promising results of the first centre, and in particular, the impact it

⁴⁸³ The Revolutionary Government of Zanzibar and UNICEF, 'T-Watoto Survey Report on Violence against Children in Zanzibar' (2017) 3 <https://www.togetherforgirls.org/wp-content/uploads/REPORT_ON_VIOLENCE_AGAINST_CHILDREN_IN_ZANZIBAR.pdf> accessed 1 April 2021.

⁴⁸⁴ UNICEF Tanzania and Others, 'Violence Against Children in Tanzania: Findings from a National Survey 2009' (United Republic of Tanzania, August 2011) 91 <https://www.togetherforgirls.org/wp-content/uploads/2017/09/2009_Tanzania_Findings-from-a-Violence-Against-Children-Survey.pdf> accessed 1 April 2021.

⁴⁸⁵ Ibid. 92.

⁴⁸⁶ Ibid. 95-96.

⁴⁸⁷ Ibid. 98. Please refer to the report for more information on VAC statistics in Zanzibar.

⁴⁸⁸ Save the Children Tanzania, 'Child Protection' (Save the Children) <<https://tanzania.savethechildren.net/what-we-do/child-protection>> accessed 15 March 2021

⁴⁸⁹ For more information see 'Zanzibar's Children's Act' (Future Policy 2015) <<https://www.futurepolicy.org/rightsofchildren/zanzibars-childrens-act/>> accessed 16 April 2021.

⁴⁹⁰ Phil Wilkinson, 'Assessment Report: Zanzibar's One Stop Centres' (Save the Children 2014) 6-7.

⁴⁹¹ The Ministry of Health, 'The One Stop Center Model in Zanzibar' (Presentation, Revolutionary Government of Zanzibar 2018).

⁴⁹² Ministry of Labour, Empowerment, Elders, Youth, Women and Children, 'National Plan of Action to End Violence Against Women and Children 2017-2022' (Revolutionary Government of Zanzibar 2017) 29 <https://www.togetherforgirls.org/wp-content/uploads/Zanzibar_National_Plan_of_Action_on_VAWC.pdf> accessed 18 April 2021.

⁴⁹³ Save the Children Tanzania (n 488).

had for child survivors of VAC, the government decided to **scale-up the OSC initiative** with the assistance of Save the Children.⁴⁹⁴ Known locally as ‘Mkono kwa Mkono’ centres,⁴⁹⁵ five new OSCs were subsequently established within the island region. Today, the six **OSCs operate** in six of the ten district hospitals, and they **play an integral role** in responding to cases of VAC **as part of a broader, systems-strengthened, and multi-stakeholder CPS.**⁴⁹⁶

CHARACTERISTICS OF ZANZIBAR’S ONE-STOP CENTRES

A Multidisciplinary Provision of Services:

Based in district hospitals, OSCs in Zanzibar are operational **twenty-four hours a day and seven days a week**, with the aim of providing collective, quick, and easy services to victims of abuse.⁴⁹⁷ These services are offered by a **multidisciplinary team** at the OSC, comprising of **social workers, police without uniform, medical personnel, and psychosocial counsellors.**⁴⁹⁸ Each OSC aims to offer the following services under one roof to **all survivors of all forms of abuse:**

➤ Medical services:

Examinations, assessments, provision of tests for HIV and STI/Ds, and treatments including the administration of PEP and emergency contraceptives are provided by health professionals (including a medical doctor).

➤ Legal and law enforcement services:

A designated police officer at the OSC assists survivors in properly reporting and filing incidents of VAC to ensure prosecution. The OSC police officer is not dressed in uniform and is professionally trained in dealing with children, which is a requirement for making the survivor feel as comfortable as possible. Paralegal services are also provided to survivors under this pillar.

➤ Psychosocial services:

OSCs are equipped with providing counselling via a social

The Interagency Collaboration at Zanzibar’s One-Stop Centres



workers, who are also tasked with following up with each patient who comes to the centre.⁴⁹⁹

Coordination, Support and Accountability of OSCs:

The centres’ operation is not only based on multidisciplinary roles within a team, but also relies on inter-ministerial and interagency collaboration. There are **three essential government pillars – health, justice, and social welfare** – directly involved in the administration of services and management. This involves coordination between the Ministry of Health, the police, legal services, the Directorate of Public Prosecution, the Ministry of Justice, as well as the Ministry of Empowerment, Social Welfare, Youth, Women and Children Development.⁵⁰⁰ Save the Children has been highly involved in supporting this collaboration of agencies and ministries too since the OSC establishment in 2011. In addition, there has been support from several

⁴⁹⁴ Ministry of Health (n 491) 2.

⁴⁹⁵ Ministry of Labour, Empowerment, Elders, Youth, Women and Children (n 492) 29.

⁴⁹⁶ Save the Children Tanzania (n 488).

⁴⁹⁷ Ministry of Health (n 491) 5; Together for Girls, ‘Visit the Mnazi Mmoja One Stop Centre’ (Together for Girls) <<https://www.togetherforgirls.org/visit-mnazi-mmoja/>> accessed 17 April 2021.

⁴⁹⁸ Save the Children Tanzania, ‘Ensuring Every Child is Protected in Zanzibar’ (Save the Children 2020) <<https://tanzania.savethechildren.net/news/ensuring-every-child-protected-zanzibar>> accessed 17 April 2021.

⁴⁹⁹ Ibid; Save the Children Tanzania (n 488).

⁵⁰⁰ Wilkinson (n 490) 6; Ministry of Health (n 491) 4.

other key international stakeholders, including UNICEF, UNFPA, and the Swedish International Development Co-operation Agency.⁵⁰¹

SUCCESSES & SHORTCOMINGS OF ZANZIBAR'S OSCS

In a region with limited resources, expertise, and previously fragmented responses to VAC, the implementation of OSCs in Zanzibar has been highly successful. These centres have also been welcomed by the CmRC in their provision of immediate support to child victims of abuse.⁵⁰² Since implementation, over the years there have been some vital successes and shortcomings that are useful inputs in understanding what contributes a well-functioning OSC. It should be duly noted that not all factors necessarily represent the climate of OSCs in Zanzibar today, but rather have been crucial observations that have contributed to the development of OSCs over time. Some successes, strengths, and enablers of OSCs include:

➤ Generally, **the number of survivors receiving comprehensive, free-of-charge, and necessary services** for their abuse has increased, which has been difficult to receive in the past.⁵⁰³

➤ Cases have been reviewed and reported through the OSC facilities, and have been **successfully prosecuted, which has increased the level of convictions per perpetration**.⁵⁰⁴

➤ **A strong legislative and policy framework**, including a national action plan that vouches to end all forms of VAC, is demonstrative of an institutional backbone for prevention and for the OSC response tool. Additionally, it has established a baseline for ministerial accountability for VAC.

➤ **Increased general awareness** of VAC and of OSCs as an intervention tool has been fostered by a **National Campaign on Violence against Women and Children** jointly supported by both the government and NGOs. The campaign targets all levels of society, from the levels of government and other respective stakeholders, community groups and members, as well as youth and adolescents, and within both the public and private domains. Messages and jingles throughout the mainstream and social media, posters, and face-to-face community dialogues have all been utilised to spread awareness of VAC and the availability of OSCs. Through consultation with a youth group, awareness activities have also been incorporated into the school curriculum.⁵⁰⁵ Prevention campaigns such as the government's positive discipline project addressing the alarmingly common use of corporal punishment in the school settings, have been another external enabler for fostering a change in attitude towards an intolerance of VAC.⁵⁰⁶

However, whilst OSCs in Zanzibar have been beneficial, barriers to and shortcomings and weaknesses in the functioning of the centres have also been identified. These include:

➤ **In the past, when OSCs were initially established, a lack of financial resources** had been a **limitation for OSCs** in their operational and technical capacities.⁵⁰⁷ For instance, a digitalised data management and coordination system was absent due to these constraints.⁵⁰⁸ By learning from these lessons, however, **financial and budgetary commitments are now central** to achieving an enabling environment in ensuring the protection and empowerment of children within the current National Plan of Action to End Violence Against Women and Children. This includes establishing a comprehensive information management system to track trends in VAC and monitor response tools such as the OSCs.⁵⁰⁹

⁵⁰¹ Wilkinson (n 490) 7.

⁵⁰² United Nations Committee on the Rights of the Child, 'Concluding Observations on the Combined Third to Fifth Periodic Reports of the United Republic of Tanzania' (2015) CRC/C/TZA/CO/3-5 para 46

⁵⁰³ Wilkinson (n 490) 9.

⁵⁰⁴ Ibid.

⁵⁰⁵ 'Consulted by the Government: to Develop Material for the National Campaign on Violence against Women and Children in Zanzibar' (SEMA Tanzania 2020) <<https://www.sematazania.org/stories/consulted-by-the-government-to-develop-materials-for-the-national-campaign-on-violence-against-women-and-children-in-zanzibar>> accessed 17 September 2021.

⁵⁰⁶ Annual Joint Education Sector Review Technical Working Group, 'Annual Joint Education Sector Review Report 2019' (The Revolutionary Government of Zanzibar 2019) 37-38 <<https://www.globalpartnership.org/sites/default/files/document/file/2020-05-Tanzania-Zanzibar-ESP-IR-JSR-AM.pdf>> accessed 18 September 2021. The project developed a teacher's manual that outlined the best positive disciplining practices, and since 2017, has been implemented in the training curriculum of staff at schools.

⁵⁰⁷ Wilkinson (n 490) 10.

⁵⁰⁸ Ibid. 9. This meant that sometimes contact details of the child and their parent/caregivers were not recorded for follow-up treatment; and nor were records of the services provided to each child survivor.

⁵⁰⁹ Ministry of Labour, Empowerment, Elders, Youth, Women and Children (n 492) 29, 35-36.

➤ In Zanzibar, resolving cases of VAC through informal mechanisms, such as through financial compensation and agreements made with the perpetrator, has been prevalent.⁵¹⁰ This has been accompanied by a **strong culture of silence**, which **has deterred parents/caregivers from reporting their child's case** to the relevant authorities and OSCs.⁵¹¹

➤ **Preference for using 'sheha'** (local administrative leaders) as a means of mediating a situation of VAC, rather than the services of the police and justice system, has been common due to some scepticism and mistrust of some services.⁵¹² However, action has been taken to improve this trust. For instance, Police Gender and Children's Desks have been implemented, which are professionally specialised in the sensitised handling of VAC and GBV cases.⁵¹³

➤ There has been concern about the absence of the effective punishment of religious **'madrasa' teachers** in Zanzibar. Madrasa schools are an essential part of religious education for children throughout the archipelago. Yet, they are also known locations where VAC is perpetrated (especially sexual violence and abuse), and some accounts have expressed concerns about insufficient investigations into such cases.⁵¹⁴ However, it should be duly noted that the several partnerships between the government, stakeholders such as UNFPA, and community/religious leaders, have, for years, conducted critical extensive outreach to communities on the harms of VAC in a bid to change minds and attitudes that foster tolerance.⁵¹⁵



⁵¹⁰ Lees and Devries (n 5) 107-108.

⁵¹¹ Save the Children Tanzania (n 498).

⁵¹² Wilkinson (n 490) 13.

⁵¹³ Rebecca Grant, 'How to Get Women to Trust the Police? 'Gender' Desks' (NPR 2018) <<https://www.npr.org/sections/goatsandsoda/2018/08/15/638872938/how-to-get-women-to-trust-the-police-gender-desks>> accessed 17 October 2021.

⁵¹⁴ Lees and Devries (n 5) 108.

⁵¹⁵ 'Faith Leaders Fight Child Marriage in Zanzibar' (UNFPA 2021) <<https://www.unfpa.org/news/faith-leaders-fight-child-marriage-zanzibar>> accessed 18 October 2021;

4.2 OSCs IN ASIA

THE CASE OF BANGLADESH

BACKGROUND

VAC in Bangladesh is a persistent problem and is not locally limited, occurring in the home, school, the workplace, on the street, and/or in prisons.⁵¹⁶ In a 2019 Multiple Indicator Cluster Survey (MICS), the overall national trend revealed alarming numbers. For instance, the percentage of children aged between one and fourteen who experienced any **violent discipline** within the last one month at the time the survey was conducted, was **88.8%**.⁵¹⁷ The **COVID-19** pandemic has only **exacerbated** the situation, with a **40% increase in calls made to the child helpline**. Additionally, it is estimated that a total of **45 million children live in homes where violent discipline is employed**.⁵¹⁸

Child marriage is also an extremely harrowing, problematic, and common practice. Results of the 2019 MICS detailed that as high as **60%** of women aged between twenty and forty-nine, were **first married before their eighteenth birthdays**, and **19.8%** of girls and women between the ages of fifteen and forty-nine were **first married prior to turning fifteen**.⁵¹⁹ Additionally, 47% of married girls aged between fifteen and nineteen who have experienced physical or sexual violence, did so through their partners or husbands.⁵²⁰

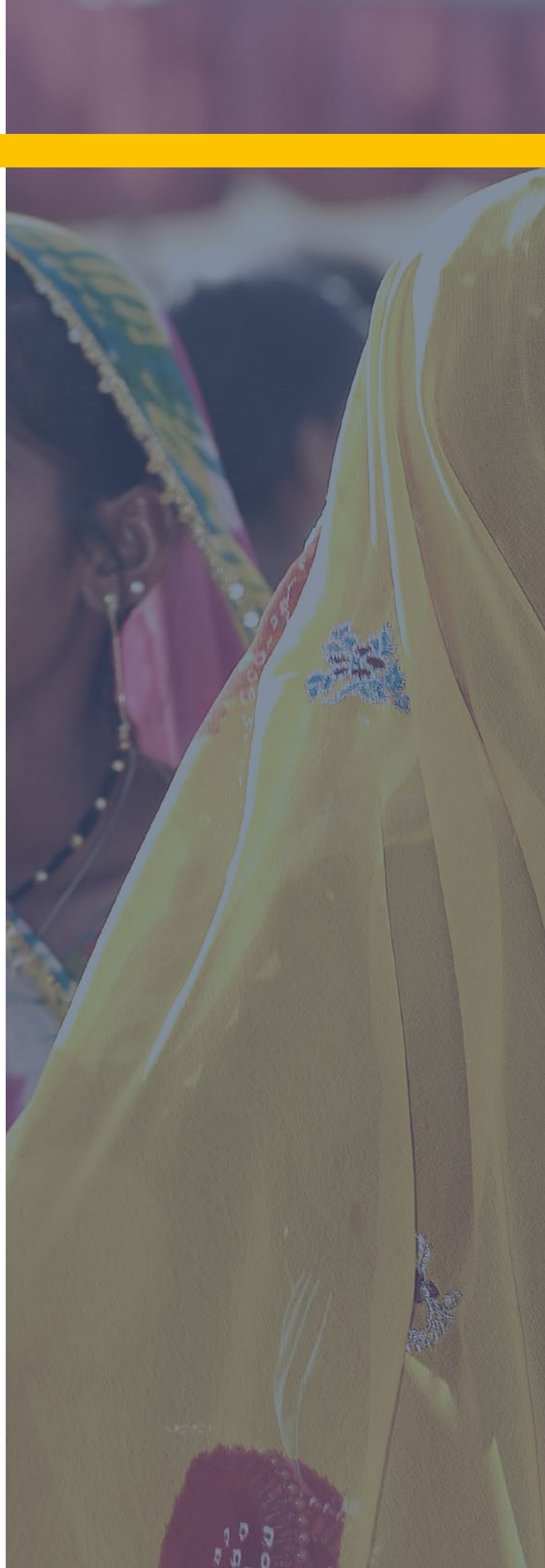
⁵¹⁶ Farzana Islam and Gulshan Ara Akhter, 'Child Abuse in Bangladesh' (2015) 9 Ibrahim Medical College Journal 18, 18.

⁵¹⁷ Bangladesh Bureau of Statistics and UNICEF Bangladesh, *Multiple Indicator Cluster Survey* (UNICEF 2019) 286.

⁵¹⁸ The Needs Assessment Working Group, 'COVID-19: Bangladesh Multi-Sectoral Anticipatory Impact and Needs Analysis' (Government of the People's Republic of Bangladesh 2020) 8 <https://reliefweb.int/sites/reliefweb.int/files/resources/COVID_NAWG%20Anticipatory%20Impacts%20and%20Needs%20Analysis.pdf> accessed 1 September 2021.

⁵¹⁹ BBS and UNICEF Bangladesh (n 517) 301.

⁵²⁰ United Nations Children's Fund, 'Violence Against Children' (UNICEF) <<https://www.unicef.org/rosa/what-we-do/child-protection/violence-against-children>> accessed 13 June 2021.



In response to these alarming numbers, the government has implemented several policies and laws aimed to align with the provisions and principles of the CRC. This includes the 2013 Children Act, the National Plan to Prevent Violence against Women and Children 2013-2025, the amended Prevention of Women and Children Repression Act of 2000, and the Child Marriage Restraint Act of 2017.⁵²¹

As the prevalence of VAC and VAW are interlinked, response and interventions have targeted both children *and* women. This includes the establishment of the **One-Stop Crisis Centres (OSCC)** based upon Malaysia's OSC model.⁵²² With the support of various stakeholders, including local and international initiatives, as well as the Royal Danish Embassy, the centres have been **operating since August 2001**.⁵²³

Although the OSCCs were created primarily with the aim of responding to women, they do include the provision of services for child survivors of violence. The *Multisectoral Programme on Violence against Women*, a project implemented by the governments of Bangladesh and Denmark⁵²⁴ was instrumental in establishing and scaling up the OSCCs at tertiary-level medical college hospitals. In addition to this, **One-Stop Crisis Cells** (hereinafter: Cells) at the district and upazilla⁵²⁵ hospitals and health-care complexes were established by the programme.⁵²⁶ Today, a total of nine OSCCs exist, which are located in each division⁵²⁷ and sixty Cells have been implemented across the country.⁵²⁸

CHARACTERISTICS OF THE ONE-STOP CRISIS CENTRES IN BANGLADESH

Multidisciplinary Provision of Services:

OSCCs provide a **free-of-charge** package of integrated and coordinated support by a multisectoral and interagency team operating **round the clock, seven days a week**.⁵²⁹ The team provides medical treatment (including both evaluation and forensic examination), multi-level crisis intervention, police assistance and legal support, psychosocial counselling, social welfare services, further rehabilitation, and, if necessary, safe shelter.⁵³⁰

Admission to OSCCs is conducted via a referral within the relevant medical college hospital. Only non-critical survivors are referred immediately to the OSCC.⁵³¹ Upon entering the OSCC, individuals receive a general examination by a doctor who makes diagnoses, administers treatment, and documents any physical evidence of violence. Following this, and if required, the survivors will receive specialist medical services, such as forensic evidence collection, paediatrics, or other specialists. Counselling, social welfare services, legal aid, follow-up support, and provision of shelter is provided following the medical services.⁵³²

The Cells, located in district and upazilla health facilities, are considered a set of referral and information clinics. They are purposed with familiarising survivors on the various available services that can be sought and may refer them to the relevant organisations, including the OSCCs.⁵³³

- ⁵²¹ Asif Amrin Khan, 'Status Report: Violence against Children in Bangladesh' (Save the Children 2020) 5 <<https://bdplatform4sdgs.net/wp-content/uploads/2020/03/Presentation-on-violence-against-children-by-Save-the-Children-in-Bangladesh.pdf>> accessed 8 September 2021; *The Children Act* (20 June 2013) [English version available at <<https://www.unicef.org/bangladesh/sites/unicef.org/bangladesh/files/2018-07/Children%20Act%202013%20English.pdf>>]; Ministry of Women and Child Affairs, SRO No 344-Law/2017 *The Child Marriage and Restraint Act* (10 December 2017) [Government of the People's Republic of Bangladesh, English version available at <<https://www.unicef.org/bangladesh/sites/unicef.org/bangladesh/files/2018-10/Child%20Marriage%20Restraint%20Act%202017%20English.pdf>>]; Ministry of Women and Child Affairs, 'National Action Plan to Prevent Violence against Women and Children 2013-2015' (Government of the People's Republic of Bangladesh) <https://mowca.portal.gov.bd/sites/default/files/files/mowca.portal.gov.bd/page/bcf75e01_95e3_48ba_bfe4_3d88ea5f593c/English-National-Action-Plan-to-Prevent-Violence-Against-Women-and-Children-2013-20251.pdf> accessed 15 July 2021.
- ⁵²² Gouranga Bairagi and others, 'One Stop Crisis Centre: A Model of Hospital-Based Service for Domestic Violence, Burn and Sexual Assault Survivors in Bangladesh' (2006) 25 *THE ORION Medical Journal* 407, 407.
- ⁵²³ *Ibid.*
- ⁵²⁴ 'Background: Multi-Sectoral Programme on Violence against Women' (Government of the People's Republic of Bangladesh) <<http://mspvaw.gov.bd/contain/3>> accessed 20 June 2021.
- ⁵²⁵ In Bangladesh, administrative regions are called upazila.
- ⁵²⁶ Rohini Prabha Pande and Others, 'Addressing Intimate Partner Violence in South Asia' (International Center for Research on Women 2017) 20-21 <<https://www.icrw.org/wp-content/uploads/2017/07/Partner-Violence-in-South-ASIA-Report-Final-file-17-04-2017.pdf>> accessed 27 April 2021.
- ⁵²⁷ Human Rights Watch, 'I Sleep in My Own Beathbed: Violence against Women and Girls in Bangladesh: Barriers to Legal Recourse and Support' (Human Rights Watch 2020) <<https://www.hrw.org/report/2020/10/29/i-sleep-my-own-deathbed/violence-against-women-and-girls-bangladesh-barriers>> 19 June 2021.
- ⁵²⁸ Pande and Others (n 526) 20-21.
- ⁵²⁹ Implementation Monitoring and Evaluation Division, 'Impact Evaluation Study of Multi-Sectoral Programme on Violence against Women (2nd Phase)' (Ministry of Planning Government of the People's Republic of Bangladesh 2014) iii <https://imed.portal.gov.bd/sites/default/files/files/imed.portal.gov.bd/page/e773d5bf_182e_4fc5_a856_dfd3c8d05ced/women.pdf> accessed 3 May 2021.
- ⁵³⁰ Bairagi and Others (n 522) 408-409; Md Abdur Rahim Mia, 'Role of One Stop Crisis Centre (OSCC) in Protecting Women's Rights: An Analysis with Special Reference to Rajshashi District' (2011) 11 *Bangladesh Journal of Law* 1, 3.
- ⁵³¹ Semi-critical and critical survivors will receive emergency services first.
- ⁵³² Bairagi and Others (n 522) 408-409.
- ⁵³³ Implementation Monitoring and Evaluation Division (n 529) 21.

Ministerial Accountability & Coordination of OSCCs:

Five ministries are involved in the coordination of OSCCs, which are: the Ministries of Health and Family Welfare, Social Welfare, Information, Home Affairs, and Children and Women Affairs, which is the lead ministry.⁵³⁴ These ministries, in collaboration with the relevant NGOs that support the centres, coordinate with an interagency Working Committee. The committee conducts monthly case management meetings and meets up once every two months to discuss team and agency strengthening, and to correct weaknesses identified.⁵³⁵ Overall management of the centres is under the control of the director of the relevant medical college hospital, although ministries are responsible for appointing the necessary staff.⁵³⁶

SUCCESSSES AND SHORTCOMINGS OF THE OSCCS

In a country where VAC is both a persistent and pertinent issue, OSCCs have been both beneficial, yet have also faced many challenges. Since implementation, over the years these identified successes and shortcomings have been useful inputs to understanding what contributes a well-functioning OSC. It should be noted, however, that these factors do not necessarily represent the climate of OSCCs in Bangladesh today, but rather represent crucial observations that have occurred since implementation and that have contributed to their development. Some identified strengths include:

➤ One evaluation has identified **strong intra-hospital team coordination between specialists and experts at the hospitals and the OSCCs**. Moreover, inter-sectoral coordination between OSCCs and the Department of Social Welfare is well organised.⁵³⁷

➤ **OSCCs located in tertiary hospitals have been beneficial for specialised referrals and immediate crisis interventions** (such as treating burns in the instance of acid attacks, a commonly perpetrated gender crime in Bangladesh affecting girls and women).⁵³⁸

On the other hand, some shortcomings, challenges, weaknesses, and barriers that have been identified, include:

➤ **Psychosocial support has been limited**. According to one evaluation from 2016, **support has been spread** between the OSCCs and other facilities, such as women support centres, most likely due to a lack of providers. This has reflected some inadequacy in service, and particularly for children and adolescent survivors of sexual violence that require continuous psychosocial support.⁵³⁹

➤ **Poor communication and coordination amongst the ministries as well between governmental and non-governmental stakeholders has previously been a challenge**. This has at times hampered efforts to convene meetings and linking survivors to NGOs for the relevant services and rehabilitation.⁵⁴⁰

➤ Some **infrastructure and capacity issues have been identified at OSCCs**. Some hospitals have not been equipped fully with, for instance, proper DNA lab facilities, special accommodation, and counselling services, and some have lacked adequate project funds necessary for the provision of medication and medical checks.⁵⁴¹ **The issue of confidentiality has also arisen due to inadequate infrastructure**. Even with safeguards in place, centres have faced constraints due to lack of space, unsuitable infrastructure, and overcrowding, which has presented a challenge for providers in securing confidentiality.⁵⁴²

⁵³⁴ Bairagi and Others (n 530) 409.

⁵³⁵ Ibid.

⁵³⁶ Ibid.

⁵³⁷ Ibid. 411.

⁵³⁸ Ibid. 410.

⁵³⁹ Evaluation Office, 'Independent Country Programme Evaluation: Bangladesh 2012-2016' (UNFPA 2016) 69 <https://www.unfpa.org/sites/default/files/admin-resource/CPE_Bangladesh.pdf> 13 June 2021.

⁵⁴⁰ Ibid. 27-28.

⁵⁴¹ Ibid. 60.

⁵⁴² United Nations Population Fund, 'Health Sector Response to Gender-Based Violence: An Assessment of the Asia Pacific Region' (UNFPA Asia and the Pacific Regional Office 2010) 70 <<https://asiapacific.unfpa.org/sites/default/files/pub-pdf/Assessment.pdf>> accessed 16 May 2021

➤ **Some specialised medical services and examinations** (such as MRI scans and DNA tests) **have not always been covered by hospital budgets.** Thus, they have at times been **unaffordable** for some survivors.⁵⁴³

➤ **According to one evaluation from 2020, the overall accountability of perpetrators had been weak,** which was demonstrated by a low number of successful conviction rates.⁵⁴⁴

➤ **The culture of silence related to stigma associated with violence,** which affects mostly girls and women, has been an external barrier to OSCCs. Often, cases have not been filed because of the fear of embarrassment in the family and the community, or out of fear of retaliation by the perpetrator.⁵⁴⁵

➤ Another **external and major weakness** that poses a threat to the OSCCs as part of a greater vision towards eliminating VAC concerns the **Child Marriage Restraint Act 2017.** OSCCs should make up just one element of a system of prevention and response mechanisms striving to eliminate VAC. This requires and begins with legislation and policy that outright prohibits VAC. Although the Act does prohibit child marriage, Section 19 allows it under **special circumstances** when it is considered in the best interests of the child.⁵⁴⁶ The existence of this provision leaves room for legal loopholes for misuse and misinterpretation, which can, therefore, directly place girls at a higher risk of (sexual and domestic) violence.⁵⁴⁷ In addition, the existence of Section 19 contradicts a commitment to eliminating VAC. The OSCCs cannot, to their maximum extent, effectively serve their purpose of contributing to a holistic child protection system that seeks to prevent and respond to VAC, if there are laws in place that allow for the perpetration of VAC in the first place.

THE CASE OF MALAYSIA

BACKGROUND

Malaysia has led the way **in the creation of OSCCs since establishing the first-ever known centres, namely the One-Stop Crisis Centres (OSCC).** The first centre was established in **1994** in the Accidents and Emergency Department of the General Hospital in Kuala Lumpur. Two years later, under the mandate of the Ministry of Health, all state hospitals were required to have OSCCs in their **emergency departments.**⁵⁴⁸ Since then, this model has been replicated in several other countries, including Bangladesh, and today, they are **located in more than 95% of Malaysian State hospitals.**⁵⁴⁹

Several key elements supported the establishment of OSCCs. This includes the **adoption of a national law on IPV** that provides a basic legal framework, **a strong women's rights movement lobbying for the centres,** as well as **commitment** from many key individuals, including those that held **senior positions** within the Ministry of Health.⁵⁵⁰ However, the centres were not just established in response to IPV and domestic violence for women, **child victims of VAC are also offered comprehensive response services at the centres,** emanating from the provisions of the Child Act of 2001.⁵⁵¹

In Malaysia, recorded numbers of child abuse are relatively low when compared to some other countries. However, considering the presence of stigmas and attitudes fostered by the public centred around child abuse, there is concern that **cases may be going unreported.**⁵⁵² Statistics from the Malaysian police documented an **increase** in child abuse,

⁵⁴³ Ibid. 61.

⁵⁴⁴ Human Rights Watch (n 527). For instance, of over 11,000 women who filed legal cases through one OSSC, only 160 of them saw successful convictions.

⁵⁴⁵ Ibid.

⁵⁴⁶ Child Marriage Restraint Act (n 521) section 19.

⁵⁴⁷ CARE Bangladesh, 'The Tipping Point Project: A Policy Brief on the Child Marriage Restraint Act' (CARE 2017) 7 <<https://www.care.org/wp-content/uploads/2020/11/Policy-Brief-final.pdf>> accessed 13 June 2021.

⁵⁴⁸ Manuela Colombini and Others, 'An Integrated Health Sector Response to Violence against Women in Malaysia: Lessons for Supporting Scale Up' (2012) 12 BMC Public Health 2 <https://www.researchgate.net/publication/230564572_An_Integrated_Health_Sector_Response_to_Violence_Against_Women_in_Malaysia_Lessons_for_Supporting_Scale_Up> accessed 3 July 2021.

⁵⁴⁹ Ibid; UNFPA (n 542) 38.

⁵⁵⁰ Ibid.

⁵⁵¹ Child Act 2011, Government of Malaysia; Irene Guat Sim Cheah, 'A Review of Research on Child Abuse in Malaysia' (2016) 71 Medical Journal of Malaysia 87, 87-88.

⁵⁵² Bala Raju Nikku and Azlinda Azman, 'Breaking the Cycle of Child Abuse in Malaysia: Linking Mandatory Reporting, Service Delivery Monitoring and Review Capacity Mechanism' (2014) 10 The Malaysian Journal of Social Administration 64, 67; Irene Cheah Guat Sim and Choo Wan Yuen, 'Child Maltreatment Prevention Readiness Assessment in Malaysia: Country Report' (University of Malaya 2011) 19 <https://www.who.int/violence_injury_prevention/violence/child/malaysia_rap_cm.pdf?ua=1> accessed 16 July 2021.

molestation and rape from 2,236 to 5,744 cases between the years 2005-2008.⁵⁵³ In the first six months of 2009 alone, a total of 2,193 cases were reported, with an average of 313 cases per month. This increase in instances is also alarming considering that, as international experience suggests, reported cases represent only 10% of total cases perpetrated.⁵⁵⁴ Nevertheless, Malaysia has implemented a series of services, programmes, and initiatives to fulfil both its CRC and national child protection obligations. Currently, there are **five government sectors** that address VAC, of which all have **coordinating functions**, including the health sector and the Ministry of Health, through the provision of OSCCs.⁵⁵⁵

CHARACTERISTICS OF MALAYSIA'S ONE-STOP CRISIS CENTRES

A Multidisciplinary Team Providing Comprehensive Services:

The aim of the OSCCs is to provide children and women survivors of IPV, domestic violence and VAC with **round the clock, seven days a week, patient-centred services**. These are delivered in one site by an **interagency team**, with the benefits of geographical proximity to all services, reduced delays, and eased referrals to both specialised and non-health services. The agencies come together to provide medical care, counselling, police aid and social support. Services are managed at three levels: the first level involves initial hospital management, the second level is follow-up, and the third level involves rehabilitation.⁵⁵⁶ Located inside hospital emergency departments, internal referral pathways within the hospital for OSCC patients have also been created for specialised on-site services.⁵⁵⁷

With cases specifically concerning children, OSCCs work in collaboration with the hospital's **Suspected Child Abuse and Neglect (SCAN) team**, which assesses *all* cases

of child abuse and neglect within a hospital. This is a **centralised, multidisciplinary, and multiagency team of hospital staff** comprising of paediatricians, gynaecologists, mental health professionals, accidents and emergency staff, forensic pathologists, nurses, police officers and medical social workers, all who are trained to manage cases of child abuse.⁵⁵⁸

Services are provided in accordance with the Ministry of Health's **One Stop Crisis Center Policy and Guidelines for Hospitals**, which delineates the tasks and roles of each agency and stakeholder involved, as well as the **Guidelines for Hospital Management of Child Abuse and Neglect**.⁵⁵⁹ The Ministry of Health also provides training for the staff of agencies at the OSCCs.⁵⁶⁰ Special guideline provisions to administer services for child victims of violence have been included in both documents, including for detection, treatment, evaluation, protection, counselling of, and investigation into VAC.⁵⁶¹

Responsibility, Coordination, Funding and Management of OSCCs:

Integrated into the healthcare system, OSCCs fall under direction of the Ministry of Health with support from women's rights NGOs, the police, and the Department of Social Welfare.⁵⁶² The Ministry of Health also funds the centres.

SUCCESSSES & SHORTCOMINGS OF OSCCS IN MALAYSIA

As the first in Asia country to implement OSCs over twenty-five years ago and successfully integrate them into the healthcare system, there are some fundamental lessons have been learnt from the Malaysian model in response to both VAC and VAW over the years. These factors represent some useful inputs to understanding what contributes to

⁵⁵³ Ibid; Tengku Fatimah Muliana and Engku Ahmad Zaki Alwi, 'Care and Protection against Child Abuse: With Special Reference to Malaysia Child Act 2001' (2012) 8 Asian Social Science 202, 203.

⁵⁵⁴ Ibid.

⁵⁵⁵ Sim and Yuen (n 552) 60; WHO and Others (n 15) 151.

⁵⁵⁶ Ministry of Health, *One Stop Crisis Center: Policy Guidelines for Hospitals* (Government of Malaysia 2015) 2 (available at <https://www.moh.gov.my/index.php/file_manager/dl_item/5547397361584e704c30395451304e666347397361574e354c6e426b5a673d3d>) accessed 16 July 2021.

⁵⁵⁷ Colombini and Others (n 548) 2.

⁵⁵⁸ Medical Development Division, *Guidelines for the Hospital Management of Child Abuse and Neglect* (Government of Malaysia 2009) (available at <https://www.moh.gov.my/index.php/file_manager/dl_item/56573570644342504a6b63675a474675494642c5a476c6864484a706179394864576c6b5a577870626d567a58305a76636c3955614756665347397a63476c3059577866545746755957646c62575675644639505a6c394461476c735a463942596e567a5a563942626d5266546d566e6247566a644335775a47593d>).

⁵⁵⁹ Ibid.

⁵⁶⁰ UNFPA (n 542) 49; Ministry of Health (n 556).

⁵⁶¹ Ibid.

⁵⁶² UNFPA (n 542) 38.



a well functioning OSC. It should be noted, however, that these factors do not necessarily represent the climate of OSCCs in Malaysia today, but rather are crucial observations that have occurred since implementation, which have contributed to their development over the years. Some successes, strengths, and enablers of the OSCCs include:

- The scale-up process of the OSCCs has been successful due to **strong government leadership** and **policy directives** given by the Ministry of Health.⁵⁶³ Without the Ministry of Health's buy-in of the OSCC proposal put forward by lobbyist groups and the necessary allocated resources, a national scale-up would not have been possible.⁵⁶⁴

- **A strong advocacy and lobbyist movement** (mostly of women's NGOs), spearheading the entire movement and pushing for the creation of centres has been indispensable to the subsequent institutionalisation and scale-up.⁵⁶⁵ This achievement was further strengthened by a partnership between the NGOs and frontline health workers.⁵⁶⁶

- Due to its status as a **middle-upper income country with a strong mainstreamed health system**, the pre-existing human resources and capacity were advantageous to a scale-up.⁵⁶⁷

- **Intra-hospital collaboration for referrals** to specialist services has proven to work well in the public tertiary hospitals of OSCCs due to the availability of specialists on site.⁵⁶⁸

- **There is a clear delineation of roles, provision of services, and (ethical) standards, which are set out in guidelines** as implemented by the Ministry of Health.⁵⁶⁹

- **OSCCs strategically located in the accidents and emergencies department** have proven to be beneficial, since they operate round the clock.⁵⁷⁰

Even with some recognisable successes and strengths in the OSCC implementation, operation, and scale-up in Malaysia, several shortcomings, weaknesses, and barriers have also been identified. These include:

- **A lack of community awareness** linked to a low demand in OSCC services has previously been observed despite a high level of availability of the centres throughout Malaysia. Referrals have been the main source of awareness-raising, although they have proven to be insufficient for the purpose.⁵⁷¹

- There have been **several barriers in the development of SCAN teams**. SCAN teams, which are supposed to be responsible for the management of all child abuse cases, have previously only been available at large government hospitals. Additionally, some private hospitals have lacked SCAN teams altogether.⁵⁷²

- Whilst initial leadership from the government was strong, some assessments have identified a **lack of long-**

⁵⁶³ Ibid. 45.

⁵⁶⁴ Manuela Colombini and Others, 'One Stop Crisis Centres: A Policy Analysis of the Malaysian Response to Intimate Partner Violence' (2011) 9 Health Research Policy and Systems 7 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3141786/>> accessed 11 June 2021.

⁵⁶⁵ Ibid. 5; UNFPA (n 542) 82.

⁵⁶⁶ Ibid. 5, 7.

⁵⁶⁷ UNFPA (n 542) 45.

⁵⁶⁸ Colombini and Others (n 548) 6.

⁵⁶⁹ Ministry of Health (n 556); Medical Development Division (n 558).

⁵⁷⁰ Chew, Zaini and Noor (n 288) 162.

⁵⁷¹ UNFPA (n 542) 44.

⁵⁷² Yarina Ahmad and Others, 'Suspected Child Abuse and Neglect Team (SCAN Team): Early Establishment, Success Stories, Challenged and the Way Forward' (2015) 12 Journal of Administrative Science 60, 69.

term commitment that may have consequences for the financial sustainability of the centres.⁵⁷³

➤ Additionally, there have been **concerns over the sustainability** of the model due to lack of resources that have led to problems with organisation and infrastructure. For instance, one study revealed that some staff had limited training in OSCC management and service.⁵⁷⁴

➤ **Harmful attitudes towards survivors and victim blaming** (in particular, towards women and adolescent girls in sexual violence cases) have previously been observed. Harmful attitudes include believing it is the responsibility of the survivor to prevent sexual violence from happening by dressing appropriately and not walking alone at night.⁵⁷⁵

➤ **A low priority at the health policy level** has previously been observed, which led to multiple **knock-on effects at OSCCs**. Low priority had transpired into an absence of monitoring violence at OSCCs in some cases, resulting in poor collaboration between agencies and a lack of overall knowledge about violence.⁵⁷⁶

➤ Although intra-hospital referrals have proven to be less challenging with the availability of specialists, at tertiary-level hospitals OSSCs, the **link to external agencies** has been difficult due to insufficient inter-agency referrals.⁵⁷⁷

➤ On the other hand, it has been identified that **referrals for OSCCs at the district level** have been challenging due to the unavailability of specialists. Some professionals have revealed that the collaboration between district hospitals and the relevant agencies are not functioning properly.⁵⁷⁸

THE CASE OF MONGOLIA

BACKGROUND

VAC is an intergenerational challenge in Mongolia and is interconnected with other forms of violence, including GBV and domestic violence. In one survey conducted by UNICEF and the National Statistic Office in 2014, it was reported that **as high as 46% of children** aged between one and fourteen had **experienced some form of physical violence**.⁵⁷⁹ This was a stark indicator of the common use of **corporal punishment** disguised as child discipline.⁵⁸⁰

Recognising the magnitude of this issue, Mongolia has committed itself to fight against VAC and, over the years, all levels of society have engaged in efforts towards its elimination.⁵⁸¹ This includes implementing a national plan of action, revising **The Law on the Rights of the Child**, and introducing **The Child Protection Law** in 2016, which included the total prohibition of corporal punishment in all settings.⁵⁸² Today, Mongolia is a *pathfinding* country in the End Violence Against Children Global Partnership. As a pathfinding country, it utilises the seven INSPIRE strategies⁵⁸³ to galvanise action for response, awareness raising, leadership commitment, and for establishing a standard of national violence prevention.⁵⁸⁴

As part of its campaign to respond to VAC (and other forms of violence), **One-Stop Service Centres (OSSCs)** were established and integrated into the **healthcare sector in 2009** by a Joint Order from the Ministry of Health and the Ministry for Social Welfare,⁵⁸⁵ with support from the UNFPA, UNICEF, UNDP, and the WHO. The aim of

⁵⁷³ Colombini and Others (n 564) 6-7.

⁵⁷⁴ Chew, Zaini and Noor (n 288) 165.

⁵⁷⁵ Ibid. 167.

⁵⁷⁶ Colombini and Others (n 548) 4.

⁵⁷⁷ Ibid. 6.

⁵⁷⁸ Ibid.

⁵⁷⁹ Mitsuaki Toyoda and Others, '24 Years Breakthrough for Mongolian Children: Review of Save the Children's Accomplishments in Mongolia (1994-2019)' (Save the Children 2020) 26 <https://resourcecentre.savethechildren.net/node/18946/pdf/scmongolia_25th_anniversary_book_en.pdf> accessed 5 September 2021; see also United Nations Children's Fund, *Violence against Children in East Asia and the Pacific: A Regional Review and Synthesis of Findings* (UNICEF 2014) 12.

⁵⁸⁰ Ibid.

⁵⁸¹ End Violence against Children, 'Mongolia' [End Violence] <<https://www.end-violence.org/impact/countries/mongolia>> accessed 5 September 2021.

⁵⁸² End Violence against Children, 'Corporal Punishment of Children in Mongolia' [End Violence 2018] 1 <<http://www.endcorporalpunishment.org/wp-content/uploads/country-reports/Mongolia.pdf>> accessed 4 September 2021.

⁵⁸³ See WHO (n 10).

⁵⁸⁴ End Violence against Children, 'Pathfinding Countries' [End Violence] <<https://www.end-violence.org/pathfinding-countries>> accessed 5 September 2021.

⁵⁸⁵ UNFPA (n 542) 33.

these centres has been to provide integrated social welfare, health, psychological, and legal support for physically and sexually abused children *and* adults.⁵⁸⁶ In addition to the six centres that existed previously, the government has since established fifteen more OSSCs.⁵⁸⁷

CHARACTERISTICS OF MONGOLIA'S ONE-STOP SERVICE CENTRES

Multidisciplinary Provision of Services in Accordance with the Law:

The revised Law on Combatting Domestic Violence, rather than The Law on Child Protection, sets out the service requirements of the OSSCs. According to Art. 33.1, an OSSC should provide (child) survivors with the following free-of-charge essential services: child protection, security, medical care, social welfare services, legal assistance, psychological services, and mediation services.⁵⁸⁸

The centres operate in a Joint Team. Social workers and psychologists are permanently staffed. Medical professionals, including paediatricians, traumatologists, and laboratory doctors work accordingly to the order of the health-care centres the OSSC is located in. Clients who come to the centre are provided with legal and psychological advice as well as information too, although it is unclear how the legal element is coordinated with the relevant sectors. Moreover, the number of staff varies according to each specific centre.⁵⁸⁹

In addition to the Law on Combatting Domestic Violence, it is important that OSSCs meet the standards encapsulated within the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence. This interagency guideline provides an essential

service package required for survivors of violence, containing seven key modules.⁵⁹⁰

SUCCESSSES & SHORTCOMINGS OF THE OSSCS

The OSSCs have yielded some crucial successes within Mongolia's efforts to eliminate VAC. In the first eight months of 2017, a 19.7% decrease in domestic violence occurrences was reported, of which the OSSCs had, in part, directly contributed to.⁵⁹¹ Since implementation, there have been some other vital successes and shortcomings that have been useful inputs in understanding what contributes to a well-functioning OSC. However, it should be noted that these factors do not necessarily represent the climate of OSSCs in Mongolia today. Rather, they represent observations that have occurred and have contributed to their development. Some key successes, strengths and enablers contributing to the OSSCs include:

- **Good coordination with international agents, such as UNICEF and UNFPA, have enabled OSSCs.** Both agencies have assisted centres in Mongolia, including during the pandemic. The agencies have developed **two guidelines** aimed at strengthening prevention and essential services response to VAC/GBV and how to address specific challenges. These guidelines were successfully applied to fifteen different OSSCs that provided services and safe housing to 1,036 survivors, of which 555 were children.⁵⁹²
- **The procedures and roles are well-governed by legislation** implemented individually or jointly by the relevant ministries. This includes the Ministry of Justice and Home Affairs' order regulating procedures for privacy and confidentiality in data, and on procedures on legal assistance for children affected by violence. The Ministry of Health

⁵⁸⁶ D Baigalmaa and Others, 'Evaluation Made on the Conditions of Policy Documents Related to a Hospital Based "One-Stop Service Center" To Provide Assistance and Care For Domestic Violence Victims' (Government of Mongolia 2019) 7 <[https://gemtel.mn/uploads/Unelgee%20nom%20angli%20hel%20\(1\).pdf](https://gemtel.mn/uploads/Unelgee%20nom%20angli%20hel%20(1).pdf)> accessed 16 June 2021.

⁵⁸⁷ Kara Apland and Others, 'Evaluation Report: Evaluation of the Implementation of the Law on Child Protection (LCP) in Mongolia' (Coram International 2021) 25 <<https://coraminternational.org/evaluation-of-the-implementation-of-the-law-on-child-protection-lcp-in-mongolia/>> accessed 31 August 2021. NB: It has been reported that new OSSCs were implemented as a result of an increase in the number of individuals seeking assistance from living in unsafe environments during the COVID-19 pandemic. However, it is unknown if those OSSCs are included in this number or if they are additional to this number.

⁵⁸⁸ Ibid. 25.

⁵⁸⁹ Ibid. 10.

⁵⁹⁰ UN Women and Others, *Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines* (United Nations 2016).

⁵⁹¹ Bolormaa Tsogtsaikhan, 'Mongolia: Comprehensive National-Level Review: Responses to Questionnaire on Implementation of the Beijing Declaration and Platform for Action' (Ministry of Labour and Social Protection 2019) 36 <[https://asiapacificgender.org/sites/default/files/documents/Mongolia_\(English\).pdf](https://asiapacificgender.org/sites/default/files/documents/Mongolia_(English).pdf)> accessed 13 June 2021. This was compared to the same period of the previous year.

⁵⁹² United Nations Children's Fund, 'Mongolia Novel Coronavirus Situational Report No. 2' (UNICEF 2020) 4 <<https://www.unicef.org/media/81356/file/Mongolia-COVID19-SitRep-5-June-2020.pdf>> accessed 13 June 2021.

has also implemented orders on the provision of medical, psychological, and counselling services.⁵⁹³

➤ One external contribution to enabling OSSC services has been in the **strengthening of referral pathways**. In 2020, classroom-based and virtual trainings were conducted on prevention, violence detection and referral. Previously, surveys indicated that many professionals working directly with children (such as teachers and social workers) did not know how to identify victims of VAC and who to refer them to, should a case be detected. Around 12,000 people have undergone this training.⁵⁹⁴

Although OSSCs in Mongolia bear some recognisable strengths, there are certain areas which are barriers and weaknesses to their performance. These include:

➤ In one evaluation from early 2021, **no gender-disaggregated information** in child protection reporting, assessment, or service provision was found to have been recorded, even whilst evidence demonstrated that stakeholders clearly understood that boys and girls face different protection risks (as recognised above in the issue of sexual violence against boys). This lack of data makes it **challenging to understand the different harms faced by boys and girls** and how to target and respond to their different needs in the correct context.⁵⁹⁵

➤ According to a jointly approved order, children and especially children with disabilities, are to be considered a priority for OSSC services.⁵⁹⁶ In reality, however, **OSSCs have not at times been properly suited for children with disabilities** and have not been able to properly meet their needs. For instance, social workers and other members of the multidisciplinary team have been found to have limited training on disability issues and, as a consequence, lacked the skills necessary to support disabled children.⁵⁹⁷

➤ Different operating hours have been recorded at different centres. For example, the **Sukhbaatar District Health Centre OSSC is only open for eight hours** on working days. This is a barrier to those that seek services outside of operating hours, which may include those who may need immediate assistance.⁵⁹⁸

➤ **OSSCs are supposed to be equipped with special rooms for children**, although this had **not always been the case** (and may vary across different centres). According to one evaluation from 2019, the National Trauma and Orthopaedic Research Centre OSSC did not have any specialised rooms, and children who were affected by violence ended up being placed in the same room as both women and men.⁵⁹⁹

➤ According to procedure, in the case of **medium or high-risk cases**, the affected child is to be **temporarily sheltered**, regardless of the proposals made by the parents or caregivers. Measures must also be taken to **isolate the child** from the perpetrator. However, in some instances it had been reported that **abusive parents or caregivers remained at the hospital** where the OSSC services were given and made it difficult for social workers to accurately assess the situation.⁶⁰⁰

➤ On some occasions, it has previously been reported that OSSCs have been overpopulated, with perpetrators following survivors to the centres. This reflects a serious breach of the **safety, security, and privacy** of survivors at a centre that is supposed to be neutral, responsive, and free from trauma.⁶⁰¹

➤ Despite a legislated procedure for provision of legal counselling, in practice, it has been identified that **getting legal aid has been difficult**. For instance, free legal aid is often limited by a quota. Thus, when a survivor seeks legal help, this quota has often already been met, rendering the services unavailable.⁶⁰²

⁵⁹³ Tsogtsaikhan (n 591) 36.

⁵⁹⁴ WHO Regional Office for the Western Pacific 'Virtual Meeting: Informal Consultation to Develop Practical Recommendations for Addressing Violence against Women and Children' (World Health Organisation 2021) 6-7 <<https://apps.who.int/iris/bitstream/handle/10665/341175/RS-2020-GE-01-virtual-eng.pdf?sequence=1&isAllowed=y>> accessed 14 June 2021.

⁵⁹⁵ Apland and Others (n 587) 62-63. The lack of gender-disaggregated data may be affecting responses too. For instance, it has been recognised that sexual abuse perpetrated against boys is a recognised issue in Mongolia, yet that OSSCs currently not equipped to deal with such cases, and as such, it tends to be overlooked or not addressed.

⁵⁹⁶ Baigalmaa and Others (n 586) 24-25.

⁵⁹⁷ Apland and Others (n 587) 63-64.

⁵⁹⁸ Baigalmaa and Others (n 586) 10.

⁵⁹⁹ Ibid. 27-28.

⁶⁰⁰ Ibid. 33.

⁶⁰¹ Ibid. 27-28.

⁶⁰² Ibid. 36.

THE CASE OF NEPAL

BACKGROUND

In 2011, fifteen One-Stop Crisis Management Centres (OCMCs) were introduced to Nepal by the Ministry of Health and Population. These centres were designed to accommodate a multisectoral and holistic response, mainly to combat **Nepal's exceedingly high rate of GBV, affecting both children (in particular girls) and women** in society.⁶⁰³ For instance, roughly 10% of adolescent girls/women between the ages of fifteen and nineteen have experienced physical violence since turning fifteen, and this number increases with age.⁶⁰⁴

This high rate of GBV is fostered by a social tolerance for and normalisation of violence committed against children and women. For example, not only is the perpetration of some forms of GBV widely deemed justifiable,⁶⁰⁵ but violent discipline is also accepted and commonly occurs. In a government and UNICEF-led MICS from 2014, **82% of children** between the ages of one and fourteen were found to have **experienced** at least one form of **psychological or physical punishment** by household members.⁶⁰⁶

In order to successfully respond to GBV, the OCMCs have been scaled up. It is reported that all **seventy-seven districts in Nepal** now have **OCMCs integrated within healthcare**.⁶⁰⁷ However, the impact of the **COVID-19 pandemic** in Nepal has also raised **increasing concern over VAC occurrences**. As risks have increased during

the pandemic, there is growing national prioritisation for children and adolescents who may be exposed to violence, whether as survivors of VAC and/or GBV, or witnesses/dependents on survivors of GBV.⁶⁰⁸

Alarming, children on average **make up 40%** of the survivors accessing **OCMCs**.⁶⁰⁹ Of the **GBV cases** reported to the police between the period of mid-2016 to mid-2020, **62% of the survivors were children**.⁶¹⁰ However, although prevention and response services for GBV have a robust infrastructure in the OCMCs, the services provided are planned with women in mind rather than children.⁶¹¹ In a recent review of the OCMC services, the government has recognised that care for child survivors remains a major challenge at the centres.⁶¹²

Since uncovering this reality, the pandemic context has instilled a strong sense of urgency in the government's efforts to curb VAC. It now has plans to integrate a specifically child-dedicated OCMC in Nepal's only Children's Hospital.⁶¹³ Because these child-specialised OCMCs will incorporate the avenues of the current OCMCs (which also already provide services to children), evaluations of them have been consulted for this country study on Nepal.

CHARACTERISTICS OF THE ONE-STOP CRISIS MANAGEMENT CENTRES

Multidisciplinary Provision of Services in Accordance with Operational Guidelines:

OCMCs are charged with providing six different services, twenty-four hours a day through a multifaceted and inter-agency team. This includes:

⁶⁰³ Population Division, 'Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres' (Ministry of Health and Population 2013) ii, 1 <<https://un.info.np/Net/NeoDocs/View/3431>> accessed 23 June 2021.

⁶⁰⁴ Ministry of Health and Population, 'Nepal: Demographic and Health Survey' (New ERA and ICF International 2012) 236-237 <[https://dhsprogram.com/pubs/pdf/FR257/FR257\[13April2012\].pdf](https://dhsprogram.com/pubs/pdf/FR257/FR257[13April2012].pdf)> accessed 5 September 2021.

⁶⁰⁵ Central Bureau of Statistics, 'Nepal Multiple Indicator Cluster Survey 2014 Final Report' (Central Bureau of Statistics and UNICEF Nepal 2015) 196 <<https://www.unicef.org/nepal/media/486/file/MICS%202014.pdf>> accessed 24 August 2021. The attitude of acceptance towards some forms of GBV is reflected in roughly 43% of women deeming that their husband's beating and hitting was justified. See the cited survey for more information.

⁶⁰⁶ Ibid. 186, 188.

⁶⁰⁷ Sikder and Others (n 394) 11.

⁶⁰⁸ Deborah Fry and Others, 'Appendix B9. The Inclusion of Services for Children in the One-Stop Crisis Management Centres (OCMCs) for Gender-Based Violence: The Case of Nepal' in Fry and Others (eds) *A Gendered Analysis of Child Protection (CP) Systems Responses in COVID-19 Programming in South Asia* (UNICEF 2021) 73 <<https://www.unicef.org/rosa/media/14081/file/Main%20Report.pdf>> accessed 18 June 2021.

⁶⁰⁹ Ibid. 74.

⁶¹⁰ Ibid.

⁶¹¹ Ibid.

⁶¹² Ibid; Ministry of Health and Population, 'Review of the Scale-Up, Functionality and Utilisation, Including Barriers to Access, of One Stop Crisis Management Centres' (Government of Nepal 2020) 47 <<https://www.nhssp.org.np/Resources/GESI/Scaling%20Up%20OCMCs%20-%20-%20April%202020.pdf>> accessed 28 August 2021.

⁶¹³ Ibid.

- Free health services treating both the immediate physical and mental health needs of survivors and provision of medicine. Medico-legal forensic assessments are also conducted.
- Psycho-legal counselling for both the survivor and the perpetrator.
- Legal advice, counselling, and support through district attorneys, paralegals, and legal counsellors.
- Safe shelter at designated homes.
- Security through collaboration with the police and district administration offices.
- Rehabilitation by providing follow-up treatment after the initial treatment at the OCMC, including counselling, to survivors and those that have been affected.⁶¹⁴

These services are provided in accordance with the Hospital-Based OCMC Operational Manual. This manual contains the core guiding principles, protocols and responsibilities per service, the responsibilities of each authority and agency, the infrastructure requirements, monitoring and evaluation guidelines, and other operational and organisational management guidelines.⁶¹⁵ In an attempt to address staffing gaps, this revised 2016 version of the manual has also appointed a minimum of one medical doctor and two to three staff nurses at the OSC for the provision of twenty-four hour services.⁶¹⁶

Coordination of the OCMCs:

The OCMC programme falls under the responsibility of the Ministry of Health and Population,⁶¹⁷ and a central Coordination Committee administers the project.⁶¹⁸ The Ministry of Health and Population also allocates funds for establishing and running the OCMCs.⁶¹⁹

SUCCESSES & SHORTCOMINGS OF THE OCMCS

The implementation of OCMCs since 2011 and the subsequent programme scale-up, has increased multisectoral and locally coordinated responses to survivors of GBV, whilst recognising their complex and multifaceted needs.⁶²⁰ Nepal, through evaluations, has constantly strived to build upon lessons learnt, which has improved the functionality of the OCMCs on different levels. The identified successes and shortcomings have been useful inputs contributing to an understanding of what constitutes a well-functioning OSC. It should be noted, however, that these factors do not necessarily represent the climate of OCMCs in Nepal today. Rather, they have been crucial identified observations that have contributed to the continual development of OCMCs over the years. Some of these key successes, strengths, and enablers include:

- There is **strong governance** including through the **direct involvement of the Prime Minister's office** in the documentation of data and monitoring of GBV prevalence.⁶²¹ Provincial leadership has also helped in forging agreements between the federal, provincial and municipal levels of government to prioritise GBV/VAC.⁶²²
- **Commitment by hospital leadership to OCMCs** has been another key enabling factor. This commitment has ensured that space, funding, and equipment has been adequately provided for the centres. The appointment of a dedicated OCMC coordinator, reinforced by local support from mayors, has also further created an environment fostering strong and positive foundations for response.⁶²³
- **Staffing gaps have been improved and addressed** in the **newly revised protocol**. This has specified the responsibilities of each actor involved in the OCMC team, and has implemented the minimum number of staff members required to be on-call so that a twenty-four hour provision of services at centres is available.⁶²⁴

⁶¹⁴ Population Division (n 603) 1; Pande and Others (n 528) 21-22.

⁶¹⁵ Ministry of Health, *Hospital-Based One-stop Crisis Management Center (OCMC) Operational Manual* (Government of Nepal 2016).

⁶¹⁶ Sidker and Others (n 394) 4.

⁶¹⁷ Ibid.

⁶¹⁸ Pande and Others (n 528) 21.

⁶¹⁹ Population Division (n 603) 12.

⁶²⁰ Ministry of Health and Population (n 612) 13.

⁶²¹ Sidker and Others (n 394) 4-5.

⁶²² Ministry of Health and Population (n 612) 50.

⁶²³ Ibid. 40.

⁶²⁴ Sidker and Others (n 394) 4.

➤ **Community awareness has been high**, reflected in the referral patterns, with some survivors contacting the centres directly.⁶²⁵ The **strong links** to community and volunteer health workers, civil society partners, NGOs, and international organisations such as UNICEF, also assist in referral and generate awareness raising of the centres.⁶²⁶

➤ In a country where social norms and gender roles are rigid, and there is a tolerance of GBV/VAC, the government has **prioritised training** to improve staff attitudes in compassion, confidentiality, and client-centredness to address judgment and negative attitudes.⁶²⁷ Staff have noted that they have gained a new sense of responsibility and have become more sensitised and respectful of survivors.⁶²⁸ Survivors have also noted this supportive behaviour.⁶²⁹

➤ As previous evaluations have identified a weakness in the quality of medical reports and documentation admissible for prosecution,⁶³⁰ the need to **strengthen forensics and medical investigation** has been prioritised by the government. Basic medical education in the past has failed to address forensic training. As such, medico-legal training of doctors has been implemented. There has been a key shift in attitude towards survivors, with some doctors noting they now felt a strong sense of responsibility to support them in achieving justice.⁶³¹

In the same way successes, strengths, and enablers to OCMCs were identified, there have been **some shortcomings, weaknesses, and barriers too**. These include:

➤ Despite the prioritisation and roll out of training, OCMCs have previously still suffered from **gaps in operational capacity, infrastructure, and human resources**. Poor operating conditions, work practices, and high staff turnover have been reported. For instance, some doctors have previously not been covered for during their regular duty while attending court hearings.⁶³² Moreover, some

OCMC staff were previously only hired for a contractual period, which resulted in the fluidity of staff.⁶³³

➤ Although the **transition to federalism** has opened avenues for new collaboration opportunities, it has also increased the complexity of the multisectoral approach, impacting budget allocations. Provincial-level government roles have been revised and defined in the new OCMC Operational Guidelines (2020), which includes their role in allocating grants to the centres and capacity development. However, reports have mentioned that provinces have not consistently taken on these roles.⁶³⁴

➤ **Coordination and collaboration** amongst the multi-sectoral actors at the operational level have at times been uneven and have varied. Additionally, because safe homes and rehabilitation had been left out of the revised system, OCMC staff had not had the means to coordinate referrals for such services. This increased the vulnerability of children and added to the stress of OCMC staff who seek to support them.⁶³⁵



⁶²⁵ Ibid. 5.

⁶²⁶ Ibid; Fry and Others (n 608) 74-75; NHSSP, 'Innovative Good Practices in Nepal's Health Sector' (Government of Nepal 2016) 3 <http://www.nhssp.org.np/NHSSP_Archives/pulse/Pulse_OCMC_good_practices_february2016.pdf> accessed 14 August 2021.

⁶²⁷ Ministry of Health and Population (n 604) 19, 42-43.

⁶²⁸ Ibid. 44.

⁶²⁹ Population Division (n 603) 27.

⁶³⁰ Pande and Others (n 528) 22.

⁶³¹ Ministry of Health and Population (n 612) 42.

⁶³² Ibid. 5, 41-42, 44.

⁶³³ Ibid. 40.

⁶³⁴ Ibid. 5-6, 46.

⁶³⁵ Ibid. 47; Population Division (n 603) 10.

4.3 FAMILY SUPPORT CENTRES IN PAPUA NEW GUINEA

In the Oceania region, centres that offer services under an OSC model do exist to a certain degree and act to respond to many forms of violence, including VAC. An example of this is Papua New Guinea, which has implemented **Family Support Centres (FSC)** since the early 21st century as a response to family and sexual violence against children and women. These centres have been comprehensively evaluated, there are some key lessons to be learnt from the Papua New Guinea experience.

BACKGROUND

VAC in Papua New Guinea (PNG) is commonly discussed, however, no national prevalence studies have been recently conducted to concretely understand it in the country.⁶³⁶ The study on family and sexual violence from 1982 still remains a key source of baseline data in PNG.⁶³⁷ Beyond this, there is a large gap in available statistical information. However, it is reported that **incident levels of VAC are likely to be higher than two in three**,⁶³⁸ and smaller studies conducted in some locales throughout country allude to this prevalence. For example, in a small study conducted in Bougainville, it was found that 85.6% of fathers surveyed reported to beating their own children, and 75% reported that their wife or partner had beat their children.⁶³⁹ This issue also appears to be an intergenerational occurrence, with 86% of men and 58% of

women also reported to having experienced physical abuse in childhood.⁶⁴⁰

The issue of VAC has also been observed at service provider centres responding to violence too. According to Dame Carol Kidu, a former PNG parliamentarian, **children below the age of sixteen comprise half of those who seek medical assistance after being raped. One in four of these cases is younger than twelve years old, and one in ten is under eight years old.**⁶⁴¹ Some studies analysing sexual violence incidents have discovered an alarming frequency of perpetration against children. For instance, in some areas, **55% of children have reported to have experienced sexual VAC.**⁶⁴² VAC occurrences are also observed in connection to VAW. For instance, at one women's shelter, it was reported that, on average, **60% of children who seek refuge with their abused mothers have also endured physical abuse.**⁶⁴³ Further, reports from Family Support Centres (FSCs) have documented that between 49-79% of the cases of violence that are presented to FSCs involve children.⁶⁴⁴

As a joint initiative between Port Moresby General Hospital (under the National Department of Health) and the Family and Sexual Violence Action Committee,⁶⁴⁵ and supported by UNICEF, FSCs were introduced to PNG in 2003 as an intervention tool to respond to the persistent and pertinent issue of family violence (including both VAC and VAW).⁶⁴⁶ These centres emerged from a key recommendation in a 2001 report, commissioned by the Family and Sexual Violence Action Committee that analysed the prevalence of family and sexual violence in PNG.⁶⁴⁷ It was **recommended that the centres adopt an OSC model approach**, delivering comprehensive and multidisciplinary

⁶³⁶ UNICEF East Asia and the Pacific Regional Office, UNFPA Asia and Pacific Regional Office, and UN Women Asia and Pacific Regional Office, 'Ending Violence against Women and Children in Papua New Guinea: Opportunities and Challenges for Collaborative and Integrative Approaches' (UNICEF 2020) 8 <<https://www.unicef.org/eap/media/8636/file/Ending%20Violence%20against%20Women%20and%20Children%20in%20Papua%20New%20Guinea.pdf>> accessed 2 June 2021.

⁶³⁷ Kate Butcher and Others, 'Independent Formative Evaluation of Family Support Centres in Papua New Guinea' (IOD PARC Australasia 2016) 4 <<https://www.unicef.org/png/media/1241/file/PNG-Reports-ChildProtection-FormativeEvaluation.pdf>> accessed 1 June 2021.

⁶³⁸ Ibid; Child Fund, 'Stop Violence against Women and Children in Papua New Guinea' (Child Fund 2013) 5 <<https://reliefweb.int/sites/reliefweb.int/files/resources/Stop%20Violence%20Against%20Women%20and%20Children%20in%20PNG%202013.pdf>> accessed 3 June 2021.

⁶³⁹ UNICEF, UNFPA and UN Women (n 636) 8; See also a summary report of the study Rachel Jewkes, Emma Fulu and Yandisa Sikweyiya, 'Family, Health and Safety Study: Autonomous Region of Bougainville, Papua New Guinea' (UNDP 2015) <https://www.undp.org/content/dam/papua_new_guinea/docs/Publications/FHSS%20Bougainville%20Summary.pdf> accessed 2 June 2021.

⁶⁴⁰ Ibid. 15.

⁶⁴¹ Child Fund (n 638) 5.

⁶⁴² Butcher and Others (n 637) 4; See also Carol Lynn Jenkins, *National Study of Sexual and Reproductive Knowledge and Behaviour in Papua New Guinea* (Papua New Guinea Institute of Medical Research 1994).

⁶⁴³ Child Fund (n 638) 5.

⁶⁴⁴ Butcher and Others (n 637) 4.

⁶⁴⁵ The Family and Sexual Violence Action Committee is a sectorial committee of the private non-profit Consultative and Implementation Monitoring Committee.

⁶⁴⁶ Butcher and Others (n 637) 6-7; UNFPA (n 542) 39.

⁶⁴⁷ Ibid. 6.



services on the premise that **victims of violence usually seek health assistance as a first priority.**⁶⁴⁸

Due to previous attrition in referral systems, with survivors usually opting out of filing police reports due to factors such as fear of retaliation and/or a cultural stigma, FSCs were introduced to address these referral gaps. Based in the health system, the centres are dedicated safe spaces for both children and women survivors seeking treatment, counselling, and legal advice.⁶⁴⁹

In 2006, the Secretary for Health issued a circular that **required all provincial level hospitals to integrate FSCs into their operations.** Shortly after this, all hospital boards were obliged to allocate sufficient budgetary funds

to enable the establishment and operation of FSCs in **all main health centres.**⁶⁵⁰ Today, there are at least **fifteen FSCs throughout the thirteen provinces of PNG.** Some FSCs are integrated into hospitals, and some are stand-alone clinics usually run and/or supported by international stakeholders such as MSF.⁶⁵¹

CHARACTERISTICS OF THE FAMILY SUPPORT CENTRES IN PAPUA NEW GUINEA

Multidisciplinary Provision of Services in Accordance with Guidelines:

In 2013, the National Department of Health adopted the *Guidelines for Public Health Authorities/Hospital Manage-*

⁶⁴⁸ Ibid.

⁶⁴⁹ Ibid. 6-7.

⁶⁵⁰ Ibid. 7.

⁶⁵¹ Ibid. 10.

ment *Establishing Hospital-Based Family Support Centres*.⁶⁵² This stipulated that the purpose of FSCs is to **provide client centred care** for the medical and psychosocial needs of survivors, to create strong linkages and improve access to justice, and to assist in the prevention of violence through advocacy and community education. This guideline also specifies a checklist for establishing an FSC, the roles and responsibilities of every agency and staff member involved in the provision of services, and the key requirements for client-centred care and operational management.⁶⁵³

Integrated into the health system, FSCs are intended to be **free of charge and operational twenty-four hours a day, seven days a week**.⁶⁵⁴ They adopt an interagency approach to delivering multidisciplinary services at one site that were specific to the medical and psycho-social needs of its target population.⁶⁵⁵ The safety and security of centres is usually safeguarded by a female security officer, who is also tasked with escorting clients to different referral departments when necessary. Physical health intervention services include the administration of health assessments, treatment, referral, and follow-up support.⁶⁵⁶ Psycho-social services offer first aid emotional support, counselling, and referral and follow-up support. The medico-legal component of the centres supports legal advice services, medical reports, and witness representation in court proceedings. Lastly, follow-up services provide emotional support, counselling, clinical management of physical injuries, and specialist services such as paediatrics and psychiatry.⁶⁵⁷

FSC staff also work in close collaboration with the staff of the nearest police station/Sexual Offences squad as well as the provincial Office of the Public Prosecutor.⁶⁵⁸

Coordination and Management of FSCs:

Since 2013, the **National Department of Health** has assumed ownership of the FSC approach, although in-

ternational stakeholders such as MSF and UNICEF have been of paramount support in the development and establishment of the centres.⁶⁵⁹ FSCs may be governed by Provincial Health Authorities or the Provincial Health Administration.⁶⁶⁰ At the operational level, hospital FSCs are managed under the direction of the hospital board and an FSC coordinator.⁶⁶¹

Funding:

At all but one centre, funding for FSC operations falls under government budgets.⁶⁶² This includes funds for staffing, equipment, supplies and overheads. Exceptions are made in one-off donor inputs, which have usually been provided for the purpose of meeting the requirements necessary to deliver services efficiently.⁶⁶³

SUCCESSES & SHORTCOMINGS OF THE FSCS

Since the implementation of FSCs in PNG, there have been both positives and negatives drawn from experience, which are useful inputs in understanding what contributes to a well-functioning OSC. It should be noted, however, that these factors do not necessarily represent the climate of FSCs in PNG today. Rather, they are crucial observations that have occurred since implementation and have contributed to the development of FSCs. Some successes, strengths and enablers that have been identified include:

- There has been **high political commitment at the national level**. The National Department of Health's Gender and Men's Health Desk, a body established in 2014, has been particularly supportive in assuming a positive and proactive role in FSCs. The unit has been instrumental in training and human resource development opportunities for FSC staff, in addition to improving the information and monitoring systems at centres. Regional

⁶⁵² Butcher and Others (n 642) 10; National Department of Health, *Guidelines for PHA/Hospital Management Establishing Hospital-Based Family Support Centres* (Government of Papua New Guinea 2013) 13, 18 (available at <<https://docplayer.net/9914862-Guidelines-for-pha-hospital-management-establishing-hospital-based-family-support-centres.html>>).

⁶⁵³ Ibid.

⁶⁵⁴ National Department of Health (n 652)

⁶⁵⁵ Butcher and Others (n 637) 12.

⁶⁵⁶ Treatment included provision of first aid; HIV and STI/D prevention; tetanus prophylaxis and hepatitis B immunisation.

⁶⁵⁷ National Department of Health (n 652) 19-20.

⁶⁵⁸ Butcher and Others (n 637) 11.

⁶⁵⁹ Ibid. 1.

⁶⁶⁰ Ibid. 9. This depends on whether there is a functioning authority, and if they are a provincial or district FSC.

⁶⁶¹ National Department of Health (n 652) 14-15.

⁶⁶² The specific allocation of budget, however, is dependent on whether the centre falls under Provincial Health Authority or Administration.

⁶⁶³ Butcher and Others (n 637) 37.

mayors and boards have also allocated more funds and grants to FSCs in some regions.⁶⁶⁴

➤ Provincially-based FSCs have **appropriate, welcoming, calming, and pleasant environments** for clients to be attended to.⁶⁶⁵

➤ **Client-centred services** are an important aspect of FSC service delivery, and the **guidelines highlight the need to consider client profiles** for identifying the needs of survivors and for appropriate responses in the delivery of services. This has proven to be particularly important for cases involving **accusations of sorcery**, which are common in some PNG regions. At times, some survivors and even whole families and clans have been the target of such accusations, which has resulted in serious assaults and individuals displaced from their homes. In these instances, **FSCs have provided asylum to the targeted individuals** by offering a place of shelter. The safety and security at FSCs had been paramount in these operations, and has been assured at all sites with a security guard and with an **effective working relationship with the police**.⁶⁶⁶

➤ **Hospital-based FSCs have been better equipped to respond** to children (and women) survivors of violence than facilities without the same level of dedicated resources.⁶⁶⁷

➤ **Referral pathways** have functioned effectively due to strong and good relationships between FSCs and referral partners. The A&E department and obstetrics and gynaecology departments have been pivotal in **intra-sectoral** pathways to centres within the healthcare system. **Inter-sectoral** referrals have been supported by the Family and sexual violence unit of the police and community development officers.⁶⁶⁸

➤ Staff of provincial-level FSCs have been supported by the central government on the government payroll.

This has been a key enabler for the **sustainability** of the centres.⁶⁶⁹

Whilst some successes and enablers have been identified in the FSCs, some fundamental shortcomings have also been addressed in the lessons learnt. These include:

➤ On average, children have made up over half of the percentage of those seeking FSC services. However, a number of staff have previously expressed that they **did not feel adequately equipped to meet the needs of children** in order to competently and fully deliver services.⁶⁷⁰

➤ **Child-oriented services** have been another identified issue at FSCs. For instance, some service providers have previously mentioned they had adopted a child-friendly approach, although this apparently only meant having toys available. Additionally, only some FSCs have had a dedicated room for children and/or a social worker professionally trained in child psychology and counselling. As well as a need to develop skills in working alongside children, there has been concern surrounding the need to increase an awareness of child protection, children's rights, and their right to justice.⁶⁷¹ Overall, the capacity and expertise directed at the protection of children has been limited due to resource constraints. Generally, there have been very few social workers in PNG due to resources constraints. Thus, social workers do not always have the specialised and professional training to address children and women separately.⁶⁷²

➤ FSCs have been designed to respond to family and sexual violence, integrating responses for both children and women. However, one evaluation identified that there had been **no specific service plan**. Integration had only been evident insofar as services had responded to whoever had sought help, and thus, actions have been decided from case to case. In addition, it has been generally recognised that children and women are connected, without analysing the implications it may have on the work in VAC, VAW

⁶⁶⁴ Ibid. 1, 23.

⁶⁶⁵ Ibid. 24.

⁶⁶⁶ Ibid. 25-26. Overall, there is a good relationship and effective coordination with the police, the Family Sexual Violence Desk and the Sexual Offences Squad.

⁶⁶⁷ Ibid. 26.

⁶⁶⁸ Ibid. 32.

⁶⁶⁹ Ibid. 42.

⁶⁷⁰ Ibid. 25, 28.

⁶⁷¹ Ibid. 29.

⁶⁷² UNICEF, UNFPA and UN Women (n 636) 19; WHO (n 594) 18.

and both children's and women's rights.⁶⁷³ Whilst there are many benefits to aligning responses for both children and women, this **alignment can reduce the specificity** of the care provided to both children and women.⁶⁷⁴

➤ **Services have been hard to access** as transport is expensive, and thus, not all survivors have been able to afford the travel costs to seek medical attention.⁶⁷⁵ This is especially challenging for individuals that live in rural areas. Moreover, the COVID-19 pandemic has only exacerbated this situation due to the closure and/or disruption of services.⁶⁷⁶

➤ **A distrust of the police has been an issue in PNG.** For instance, even with access to medical reports intended to be used to file a police report, many have opted not to follow through and visit police stations for fear of an **un-sympathetic responses**.⁶⁷⁷

➤ There have been concerns about the **appropriateness** of hospital based **FSCs falling under Medical and Curative Services**, thus appearing as if VAC is predominantly a health issue. Response and health intervention tools are only the end point of VAC and calls for prioritising prevention as a primary focus have been echoed by Provincial Health Authorities and medical officers.⁶⁷⁸

➤ **District-level FSCs have lacked the political support** necessary to sustain themselves. This has at times resulted in confusion over who carries the responsibility of governance of the FSCs.⁶⁷⁹ This is has largely been due to decentralisation.

➤ FSCs were designed to follow an OSC model, with all services located at one site and under one roof. However, this has not always been the case, as **some FSCs have served mainly as a hub for referrals** from where relevant services (such as medical, psychosocial, and/or legal/justice-related services) could be accessed.⁶⁸⁰

➤ **One evaluation identified that access to justice had been hindered by multiple factors.** For instance, at some FSCs, legal services have been **charged to clients**. On the other hand, some FSCs had reported their frustration with the low number of convictions, which had been due to a serious **shortage of judges** to hear cases.⁶⁸¹

➤ At some FSCs a **systematic feedback system** that allows for anonymous suggestions for improvement had been absent.⁶⁸² Feedback is always essential for the evaluation of any shortcomings that are needed to be addressed.

➤ **Constraints in data collection and management has previously been another identified shortcoming.** As different sites have applied have applied different interpretations of the types of violence, indicators, and different age ranges, this had made it exceedingly difficult to draw comparisons across centres and evaluate data to gauge the effectiveness of the FSCs.⁶⁸³

➤ The government-led and NGO support combination has previously led to **tensions in the partnership**. For instance, in one FSC, MSF staff supporting a hospital-based centre were often seen as outsiders infringing on the authority and administration of the hospital.⁶⁸⁴

⁶⁷³ Ibid.

⁶⁷⁴ WHO (n 594) 4.

⁶⁷⁵ Child Fund (n 638) 11.

⁶⁷⁶ WHO (n 594) 7.

⁶⁷⁷ Butcher and Others (n 637) 6.

⁶⁷⁸ Ibid. 23.

⁶⁷⁹ Ibid. 23.

⁶⁸⁰ Ibid. 24.

⁶⁸¹ Ibid. 25, 32.

⁶⁸² Ibid.

⁶⁸³ Ibid. 31.

⁶⁸⁴ UNFPA (n 542) 45.

4.4 AN EXCURSUS OF MODELS SIMILAR TO THE OSC

Across the world, similar models to the OSC have emerged that offer holistic, integrated, interagency, and multidisciplinary services whilst utilising a one-stop shop/centre approach. In the USA, Children's Advocacy Centers (CAC) have been in operation since the mid-1980s. Today, these centres have expanded to include over 1,000 centres within the country and have been implemented within thirty-four other countries across the globe, including Guyana. Taking inspiration from the CAC model, the Barnahus model was established in the mid-1990s, which today is a leading and best practice model, that has rapidly diffused throughout and beyond Europe.

THE BARNAHUS MODEL IN EUROPE

WHAT IS A BARNAHUS?

In the mid-1990s, following the impact of the first World Congress Against Sexual Exploitation, Iceland carried out a study on the prevalence of sexual violence committed against children. The results were shocking, and confronted the denial felt by much of Iceland's society.⁶⁸⁵ In the debate following the results of this study, demands were made for reforms seeking greater protection for children.⁶⁸⁶ Bragi Guðbrandsson, who at the time was the director for the Government Child Protection Agency (an agency that was already working on reforms for coordination and competence building in the child welfare system)⁶⁸⁷ embarked upon a mission to find a model to address child sexual abuse that was both **multiagency** and **child-friendly**.⁶⁸⁸

After intensive research and a trip to the USA, Guðbrandsson found what he was looking for in the USA's **Children's Advocacy Centers (CAC)** (see next section). Upon returning to Iceland, **his vision of a Barnahus (meaning 'a house for children' in Icelandic)**⁶⁸⁹ was born. In colla-

boration with multiple partner agencies, the CAC concept was adapted and integrated to fit the Icelandic welfare system, and in 1998 the first Barnahus was established as a pilot project.⁶⁹⁰

Today, the Barnahus model is a leading and well-developed European multidisciplinary and interagency centre for children. Similar to the OSC, it offers a one-stop-shop approach⁶⁹¹ by providing several services that jointly engage in carrying out assessments and investigations and in deciding on the necessary follow-up services and/or interventions in an integrated manner. The collaboration involves multidisciplinary services from law enforcement, criminal justice, child protection, and medical and mental health in a 'four room' structure.⁶⁹² One key role of Barnahus is to assist in producing valid evidence for judicial proceedings by eliciting the child's disclosure so that they do not have to appear in court in the case of prosecution.⁶⁹³ This multidisciplinary approach balances facilitating a safe path to recovery and access to child-friendly justice without causing retraumatisation and secondary revictimisation.

The implementation and functioning of Barnahus varies according to the national context, which can be achieved through different institutional arrangements.⁶⁹⁴ For example, in the Nordic Barnahus', the centres are institutionally embedded within the national authorities, such

⁶⁸⁵ Bragi Guðbrandsson, 'Foreword' in Susanna Johansson and Others (eds) *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model* (Palgrave Macmillan 2018) v.

⁶⁸⁶ Ibid.

⁶⁸⁷ Ibid. v-vi.

⁶⁸⁸ Ibid.

⁶⁸⁹ Ibid.

⁶⁹⁰ Ibid.

⁶⁹¹ Olivia Lind Haldorsson, *Barnahus Quality Standards* (Council of the Baltic Sea States Secretariat and Child Circle 2017) 12 <<https://www.barnahus.eu/en/wp-content/uploads/2020/02/PROMISE-Barnahus-Quality-Standards.pdf>> accessed 17 July 2021.

⁶⁹² 'About Barnahus' (Promise Barnahus Network) <<https://www.barnahus.eu/en/about-barnahus>> accessed 16 July 2021.

⁶⁹³ Haldorsson (n 691) 12.

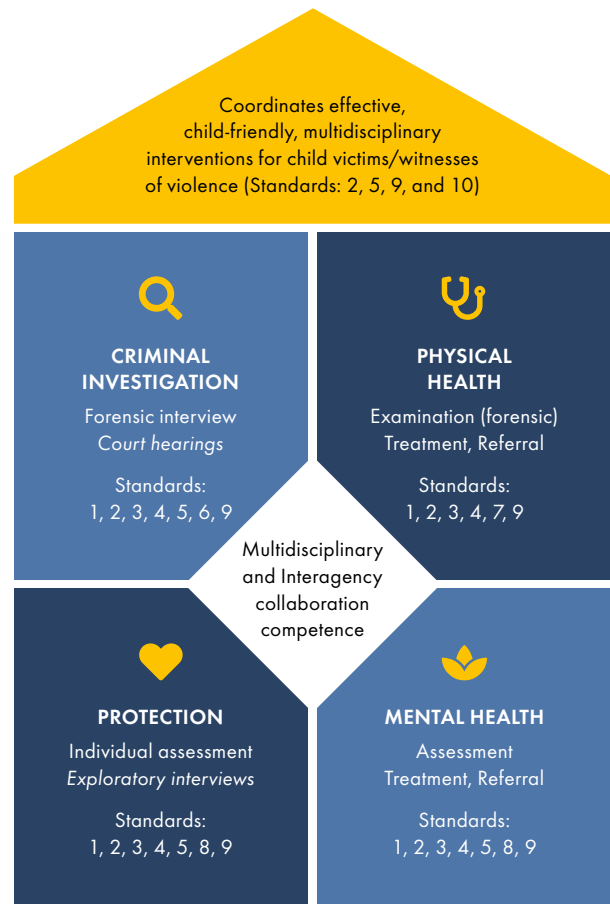
⁶⁹⁴ Ibid.

Key Common Criteria of Barnahus

- The forensic interview is carried out according to an evidence-based protocol;
- The evidentiary validity of the child's statement respects the due process, whilst avoiding a need for the child to repeat her/his statement during court proceedings if an indictment is made;
- A medical evaluation is carried out for forensic investigative purposes and to ensure the child's physical well-being and recovery;
- Psychological support is available, including short and long-term therapeutic services addressing the trauma of the child and non-offending family members and caregivers;
- An assessment of the protection needs is carried out and followed up concerning the child victim and siblings in the family.

The Barnahus' Four Rooms & the Barnahus Quality Standards

Adapted from Promise Barnahus Network <www.barnahus.eu>



as social services, health, child protection, as well as the judicial system.⁶⁹⁵ However, there are many other countries that have also embedded Barnahus into their systems. For instance, Estonia's Barnahus is embedded within its CPS, Slovenia's is embedded within the justice system, and in both the UK and Germany, the Barnahus model has been embedded in the health system. However, it should also be noted that there are several other centres which embrace multidisciplinary and interagency collaboration in *one child-friendly premise* and provide a balanced intervention, adapted to the needs of the child as required by Barna-

hus.⁶⁹⁶ For instance, in Croatia, the Child and Youth Protection Centre model embedded in the healthcare system and located in Zagreb, has been in operation since 2002. In the Netherlands, the MDCK model was established in 2015, which is rather a network of organisations that includes safe at home, youth protection medical, judicial/law enforcement, health, and youth care organisations.⁶⁹⁷ Whilst both centres operate based on their own models, their team of experts have contributed to the development of the Barnahus Quality Standards (see below).⁶⁹⁸

⁶⁹⁵ Ibid.

⁶⁹⁶ Ibid; Promise Barnahus Network (n 692).

⁶⁹⁷ Ibid. 18-19.

⁶⁹⁸ Ibid. 10.

THE COMPONENTS OF BARNAHUS

At Barnahus, professionals from different disciplines work together to collaborate and coordinate a balanced and integrated response, respecting the needs of the child and ensuring no further trauma is inflicted.⁶⁹⁹ The (recorded) forensic interview conducted solely by one specialised interviewer forms an integral part of this collaboration. It informs all the services and joint case planning and management.⁷⁰⁰ The ‘four rooms’ of Barnahus include the different agencies, authorities, and professionals of the different disciplines that work together.⁷⁰¹ These include:

➤ Child protection:

Barnahus contributes to the assessment of the protection needs and supports follow-up services concerning the child victim and siblings within the family. Individual assessment and exploratory interviews form part of this process.⁷⁰²

➤ Criminal justice investigation & proceedings:

Criminal investigation, involving actors such as the police, prosecution, and lawyers, respects the procedural safeguards and due process of both the child and the accused. Child-friendly interviews are conducted in accordance with an evidence-based protocol by a trained and specialised forensic interviewer in private. This interview is recorded and observed by the multidisciplinary team in a separate room. The goal of the interview is to protect the child from retraumatisation and to secure the best possible evidence. As evidence is taken in due process, it is admissible evidence in a court of law should the case be prosecuted. Thus, the child does not have to appear in court.⁷⁰³

➤ Medical examination and treatment:

A child-friendly medical examination and evaluation forms an integral component of Barnahus. This is carried out by specialised and highly competent staff both for forensic

purposes and to ensure the child’s physical well-being, and to ensure the appropriate remedy for recovery.⁷⁰⁴

➤ Mental Health Examination and Treatment:

Children are offered a mental health assessment and appropriate support, which is provided by specialised and highly competent staff. This includes crisis-support, and short and long-term therapeutic services, which address the trauma of the child and for the non-offending family members and/or caregivers.⁷⁰⁵

THE ICELANDIC BARNAHUS & THE EUROPEAN DIFFUSION (& BEYOND)

Barnahus Iceland took inspiration from the CAC, but it was adapted to **possess several key differences**. First, unlike the privately-run CAC model,⁷⁰⁶ Barnahus Iceland was **integrated into the system**, giving a voice to children in their right to give testimony and participate. Second, **Barnahus was structured to form “an integral part of the institutional landscape of the child welfare system** that is operated by the central and local authorities”.⁷⁰⁷ Lastly, since there was formal **recognition of the judicial system** within the centre, it could produce valid evidence for court proceedings without the child having to appear in court themselves to provide testimony. This was an integral aspect to both avoiding retraumatisation of the child and effective investigation.⁷⁰⁸

After its successful implementation, interest in the model came to light in the early 2000s. This began with the other Nordic countries: colleagues who had frequently shared their knowledge and experiences of child welfare with Iceland.⁷⁰⁹ Further international recognition was enhanced when Save the Children published their report on *Child Abuse and Adult Justice*⁷¹⁰ in 2002, which endorsed the Barnahus as best practice.⁷¹¹ To stakeholders this was appealing: whilst Barnahus benefitted children and their

699 ‘The Promise Vision’ (Promise Barnahus Network) <<https://www.barnahus.eu/en/vision/>> accessed 17 July 2021.

700 Shawna von Blixen, ‘Barnahus, What, Why and First Steps’ (29 October 2020) <https://www.youtube.com/watch?v=VM_r7paDnA0&t=1006s> accessed 7 June 2021.

701 Haldorsson (n 691) 12.

702 Promise Barnahus Network (n 699).

703 Ibid.

704 Ibid.

705 Ibid.

706 Promise Barnahus Network (n 692).

707 Guðbrandsson (n 685) vi.

708 Haldorsson (n 691) 12-13; Promise Barnahus Network (n 692).

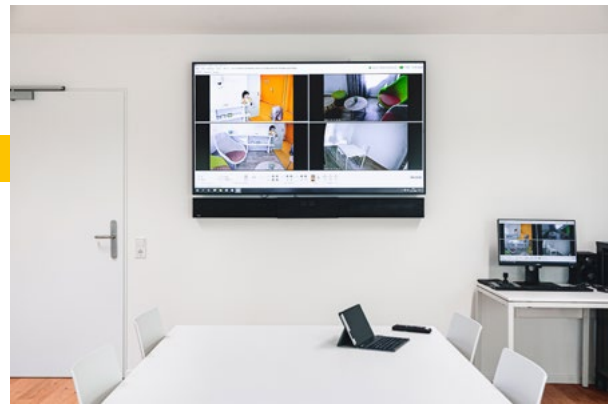
709 Guðbrandsson (n 685) vii.

710 Christian Diesen, *Child Abuse and Adult Justice: A Comparative Study of Different European Criminal Justice Systems Handling of Cases Concerning Child Sexual Abuse* (Save the Children 2002) 43-44, 65.

711 Ibid. 44; Guðbrandsson (n 685) vii.



Counselling room at Childhood-Haus Heidelberg, Germany.



Broadcast room at Childhood-Haus Duesseldorf, Germany.

welfare, at the same time, it was, at the same time, concrete, tangible, and inexpensive.⁷¹² In 2006, recognition of the Icelandic Barnahus was achieved by its nomination for The International Society for the Prevention of Child Abuse and Neglect's (ISPCAN) multidisciplinary award.⁷¹³

Sweden, Norway, and Denmark respectively, were next to follow suit in implementing and integrating Barnahus.⁷¹⁴ This action was bolstered by a governmental collaboration facilitated by the **Council of the Baltic Sea States (CBSS)** expert group on Children at Risk.⁷¹⁵

Today, the Children at Risk Unit at the CBSS secretariat hosts the **PROMISE Barnahus Network**.⁷¹⁶ PROMISE was initiated in the year the year 2015 as a project co-funded by the EU, with the aim of promoting the implementation of the Barnahus model and similar multidisciplinary initiatives across Europe that supports implementation of international and national laws on child-friendly procedural safeguards and assistance to child victims of violence.⁷¹⁷ In total, it engages with forty national contexts by benefiting on existing child protection expertise and/or is influencing national progress on Barnahus.⁷¹⁸ Many organisations are directly involved with the diffusion of the model both within and beyond Europe too. For instance, the World Childhood Foundation founded by Queen Silvia of Sweden in 1999, has been actively involved in introducing and supporting centres. This includes in Sweden, Belarus, Germany, Moldova, and even beyond the European context in Brazil.⁷¹⁹

THE BARNAHUS QUALITY STANDARDS

One key goal that is supported by PROMISE is to “establish Barnahus or similar models that work to **progressively achieve** international obligations, professional guidelines and the *Barnahus Quality Standards*.”⁷²⁰ The network adopts a child's rights-based approach and embraces international standards, such as the CRC, and regional legal frameworks from the European Union and the Council of Europe. The Quality Standards draw upon these instruments and provide a common organisational framework to ensure minimum standards are upheld through the integrated and coordinated collaboration amongst professions, the promotion of practice to prevent retraumatisation, the securing of testimonies for court, and to comply with children's rights to protection, assistance, and child-friendly justice.⁷²¹ These quality standards are summarised on the next page.⁷²²

DISCUSSION

Barnahus is a well-developed and leading model moulded upon evidence-based practice with standards and requirements utilising a one-stop-shop multidisciplinary and interagency approach. Through its recognition, it has rapidly diffused not only across the Nordic context, but also throughout multiple European states. Evaluations and surveys containing first-hand accounts from children depict a positive experience and an appreciation for an atmosphere of ease.⁷²³ It has been concluded that Barnahus,

⁷¹² Ibid. vii-viii.

⁷¹³ Ibid. ix-x.

⁷¹⁴ Ibid. vii-viii.

⁷¹⁵ Ibid. The Council of the Baltic Sea States consists of 11 members (Denmark, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, Russia and Sweden). CAR is managed by the CBSS Expert Group that represents all the Member States. The CAR collaboration is a flagship priority under the CBSS's long-term priority area of a safe and secure region.

⁷¹⁶ Ibid.

⁷¹⁷ 'About PROMISE' (Promise Barnahus Network) <<https://www.barnahus.eu/en/about-us/>> accessed 18 August 2021.

⁷¹⁸ 'PROMISE Barnahus Greater Network' (Promise Barnahus Network) <<https://www.barnahus.eu/en/about-us/>> accessed 18 August 2021.

⁷¹⁹ 'Barnahus Child Advocacy Centers' (World Childhood Foundation) <<https://childhood.org/project/barnahus-child-advocacy-centers/>> accessed 18 October 2021.

⁷²⁰ Promise Barnahus Network (n 699).

⁷²¹ Haldorsson (n 691) 8.

⁷²² Please refer to the official document of the Barnahus Quality Standards for in-depth explanation on each standard. See Haldorsson (n 691).

⁷²³ Kari Stefansen, 'Staging a Caring Atmosphere: Child-Friendliness in Barnahus as a Multidimensional Phenomenon' in Susanna Johansson and Others (eds) *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model* (Palgrave Macmillan 2018) 46-49; See also Gisli Gudjonsson and Others, 'The Ability of Suspected Victims of Childhood Sexual Abuse (CSA) to Give Evidence. Findings from the Children's House in Iceland' (2010) 21 *The Journal of Forensic Psychiatry and Psychology* 569, 581-583.

A Summary on the 10 Barnahus Quality Standards

Promise Barnahus Network,
<www.barnahus.eu>

STANDARD 1

Key Principles and Cross-Cutting Activities

Three principles inform the multidisciplinary practice and decision making in Barnahus are. Firstly, the best interests of the child are a primary consideration at the heart of all decisions and actions made in matters that affect the child. Secondly, children have the right to be heard; meaning they have the right to express their views must be respected and fulfilled. Lastly, all necessary measures must be taken to avoid undue delay, by ensuring that forensic interviews, child protection assessments and mental/medical health examinations are fulfilled within a stipulated time frame.

STANDARD 2

Multidisciplinary and Interagency Collaboration

The Barnahus is embedded in the national or local system, such as the social or child protection services, law enforcement/the judiciary, or the health system. The Barnahus may also operate independently if it enjoys a statutory role, is recognised by the authorities, and is mandated to collaborate with the national agencies. Within the Barnahus, the multidisciplinary and interagency collaboration functions upon transparent, clearly established roles, mandates, mechanisms, monitoring and evaluation to ensure the continuity and stability of services. The process of collaboration begins with an initial report and is guided by processes of interventions throughout the case.

STANDARD 3

Inclusive Target Group

At Barnahus, all children are children who are victims and/or witnesses to VAC are the target group. Non-offending family is the secondary target group. In respect of the principle of non-discrimination, special effort must be made to reach all child victims and witnesses of VAC, regardless of which ever form it may manifest.

STANDARD 4

Child-Friendly Environment

Barnahus are preferably situated in a detached building and located in an area familiar to children. It should be accessible by public transport and accessible to all children, including for children with disabilities and special needs. The interior of Barnahus should be furnished with safe, child and family-friendly, age and developmental stage-appropriate furnishings, including for children with disabilities and special needs. The privacy of premises must be upheld at all given times; ensuring that separated, soundproof and private areas are available. Moreover, Barnahus should be set up to prevent contact of the victim with the suspected perpetrator at all given times. Barnahus must have an interview room, and a separate observation room for the interagency team to watch live interviews.

STANDARD 5

Interagency Case Management

The multidisciplinary and interagency team case review and planning is formalised by mutually agreed upon procedures and routines. Planning and review is continuous via regular meetings involving the relevant agencies. Cases are continuously tracked through documentation and ensuring that the interagency team members have access to information until the case is closed. A designated, trained individual or member of the Barnahus team should be made the support person monitoring the multidisciplinary response to ensure continuity of support and follow-up with the child and the non-offending family and/or caregiver(s).

STANDARD 6

Forensic Interview

Forensic interviews are carried out in accordance with evidence-based practice and protocols, which ensures the quality and quantity of the evidence obtained. The main aim of the interview is to avoid re-traumatisation and to elicit the child's free narrative in as much detail as possible whilst complying with the rules of evidence and the rights of the defence. Interviews are carried out by specialised staff who receive regular training in conducting interviews. The interview(s) are carried out by one interviewer (even in the case of multiple interviews) in the Barnahus and are audio-visually recorded to avoid repeated interviewing by different professionals who require access to the child's disclosure. All multidisciplinary and interagency members should be able to observe the forensic interview in either an adjacent room or through recordings and can interact with the interviewer so that questions can be posed to the child from the team. Arrangements should be in place that respect the rights of the defence and allow them to pose questions to the child victim/witnesses via the forensic interviewer. Moreover, the interview is adapted to the child's age, development, and cultural background, considering special needs including interpretations. This may include minimising the length of interviews, allowing breaks, and potentially conducting the interview over more than one session. The number of interviews is limited to the minimum necessary for criminal investigation.

STANDARD 7

Medical Examination

Medical and/or forensic medical evaluations are routinely carried out in the Barnahus by specialised staff. These staff are trained to recognise the indicators of physical, sexual and emotional abuse as well as neglect. Medical treatment is carried out in the Barnahus premises (unless in the event of urgent or complicated cases which require special interventions at a hospital setting). Specialised medical staff carry out medical examinations. Case review and planning meetings are conducted with medical staff present as appropriate. In the process of evaluating, children and family/caregivers receive adequate information regarding the available and necessary treatments, and the child's right to participation is ensured in their capacity to influence the timing, location and set up of medical interventions.

STANDARD 8

Therapeutic Services

Mental health assessment and treatment is routinely made available for child victims and witnesses, by professionals with specialised training and expertise. Children and family/caregivers that the right to receive adequate information regarding the available and necessary treatments, and the right of the child to participate is ensured at all times in their capacity to influence the timing, location and set up of interventions. Staff also routinely offer crisis support intervention for the child and non-offending family members/caregivers if needed.

STANDARD 9

Capacity Building

Members of the Barnahus team and the involved agencies are provided with regular training in their specific areas of expertise and are offered joint training in cross-cutting issues. Members also have access to regular guidance, supervision, counselling, and peer review both in relation to individual cases and in addressing professional and personal strain, challenges and ethical dilemmas working with child victims of VAC.

STANDARD 10

Prevention: Information Sharing, Awareness Raising and External Competence Building

Aggregated and disaggregated data/statistics is collected, and the information is shared with relevant stakeholders including decision-makers, academia, child protection professionals, and the broader public to create awareness about VAC and the role of multidisciplinary and interagency responses, to facilitate research and to support evidence-based legislation, policy, and procedures. Barnahus also offers targeted action to increase competence and knowledge among professionals working for and with children by, for example, organising study visits, information meetings and producing written materials.

in many respects, is a promising model that meets the needs of victimised children and safeguards their rights.⁷²⁴

The Barnahus Quality Standards demonstrate how different disciplines are organised, recognised, and have significant yet coordinated roles. These are grounded upon evidence-based research and require child-friendly provision of services necessary to secure the child's rights. The process of Barnahus, even when assessments produce no evidence, are structured to offer reassurance to every child in the manner that is *best suited* to them.⁷²⁵ The child-friendly facilities are accompanied by professional, specialised, and regularly trained staff. This environment has helped lessen the distress felt by children and offers a comfortable space for children to disclose their stories.⁷²⁶

It is worth noting that the success of (in particular) the Nordic Barnahus models, is not only attributable to the cohesive, concrete, multidisciplinary and interagency components of the centres, but the institutional setting has also played a significant role. Barnahus was integrated and adapted to fit a well-developed landscape: welfare systems had already existed not only in child protection, but also in education, social security, and health services. The child welfare system, characterised by family service orientation together with the existing structures for detecting children at risk was a common pre-existing aspect within these countries.⁷²⁷

The Nordic countries had also experienced a radical shift and cultural change to the zero legal and social tolerance towards child abuse, including in acts of discipline.⁷²⁸ This shift occurred in as early as the 1970s and 1980s, when Sweden, Finland, and Norway, respectively, outlawed corporal punishment. Since then, additional amendments have also set a very low bar on what constitutes violence too.⁷²⁹

The Barnahus model was originally moulded to fit this landscape, both institutionally and culturally. However, its recent rapid diffusion in many other European contexts reflects the model's flexibility and ability to expand beyond this setting. For instance, the landscape of the CPS in England adopts a mainly interventionist and curative approach. As opposed to focusing on delivering family support services through self-referral and voluntary participation (as seen particularly in Sweden and the other Scandinavian countries), it focuses on child protection in cases of crisis intervention.⁷³⁰ Even so, since October 2018, the Barnahus model has been integrated and institutionalised to fit into the health system under the National Health Service. These so-called Lighthouses are currently based in London hospitals and focus on responding to child survivors of sexual abuse and exploitation.⁷³¹

The variations and steering mechanisms that crystallised differently within the European settings should not be seen as being separate from an existing framework supported by developed infrastructure and institutions.⁷³² Existing premises in European settings might be better than those outside Europe, especially compared to lower resource settings or settings where the awareness of VAC is not as prioritised.⁷³³ However, emphasis should be drawn to the *progressive development* of the Barnahus Quality Standards. Whilst they exist to serve core guidance for the implementation of and operative standards in the model, they can be progressively developed over the different stages of establishment. Even when Barnahus is implemented in landscapes where VAC is not yet high enough on the agenda or where existing frameworks ought to be strengthened, the implementation may nevertheless serve be a critical step in shifting responses to and attitudes towards an intolerance of VAC.⁷³⁴

⁷²⁴ Kari Stefansen and Others, 'Epilogue: The Barnahus Model: Potentials and Challenges in the Nordic Context and Beyond' in Susanna Johansson and Others (eds) *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model* (Palgrave Macmillan 2018) 332-333.

⁷²⁵ Shawna von Blixen (n 700).

⁷²⁶ Gunn Astrid Baugerud and Miriam Sinkerus Johnson, 'The NICHD Protocol: Guide to Follow Recommended Investigative Interview Practices at the Barnahus?' in Susanna Johansson and Others (eds) *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model* (Palgrave Macmillan 2018) 134.

⁷²⁷ Stefansen and Others (n 724) 332-333.

⁷²⁸ Ibid 333; Susanna Johansson and others, 'Implementing the Nordic Barnahus Model: Characteristics and Local Adaptations' in Susanna Johansson and Others (eds) *Collaborating Against Child Abuse: Exploring the Nordic Barnahus Model* (Palgrave Macmillan 2018) 2-3

⁷²⁹ Ibid. 3.

⁷³⁰ Mary Daly, 'England' in Mary Daly and Others (eds) *Family and Parenting Support: Policy and Provision in a Global Context Innocenti Insight* (UNICEF Office of Research 2015) 70.

⁷³¹ 'The Lighthouse' (National Society for the Prevention of Cruelty to Children 2021) <<https://learning.nspcc.org.uk/services-children-families/the-lighthouse#heading-top>> accessed 24 August 2021.

⁷³² Johansson and Others (n 728) 13; Stefansen and Others (n 724) 334, 336.

⁷³³ Guðbrandsson (n 685) ix.

⁷³⁴ Anna Kaldal, 'Joint EU DG Reform – Council of Europe Project to Support the Implementation of Barnahus in Slovenia (phase II): Comparative Review of Legislation Related to Barnahus in Nordic Countries' (European Union and the Council of Europe 2020) 15-16 <<https://rm.coe.int/barnahus-comparative-review-anna-kaldal-14092020/1680a0437f#:text=The%20Barnahus%20model%2C%20which%20was,thereafter%20in%20Norway%20and%20Denmark.>> accessed 22 August 2021.

The balance of professions played out between criminal investigations, on the one hand, and child welfare and treatment of the child, on the other, is another point of discussion. This balance, seen as an idea rather than an in-built feature of Barnahus,⁷³⁵ can naturally suffer from tensions experienced when shifts in the balance of power between both professional areas are influenced.⁷³⁶ In Norway, for instance, a mandatory use of Barnahus for child investigative interviews was implemented as a result of children being less distressed and upset when these were carried out in Barnahus.⁷³⁷ This has led to an increased concern that staff may prioritise the coordination of tasks related to the investigative interviews over the provision of treatment and support.⁷³⁸ However, these tensions can be reduced through adopting a child's rights-based approach and the Barnahus Quality Standards. Tensions can be alleviated through constant comparative and critical analysis, striking a balance between both logics. Professionalism is a critical aspect of the interdisciplinary and agency teamwork, which can be implemented through capacity building and joint training incentives.⁷³⁹

Despite these considerations and potential tensions, Barnahus is a consistently adapting model working at the “core of an emerging institutional field...interlink[ing] child welfare and child justice”.⁷⁴⁰ Evaluations, new studies and research are supported by a continually expanding PROMISE network. Through education and training, the identification of potentials and challenges are constantly seeking to better strengthen the professionalism in multidisciplinary teamwork. These factors, combined with positive reflections made by children, undoubtedly have meant a step in the right direction to eliminating VAC.⁷⁴¹

THE USA'S CHILDREN'S ADVOCACY CENTERS

WHAT ARE CHILDREN'S ADVOCACY CENTERS (CAC)?

History and Development:

In the USA, the Children's Advocacy Center (CAC) model was implemented in response to criticism that investigations into cases concerning child sexual abuse lacked sensitivity and caused retraumatisation. In addition to low conviction rates, child survivors were often repeatedly interviewed in multiple locations by multiple different professionals and were taken to court to give testimony.⁷⁴² It was former Congressman Robert Cramar of Alabama that pioneered this model, revolutionising the USA's response to child sexual abuse. Realising that the social services and justice systems were failing to effectively work together, the first ever CAC was established in Huntsville, Alabama in 1985.⁷⁴³

Utilising a multidisciplinary team approach, Cramar and a group of key individuals brought together professionals from various agencies including law enforcement, criminal justice, child protection services, and the medical and mental health sectors under one dynamic team.⁷⁴⁴ The stand-alone centres serve as a focal point for this multidisciplinary and multiagency team collaborating on investigation.⁷⁴⁵

After developing its innovative approach to child sexual abuse cases in Alabama, the centres earned themselves a reputation nationally. Through its influence, training began throughout other communities in the country,⁷⁴⁶

⁷³⁵ Stefansen and Others (n 724) 336.

⁷³⁶ Ibid.

⁷³⁷ Baugerud and Johnson (n 726) 133.

⁷³⁸ Stefansen and Others (n 724) 336; Kaldal (n 734) 15-16.

⁷³⁹ Ibid; Haldorsson (n 691) 102.

⁷⁴⁰ Stefansen and Others (n 724) 344, 348.

⁷⁴¹ Kaldal (n 734) 15.

⁷⁴² Maureen C Keeny and Others, 'Implementation and Program Evaluation of Trauma-Informed Care Training Across State Child Advocacy Centers: An Exploratory Study' (2017) 73 *Children and Youth Services Review* 15, 15.

⁷⁴³ 'History' (National Children's Advocacy Center 2021) <<https://www.nationalcac.org/history/>> accessed 18 September 2021.

⁷⁴⁴ Ibid.

⁷⁴⁵ James Leslie Herbert and Leah Bromfield, 'Evidence for the Efficacy of the Child Advocacy Center Model: A Systematic Review' (2015) 17 *Trauma, Violence and Abuse* 341, 341.

⁷⁴⁶ National Children's Advocacy Center (n 743).



and today the model has expanded nation-wide to include over 1,000 CACs which now focus on all forms of child abuse in general. These centres form part of a network within an accredited organisation namely, the National Children's Alliance (NCA).⁷⁴⁷ However, the model has not only spread and expanded across the USA. In addition to forming the basis for the creation of the European Barnahus model, there are more than thirty-four countries worldwide that have integrated the CAC model into their jurisdictions.⁷⁴⁸

Key Requirements of CACs:

The NCA offers four different levels of membership to centres that are designed to meet the specific individual needs of the centres and communities. The *accredited level* CACs **must** meet their ten standards in delivering services.⁷⁴⁹

➤ A child-focused setting:

The facilities for CACs are required to be neutral, child-oriented, and provide safety, comfort, and privacy for children and their families where forensic interviews and other services can be appropriately provided. This means that they are maintained in a manner that is physically and psychologically safe, that provides for observation

or supervision, that is convenient and accessible, and that is childproofed.⁷⁵⁰

➤ A multidisciplinary team:

The team *must* include law enforcement, child protective services, mental health, medical, prosecution, victim advocacy professionals, and CAC representation.⁷⁵¹ These members formally collaborate under a *written interagency agreement*, which is signed by authorised representatives of all the disciplines and agency components. This agreement is vital, not only for formalising cooperation but also to ensure continuity of practice. The team also regularly exchanges information and operates in accordance with a written protocol and/or guideline that addresses the function of the team, the roles and responsibilities of each member, and their interaction with the centre. To ensure that the unique needs of children are recognised and met at all stages, all members are routinely involved in investigations and interventions.⁷⁵²

➤ Organisational capacity:

The CAC must have a designated legal entity that is responsible for the governance of the centre and its operations. Overseeing the work of the CAC, the entity ensures the correct setting and implementation of law and administrative policies, hiring and managing staff, obtaining

⁷⁴⁷ Gail Honor, 'Child Advocacy Centers: Providing Support to Primary Care Providers' (2008) 22 *Journal of Pediatric Health Care* 35, 37.

⁷⁴⁸ National Children's Advocacy Center (n 743).

⁷⁴⁹ Honor (n 747) 37; National Children's Alliance, 'Standards for Accredited Members' (National Children's Alliance 2017) 12-14 <<https://www.nationalchildrensalliance.org/wp-content/uploads/2015/06/NCA-Standards-for-Accredited-Members-2017.pdf>> accessed 19 July 2021.

⁷⁵⁰ Ibid. 52.

⁷⁵¹ Honor (n 747) 37.

⁷⁵² Ibid.

funding, supervising the programme and fiscal operations, and long-term planning. A CAC itself may be structured and operated depending on the unique needs of its community. Thus, CACs may be independent non-profit agencies, integrated in state systems (such as prosecution, healthcare, social services and/or law enforcement), or may be affiliated with an umbrella organisation such as a hospital. All options have strengths and limitations for collaboration, governance, planning, and partnerships. For a successful CAC, regardless of where the programme is housed or under whichever legal auspices, all agencies involved must bear ownership and equal investment in the programme.⁷⁵³

➤ **Cultural competence and diversity:**

All children have the right to accessible services, and thus, special consideration must be made to ensure that non-English speaking and deaf or hard of hearing children and their family members are accommodated throughout the process of investigation and intervention. Services must also be tailored to meet the individualised needs of children regarding their culture and developmental stages too. Importantly, staff must also represent the demographics of the community.⁷⁵⁴

➤ **Forensic interviews:**

Forensic interviews must be conducted in a neutral and unbiased manner with open-ended fact-finding questions and must be coordinated with other professionals of the team representing their agencies. This is crucial to avoid multiple interviews. A forensic interviewer must have successfully completed training.⁷⁵⁵

➤ **Victim support and advocacy:**

Parent and caregiver support is essential in reducing trauma and improving outcomes for children. Thus, client access to, and participation in, investigation, prosecution, treatment, and support services are a necessary component of the team's response. In a time of crisis, child survivors and

their families require assistance in navigating the multiple systems involved within the CAC's response. Advocates must be duly trained to provide this.⁷⁵⁶ It is their responsibility to ensure that there is active outreach and follow-up support available.⁷⁵⁷

➤ **Medical evaluation:**

Medical assessments and examinations are on site and conducted by healthcare providers with specific (and specialised) professional training in child abuse and in accordance with training qualifications, certification, and eligibility standards. The medical worker must be familiar with up-to-date published research studies on the findings of abused and non-abused children, as well as transmission of infections, current medical guidelines, and recommendations. Findings must be documented and submitted for expert review, preferably by a child abuse paediatrician.⁷⁵⁸

➤ **Mental health:**

The CAC's mission is to protect children, provide justice, and promote healing. Without therapeutic intervention, many traumatised children may suffer with ongoing and long-term adverse effects (for example, in health, social, developmental, and cognitive aspects). Thus, specialised mental health services must be available to the child survivor and their non-offending family. Healing must be fostered by minimising potential trauma. These services must be provided by qualified and trained professionals, who participate in ongoing supervision and consultation that delivers trauma-focused and evidence-supported mental health treatment.⁷⁵⁹

➤ **Case review:**

This is a formal process that allows the team to assess and monitor its collective effectiveness to ensure the safety and well-being of children and their families. These reviews foster a number of elements including experience, expertise sharing, and discussions.⁷⁶⁰

⁷⁵³ Ibid. 48.

⁷⁵⁴ Ibid. 18.

⁷⁵⁵ Ibid. 21; Honor (n 747) 37. This includes that they can assure accurate information is obtained during the interview; have had a minimum of 32 hours of instruction and practice; evidence-supported interview protocol; pre- and post-testing that reflect understand of the principles of legally sound interviewing; content that includes child development, cultural competency, implementation of protocol, question design and suggestibility.

⁷⁵⁶ Ibid. 27. Advocates are specifically trained in dynamics of abuse; trauma-informed services; crisis assessment and intervention; risk assessment and safety planning; multidisciplinary response; assistance in accessing/obtaining victims' rights; court education, support and accompaniment; assistance with access to treatment and other services.

⁷⁵⁷ Ibid. 28.

⁷⁵⁸ Ibid. 31-34.

⁷⁵⁹ Ibid. 36-39; Honor (n 747) 37.

⁷⁶⁰ Ibid. 41. Discussions can concern collaboration efforts; formal and informal communications; mutual support; protocols, agreements and guidelines needed to be reviewed; and collective decision-making in cases.

➤ **Case tracking:**

Demographic, statistical, and case information, as well as investigation and intervention outcomes are vital in programme evaluation and generating reports. This tracking system enables team members to accurately inform children and families about the current status and disposition of their cases.⁷⁶¹

The NCA also offers other forms of membership. Associate-level centres are CACs that are developing their implementation of the ten standards but have not yet achieved them all. Affiliate membership is offered to multidisciplinary teams that work in providing services to survivors of VAC. Lastly, support and individual membership is given to individuals or organisations wishing to make a difference in children's lives by supporting the work of the NCA.⁷⁶²

DISCUSSION

With its diffusion across the country and global influence for other models responding to VAC, the CAC has undoubtedly achieved both national and international prominence. It has been the cornerstone for the development of holistic, multidisciplinary, and interagency responses to VAC, which has attracted various community leaders and energised child advocates.⁷⁶³

Nevertheless, there are some valuable assessments made over the years of the CAC that may be useful considerations when adopting the OSC approach too. Of these lessons learnt, the unique and vital component of child and family victim support and advocates, who are specifically trained to detect symptoms and liaise with children and their families through the navigation of their case, are a valuable feature of the centres.

The diverse nature of this role requires advocates to be knowledgeable in factors such as crisis assessment, in-

tervention, the dynamics of child abuse, the interaction between the services, and the child welfare and criminal justice systems.⁷⁶⁴ These serve as the gateway to outreach and connect children and their families to services that are required to ameliorate the adverse effects of VAC.⁷⁶⁵

Despite their crucial role, some studies have revealed how insufficient training can negatively impact the outcome for some children's cases and the services received. For instance, at some centres, mixed perceptions in the importance of administering specific types of services to young children under the age of six have been observed. One of the most concerning qualitative results was that young children were less likely to receive or be referred for treatment services in the case of VAC. In this study, reasons commonly cited were that the parent/caregiver did not report the child's symptoms as justifying intervention.⁷⁶⁶ However, younger children manifest trauma symptoms differently to older children. For example, they may present post-traumatic stress and restrictive play symptoms. When parents are not aware of these symptoms, and an advocate has not received proper and up-to-date training to inquire about these symptoms, younger children may be perceived as asymptomatic.⁷⁶⁷ A lack of accurate knowledge can adversely impact how advocates interact with children and their families, thereby influencing parents/caregivers in their decision to seek services for their children (or not).⁷⁶⁸

These lessons learnt showed that there was a need to expand the system of service delivery for the youngest and most vulnerable child survivors of VAC,⁷⁶⁹ starting with consistent, available, and accessible training.⁷⁷⁰ Educating advocates and parents, especially about trauma, developmental stages, and mental health in younger children, has proven to be vital.⁷⁷¹

⁷⁶¹ Ibid. 45.

⁷⁶² National Children's Alliance, 'Accreditation Guidelines for Children's Advocacy Centers' (National Children's Alliance 2013) 4 <https://cyfd.org/docs/2013_Accreditation_Guidelines_for_Centers.pdf> accessed 19 July 2021.

⁷⁶³ J Robert Flores, 'Evaluating Children's Advocacy Centers' Response to Child Sexual Abuse' (Office of Juvenile Justice and Delinquency Prevention 2008) 8 <<https://www.ojp.gov/pdffiles1/ojjdp/218530.pdf>> accessed 19 July 2021.

⁷⁶⁴ Teresa L Young and Others, 'A Qualitative Data Analysis: Family Victims Advocates in Child Advocacy Centres' (2019) *Journal of Family Social Work* 1, 4.

⁷⁶⁵ Karin Vanderzee and Others, 'Who is Advocating for Children Under Six? Uncovering Unmet Needs in Child Advocacy Centres' (2016) 61 *Children and Youth Services Review* 303, 304.

⁷⁶⁶ Ibid. 308.

⁷⁶⁷ Ibid.

⁷⁶⁸ Ibid.

⁷⁶⁹ Ibid.

⁷⁷⁰ Young and Others (n 764) 13.

⁷⁷¹ Vanderzee and Others (n 765) 308.

CHILD ADVOCACY CENTRES IN GUYANA

THE DEVELOPMENT OF GUYANA'S CHILD ADVOCACY CENTRES

Guyana is an example of a South American country that has incorporated the USA's Children's Advocacy Center (CAC) model into its jurisdiction as a response to child sexual abuse. The first ever CAC was established in Guyana in 2014 as a joint government, NGO, and international agency coordinated response.⁷⁷²

This partnership consists of multiple stakeholders. At the government's level, the Ministry of Human Services and Social Security, along with its Child Care and Protection Agency and the Guyana Police Force, are all involved in supporting the CACs. International stakeholders such as UNICEF and UNFPA support local NGOs, such as Blossom Inc. and Child Link, in their provision of services, training, and infrastructure.⁷⁷³

Blossom Inc.'s work has been pertinent in expanding the centres since their establishment. In fact, the NGO itself was established in 2014 as a response to a call for collaboration from the child protection agency. Of the CACs that exist in Guyana, Blossom Inc. manages the centres based in four of the country's ten administrative regions. Warned about children being at increased risk of VAC driven by the pandemic, the NGO recently launched CACs in Kwakwani and Mabarumba, in collaboration with UNICEF and the governmental bodies.⁷⁷⁴

CHARACTERISTICS OF GUYANA'S CACS

Utilising a one-stop shop/centre approach, CACs in Guyana offer a range of child-focused and facility-based programme responses to child sexual abuse.⁷⁷⁵ From the

time a report is made by the police or the child protection authority, these CACs are second respondents in the line of service. Once contact is made with the CACs, the child is brought to the safe and secure, agency-neutral, and child-friendly centre to proceed with the required services.⁷⁷⁶

Blossom Inc. centres are designed to provide a safe, comfortable, and neutral space for forensic interviews to be conducted, and other services to be provided as appropriately. Representatives from disciplines such as law enforcement, child protection, prosecution, mental health, and medical and victim advocacy, comprise of the multidisciplinary team delivering services at these CACs. The team comes together to conduct joint investigations, interviews, make decisions, provide treatment, manage, and facilitate prosecution in child abuse cases.⁷⁷⁷

Together, they follow three fundamental objectives in provision of services:

- To provide a **safe space** where children will be required only once to tell professionals of the sexual abuse they have experienced, thus preventing the retraumatisation.
- To provide **evidence-based trauma-informed mental health therapy** to the child survivor and their non-offending family members to begin with the healing process.
- To **increase successful prosecutions** of the perpetrators of sexual VAC.⁷⁷⁸

Multidisciplinary Provision of Services:

At Blossom Inc. managed CACs, the following services are provided, which integrate some of the ten standards of the USA's model:

➤ Forensic interviews:

To avoid duplicating interviews, forensic interviews are recorded. They are conducted in a manner that are de-

⁷⁷² Ayana George, 'Criminalise Sexual Violence - CPA Director' (Government of Guyana 2019) <<https://dpi.gov.gy/criminalise-sexual-violence-cpa-director/>> accessed 20 July 2021.

⁷⁷³ 'Launch of Children's Advocacy Centre in Region 7' (Government of Guyana 2018) <<https://dpi.gov.gy/launch-of-childrens-advocacy-centre-in-region-7/>> accessed 21 July 2021; 'One-stop Child Advocacy Centre Opened in Kwakwani' (UNICEF 2020) <<https://www.unicef.org/guyanasuriname/press-releases/one-stop-child-advocacy-centre-opened-kwakwani>> accessed 17 August 2021.

⁷⁷⁴ Ibid; 'Child Advocacy Centre Services' (UNICEF 2020) <<https://www.unicef.org/guyanasuriname/stories/child-advocacy-centre-services>> accessed 17 August 2021.

⁷⁷⁵ Government of Guyana [n 773].

⁷⁷⁶ UNICEF [n 774]; Government of Guyana [n 773].

⁷⁷⁷ 'Child Advocacy Centre: Child-Focused, Facility-Based Programme' (Blossoms Incorporated 2021) <<https://blossominc.org/child-advocacy-centre/>> accessed 17 August 2021.

⁷⁷⁸ Ibid.

velopmentally and culturally appropriate to the child survivor of sexual abuse; sensitive; unbiased; fact-finding; and legally sound in the method of gathering information regarding allegations of sexual abuse. These interviews are conducted by trained forensic interviewer professionals, who have received training by the USA's National Child Advocacy Center. Forensic interviews are also observed by representatives of the multidisciplinary team, including members from the Guyana Police Force, the Childcare and Protection Agency, Mental Health, and Victim Advocate Services. Together the team provides guidance based on the information collected in the interview and decides on whether a case can be brought against the perpetrator.⁷⁷⁹

➤ **Medical evaluations:**

Children who are suspected survivors of child sexual abuse are entitled to a medical evaluation provided by a professional with specialised training in dealing with children. Not only do they provide treatment, but they also collect and document any possible forensically significant findings. However, some CACs do not have facilities for sexual abuse examinations, thus, specialised cases of sexual abuse are referred to the public health facilities for medical examinations.⁷⁸⁰

➤ **Mental health services:**

To promote healing and adverse long-term emotional, developmental and health outcomes, evidence-based trauma-focused cognitive behavioural therapy and integrated play therapy are provided to the child survivor. This is fostered in a way that minimises any potential further trauma for the child.⁷⁸¹

➤ **Victim support and advocacy services:**

Improving outcomes for children and (non-offending) family members is crucial, and up-to-date information and ongoing access to comprehensive care and services are necessary for this. Thus, family support, and client access to participation in, investigation, possible prosecution and treatment services are a core element of the multidisciplinary response, as encouraged by coordinated victim advocacy services. This support is provided before and during the judicial process (if there is one).⁷⁸²

➤ **Case review and case tracking:**

As part of CAC management, the multidisciplinary team conducts quarterly Case Reviews. This is a formal process enabling the team to monitor and assess its accountability and independent and collective effectiveness to ensure the safety and well-being of children and their non-offending families. Case tracking is conducted via a system that monitors cases to provide essential demographic and case information and investigation/intervention outcomes to generate statistical reports. Both case review and tracking are paramount to programme evaluation, where the team can identify and assess any shortcomings and/or areas for continuous quality improvement.⁷⁸³

➤ **Cultural competence and diversity:**

It is a core principle that the provision of services at Blossom Inc. CACs are provided in a manner that is culturally competent. This means that services are provided with “the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community.”⁷⁸⁴ As developmental considerations influence much of a child's life and capacity, cultural norms also influence almost every aspect of their lives, and thus this is a crucial consideration when working with children and their families.

⁷⁷⁹ Ibid.

⁷⁸⁰ Ibid.

⁷⁸¹ Ibid.

⁷⁸² Ibid.

⁷⁸³ Ibid.

⁷⁸⁴ Ibid.

CHAPTER 5

LESSONS LEARNT & RECOMMENDATIONS

Of the fourteen jurisdictions and regions studied in this brochure, there are some key and valuable lessons to be learnt from the best practices and shortcomings based on these experiences. Undoubtedly, when striving towards strengthening a CPS and responding to VAC, OSCs deliver a range of holistic and integrated services to all children, which our past thematic-focused efforts failed to capture. Their services located under one roof have been critical in preventing retraumatisation and revictimisation. However, these comparisons and differences across the centres studied within each country demonstrate that an OSC is not a one-size-fits-all concept. For instance, utilising community structures for referrals may be more feasible in collectivist societies as opposed to societies that are more individualistic. Thus, by considering the various lessons learnt from all the centres studied, the following recommendations should be considered for policymakers and other stakeholders looking to implement or improve their approaches to OSCs.

Critical and Minimum Standards for the Implementation and Operation of OSCs Responding to VAC

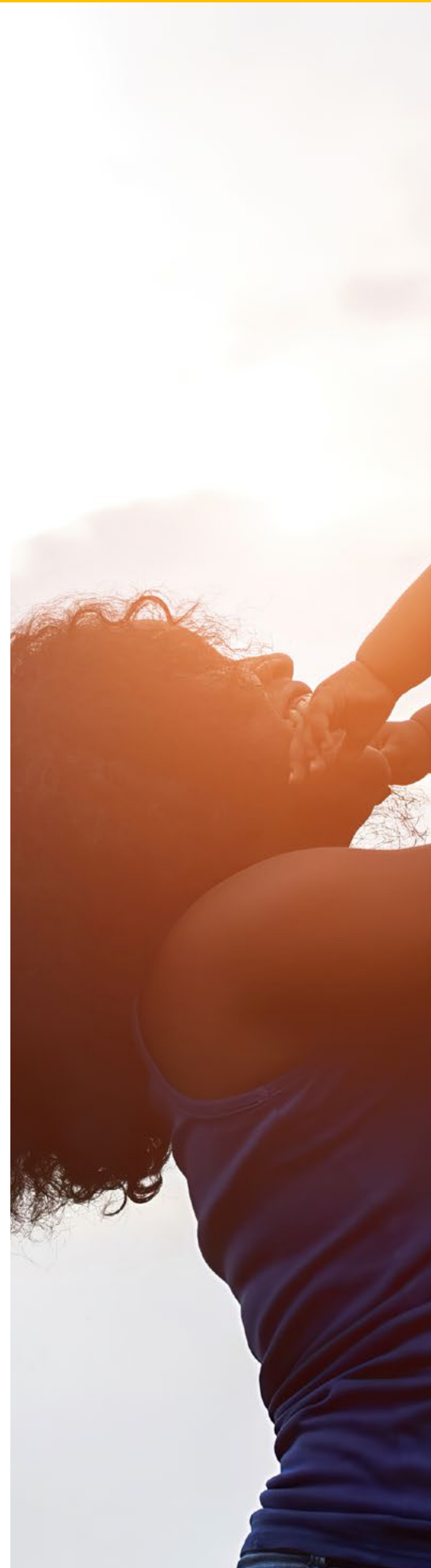
1

A children rights-based approach that recognises every child as a unique, respected, and protected rights-bearing individual with dignity and integrity, is paramount to the functioning of OSCs responding to VAC. Many OSCs are still centred around general or broader responses to violence, targeted not only at children but also women and men. As VAC and VAW are interlinked in many aspects, there certainly are benefits of aligning responses. However, alignment can easily overlook the importance of responses to both forms of violence. Children's rights to protection may become secondary, and, among other challenges, may reduce the specificity of care provided, especially when considering that children are different and many factors such as gender, race, ethnic group, age, and/or disability can be unique to each child's life. In resource-constrained countries that are affected by multiple forms of violence too, alignment may be the most economically viable option, however, the rights and needs of children may be left neglected without the proper consideration and safeguards in place.⁷⁸⁵

RECOMMENDATION: In implementing and operating OSCs, states must adopt all necessary approaches and measures that uphold and respect the rights of children. This should be provided with due consideration to their different needs and the factors that may render some children more vulnerable than others. Thus with due consideration for the child's developmental stage and cultural background, the best interests of the child, non-discrimination, and the rights to privacy and confidentiality in the assessment and management of a case *must* be upheld at all times. Additionally, securing a rights-based approach requires that the child's right to participate in any step of the response, assessment, and investigation into their experience, is indispensable. This means they have the right to be heard, informed, consulted, and empowered so that they can convey their own unique, complex, and differing needs in any decision that affects them and throughout all stages of the process.⁷⁸⁶

⁷⁸⁵ WHO Regional Office for the Western Pacific (n 594) 4; CmRC (n 28) para 59.

⁷⁸⁶ *Ibid.* para 21.





2

The functioning of an OSC is dependent on implemented **protocols and/or guidelines** that delineate procedures, clear roles, and responsibilities of all service providers and agents involved in the multidisciplinary team.

RECOMMENDATION: States should adopt a protocol on the minimum standards required in the multidisciplinary and interagency provision of services at OSCs. This should include (but is not limited to) safeguarding core principles in accordance with children's rights standards; the delineation of clear roles and responsibilities of each member of staff and agency; professional and child-friendly procedures in provision of services, operational and technical procedures; case management and coordination of OSCs including regular meetings for information sharing at staff and agency level; ethical standards for conducting forensic interviews; and regular training. Protocols should also ensure that agencies and cooperation with partner stakeholders have equal responsibility in their roles. This is requisite to ensure that the response is not dominated by one sector and the coordination between partners does not break down.⁷⁸⁷ If necessary, an interagency agreement within the OSC can also be concluded to ensure commitments are carried out.

3

In safeguarding the principle of non-discrimination, OSC services **must be accessible to all child survivors** of VAC within their jurisdictions. This is irrespective of the violence they have witnessed and/or experienced, their age, nationality, and socio-economic backgrounds. As many cases in this brochure have demonstrated, increasing the number of survivors receiving response services requires the provision of services to be free of charge.

RECOMMENDATION: States must ensure that OSCs cater to all child survivors of all forms of violence, of all demographics, and have the capacity to include the provision of services for children with disabilities. Additionally, measures should be in place that ensure services are operative round the clock and free of charge, including for specialised examinations and treatment.

⁷⁸⁷ See Vetten (n 436) 31-32, 39-40.

4

Safe-guarding a child's rights-based approach requires a **child-focused and friendly environment**. Many centres assessed fell short of this aspect, which may be easily overlooked if OSCs are not specifically oriented around VAC.

RECOMMENDATION: To reduce anxiety and retraumatisation, it is fundamental that OSCs provide an environment for children to feel and be safe and secure. This environment should be neutral, where children feel they are able to disclose their experiences. The facilities should accommodate the needs of children in accordance with their developmental stages, with cultural sensitivity, and an understanding of their experiences and needs. For instance, toys for younger children should be provided and interior should include child-friendly furniture.⁷⁸⁸ It is an absolute requirement that centres are completely secured from perpetrators, even when that person is a parent/caregiver. Moreover, the location of the OSC plays an important role in ensuring a child-friendly environment. Hospital-based centres may be the most economically feasible in constrained resource settings since they can be easily budgeted into hospital costs. However, this setting may be intimidating for children and may impede on their privacy if they are located in busy departments such as the accidents and emergency department. Therefore, it is recommended that they are based in their own separate department with secured confidentiality when integrated into health facilities (as is the case in Zanzibar).

5

Provision of services by OSC staff that are professionally trained in responding to child survivors of VAC is fundamental and indispensable. This aspect has been challenging for centres that are not specifically child focused. Yet, the provision of services by untrained nor professional staff may jeopardise a child's rights-based approach, the understanding of the unique needs of each child, and may cause retraumatisation.

RECOMMENDATION: States must ensure that the provision of services are carried out by trained professionals in their respective disciplines. Professionals must be trained to recognise indicators of VAC and trauma in children of all stages of development and with cultural sensitivity, in detecting the specific needs of children, and duly responding to child survivors of VAC according to these needs. Training must be regularly and professionally administered and up to date in accordance with the current guidelines and studies of each profession. It is understandable that in lower resource settings, this may be difficult to achieve and there may not be enough expertise available in the various disciplines. Thus, it is recommended that states plan to prioritise long-term incentives that aim to increase the amount of expertise per profession available within the country. Strong links with NGOs and other international stakeholders have proven to be effective for providing technical expertise and training. As we have also seen from the case of Zambia, village OSC services have been successfully provided by community members who have been trained by external partners.⁷⁸⁹

⁷⁸⁸ See for example Haldorsson (n 691) 58; CmRC (n 28) para 52.

⁷⁸⁹ Ibid. para 50.



6

An effectively functioning OSC requires continual **capacity strengthening and guidance** for staff, both in their provision of services, and for technical roles such as for documentation and data management. Without such training, services may be insufficiently provided and gaps in performance may be inadequately addressed.⁷⁹⁰ Many centres have demonstrated that without **support provided to staff**, burnout, decreased motivation, high turnover, and harmful attitudes may affect the level of professionalism in service delivery to child survivors.

RECOMMENDATION: Services must not only be provided by professionals in the relevant fields, but training must be regularly administered in accordance with up-to-date standards, curricula, and protocols. This must include training within each respective discipline, training in joint multidisciplinary and interagency team collaboration and case management, and training that targets any wrong, misconceived and stigma-fuelled harmful attitudes towards specific forms of violence and/or survivors.⁷⁹¹ To address turnover, it should be ensured that staff rights to reimbursement for work and fair working conditions are provided at all times. Moreover, to prevent burnout, interventions must always be in place to ensure employee well-being. Staff must have access to guidance and counselling to address any potential emotional or other strains from working in a multidisciplinary response to VAC.⁷⁹²

7

Multiple interviews conducted by **untrained professionals** have the **potential to inflict retraumatisation and secondary victimisation** especially if child appropriate safeguards are not in place.

RECOMMENDATION: To avoid retraumatisation and subjecting the child to further harm, the number of forensic interviews carried out should be limited to an *absolute minimum*. Interviews ideally should only be conducted by *one* forensically trained professional capable of producing valid evidence to be used in court. Interviews should be both child's rights-based, sensitive, and conducted in accordance with protocol and evidence-based standards.⁷⁹³ It is paramount that children (of all ages) should *not* have to repeat their experiences at each point of service within the OSC. Thus, it is vital that representatives of each agency coordinate with the interviewer for the observation of the interview. This may be done either through live hearings in another room, or recorded footage.⁷⁹⁴

⁷⁹⁰ Haldorsson (n 691) 102; Bernath and Gahongayire (n 373) 49; Chelwa and Others (n 477) 16.

⁷⁹¹ Ibid.

⁷⁹² Ibid.

⁷⁹³ Ibid. 76; CmRC (n 28) para 51; See also National Children's Advocacy Center, 'National Children's Advocacy Center's Child Forensic Interview Structure' (National Children's Advocacy Center 2019) <https://www.nationalcac.org/wp-content/uploads/2019/02/NCAC_CFIS_Feb-2019.pdf> accessed 14 September 2021. The NCAC resource offers extensive guidance on child-friendly and professional methods and standard in appropriately interviewing a child survivor of VAC.

⁷⁹⁴ Ibid.

8

To ensure that the safety and well-being of the child survivor and their (non-offending) family is regarded at all times, the **management of cases** is dependent on formally coordinated processes of the interagency case review.

RECOMMENDATION: It should be ensured that case review and tracking mechanisms are in place and in accordance with formal procedures written in protocols and allow for the assessment of the effectiveness of services. For coordination to be successful in case management, agencies should have a mutual understanding and trust of the common procedures in place. This requires that regular coordinating meetings should be held to discuss cases, so as to ensure investigations occur holistically and without overlap.

9

As we have seen from many centres in this brochure, without a **data collection system** in place or processes that capture accurate data, the evaluation of any documented shortcomings is limited.

RECOMMENDATION: OSCs must be equipped with a centralised and digitalised data management system. Data collection should be made by staff members in accordance with protocol, which should delineate clear interpretations of the necessary collected information. Information collected should include elements such as gender, demographics, type of case, investigation, and treatment/intervention. This information should not only be used to evaluate the effectiveness of the response, but also to understand the needs of different children and assess the prevalence of cases of VAC.⁷⁹⁵

⁷⁹⁵ CmRC (n 28) para 42(a)(v).





10

Many elements in the provision of services are disrupted when an OSC lacks **adequate infrastructure** to provide them, even if there are protocols in place that list the necessary elements of an OSC. For instance, the chain of prosecution can be disrupted when there are no facilities to store forensic DNA samples with refrigeration, and sexual violence assessments that cannot be carried out without the availability of rape kits. This may not only hinder the chances of prosecution but may also interrupt services for even the most basic needs of child survivors.

RECOMMENDATION: It is the responsibility of the state to ensure that there is adequate infrastructure to support response services by a multidisciplinary team. In lower resource settings, this may be challenging. Thus, linking partnerships with external stakeholders to temporarily assist in aid to provide infrastructure should be made whilst being cautious of dependency.

11

Links to local **child protection services** are fundamental for detecting and assessing child abuse and neglect, and are vital for initiating proceedings and accordingly responding to VAC. In some studies, child protection links were a totally missing element for OSCs.

RECOMMENDATION: It is crucial that child protection authorities are allocated a function as part of the OSC responding to cases of VAC. How this is institutionally arranged depends on the OSC as an entity (i.e., whether it is a stand-alone and/or a private entity, embedded into a national system, or as a function of an authority, which could also be the child protection agency itself). In whichever way this is arranged, child protection agents are responsible for conducting child protection risk assessments, which may occur within the centre itself or through an authority that makes referrals to an OSC for intervention. This is fundamental, as the assessment determines the severity of the case, the appropriate steps needed to be taken in the intervention and on-going safety assessments that can prevent future occurrences of VAC.

12

Links to the **police and prosecution authorities** are foundational for initiating criminal proceedings. Unfortunately, not all OSCs in the country studies had this function at the centres, which directly impacted the potential for the prosecution and the conviction rates of perpetrators.

RECOMMENDATION: It is recommended that dedicated police officers, who are professionally trained in dealing with child survivors of violence, are stationed at OSCs. If this is not the case, then formal links to the police must be established. Links to the prosecuting authorities should also be made through law enforcement.

13

A **legal component** is a necessary element of OSCs, as they provide both representation for and legal information to child survivors and their parents/caregivers and play a vital role in the investigation and prosecution of cases. As seen from the country studies, many centres lack this component, which has affected the prosecution and conviction of perpetrators.

RECOMMENDATION: Whilst legal counsel and representatives do not necessarily have to be in-house members of the OSCs, it should be ensured that in every case that involves child protection and/or criminal proceedings, a legal representative for the child survivor is appointed when necessary. Thus, it is recommended that legal staff are appointed, or links with the proper agencies are secured. Child survivors and their non-offending parents/caregivers should also have access to legal counselling to inform them of their rights and of the directions that may be pursued in prosecution, as well as the right to receive compensation.⁷⁹⁶

14

A major challenge across many OSCs was a lack of **follow-up** services due to several reasons such as transportation costs, inadequate distribution of funds to provide such services, and/or a cultural lack of priority, mainly towards psychosocial care.

RECOMMENDATION: Follow-up service is a necessary intervention in responding to VAC. They can be a useful tool in providing mentorship to families that have experienced violence and are utilised to assess long-term elements such as continual child protection assessment, and other treatments, including therapy and social services. It is recommended that sufficient funds are allocated to provide follow-up services, and/or that incentives are deployed so that survivors do not have to constantly travel back and forth to facilities that may be too far for them and thus, costly. For instance, setting up links between community partners that could be trained in providing some of these services may be a solution.⁷⁹⁷

15

Continual **awareness-raising** incentives are an important element of OSCs. Unfortunately, despite their existence, a lack of knowledge in the centres in some studies has led to a low demand for their services. Often, the promotion of centres is only done at the very beginning of the project and is not continually pursued.

RECOMMENDATION: It is recommended that the promotion of OSCs is *continuous* through any necessary and appropriate platform. For instance, campaigns through television and radio adverts have been utilised in Rwanda. Education on OSCs at schools is another means of promotion. Strong links to community leadership in Zambia have also proven to be an effective way of campaigning to eliminate child abuse and promoting the centres. Awareness-raising incentives could also include information such as how to spot indicators of VAC, which can be utilised by the public to inform OSCs, police, and child protection services.

⁷⁹⁶ Ibid. para 52, 56.

⁷⁹⁷ Ibid. para 53.





General Recommendations

Institutional Accountability of OSCs

- The implementation of **laws** that establish a formal role of government-level institutions in response to VAC through multidisciplinary and interagency approaches (such as implementation of OSCs) is recommended. This is a key criterion for holding national institutions account and is one step towards stimulating top-level leadership, support, and commitment to the project.
- However, laws do not exist in vacuum. Thus, the implementation of a **national policy framework** establishing OSCs, supporting programmes that strengthen their operations and integrating centres into the national system is recommended. This sets strategic targets and goals to be achieved and further establishes accountability and commitments. A national policy will also demonstrate that eliminating VAC is a prioritised item on the agenda.
- As VAC is a multifaceted problem, **coordination and cooperation must also be safeguarded at the institutional level between ministries**. A systems-strengthened approach requires multisectoral, interagency, and interdisciplinary coordination to holistically realise, at all socio-ecological layers, the protection of children against VAC and mitigate its consequences. Thus, inter-ministerial cooperation and coordination is contingent to such an approach to ensure coherence in the holistic prevention of and response to VAC. Thus, it is vitally recommended that all relevant ministries, bound by law, their policies, and who are direct stakeholders in the greater child protection system, together directly cooperate for the coordination and oversight of OSCs, to ensure all sectors, agencies, and disciplines involved are continually synergised in the prevention of and response to VAC.

Sustainability of OSCs

- A significant problem that has emerged in several OSCs across different regions is the **reliance on donors** for funding. In low resource settings this certainly may be the only feasible option for establishing OSCs. However, this practice is not sustainable as financial support from donors may be inconsistent and only in place for a temporary period. Therefore, in the implementation of OSCs, there is a need to ensure proper financing is safeguarded within its own resources. For established centres, there is a need to develop a phasing-out or exit-strategy and sustainability plan. This plan should not only include financial considerations, but also human resource capacity. Thus, incentives to increase expertise and training amongst the population in responding to VAC should also be included.⁷⁹⁸

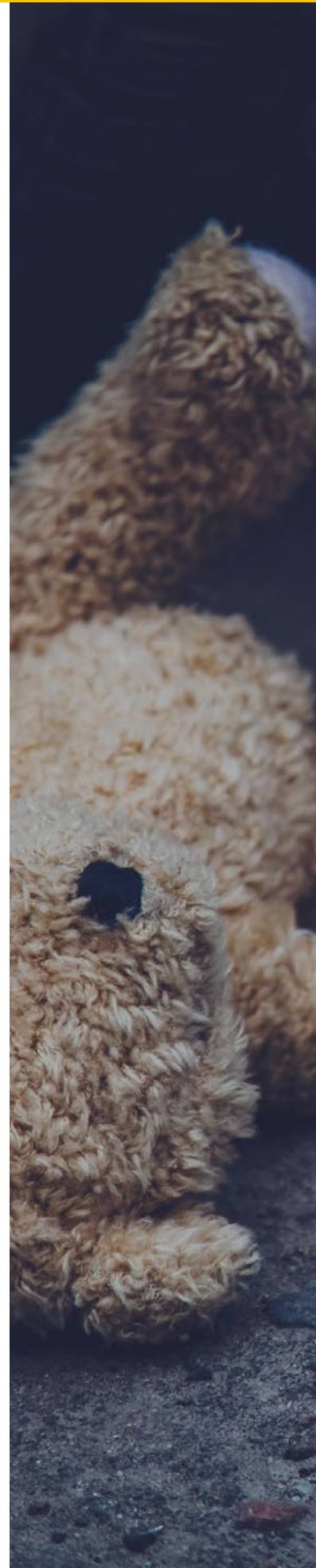
⁷⁹⁸ Zimbizi, Milapo and Holsbrink (n 458) 81, 83.

Recommendations for External Factors

- It is urgently recommended and is utterly paramount that **all forms of violence against children in all settings are prohibited by law**. This fundamentally includes outlawing violent discipline and harmful and occult practices, such as child marriage, virgin cleansing, and child sacrifice. It is an incomplete commitment by states that implement OSCs as a response tool to VAC if there are laws in place that threaten the very life and dignity of the child, and their right to be free from violence in all its forms. **Prevention is and always should be at the forefront of ending VAC** once and for all, and this starts with the legislation in place that sets the tone.
- Even where practices are illegal, incentives for prevention should be put in place that promotes a mentality intolerant of VAC, and fosters change in perception to one where children are perceived as individual beings with inherent dignity.⁷⁹⁹ This includes **awareness-raising** initiatives and programmes regarding the multifaceted consequences of VAC, which target all levels of our societies. For instance, evidence-based **positive parenting campaigns** have been designed to increase parents' awareness of VAC, and enhance practices and skills in non-violent discipline, that have been proven to effectively reduce the risk of incidents.⁸⁰⁰
- At the societal level, many forms of **harmful attitudes and stigmatisation** exists. This includes stigma directed at persons with disabilities and towards some forms of VAC such as sexual violence, which further encourage a culture of silence. Additionally some studies have revealed that some **cultural customs and attitudes can fail to prioritise mental health**, which has deterred individuals from seeking follow-up support. Thus, it is recommended that incentives are provided to raise awareness of all kinds of stigmatisation and highlight their devastating consequences. Education could be a useful tool for this.
- Utilising existing **community structures** in the fight against VAC has proven beneficial in regions where these roles strongly exist. Because community leaders often command great respect from society, they have the capacity to play an influential role in disseminating prevention and awareness centred around VAC. In addition, these structures can also be used to detect any indicators of VAC to either make referrals to OSCs or inform the OSCs of cases. The involvement of leaders can also stimulate greater community engagement. Therefore, it is recommended that states expand their links to these structures to improve responses to VAC through OSCs.
- In some studies, distrust and corruption amongst institutions posed a major barrier. This deterred individuals from seeking services at government-led OSCs. Thus, incentives that establish **trust** in existing institutions to **demonstrate integrity, fairness, and openness** are fundamental and crucial. This is necessary not only for strengthening the perception of OSCs, but also of the greater national systems in place.

⁷⁹⁹ Todres (n 1) 226.

⁸⁰⁰ Wendy Knerr, Francis Gardner and Lucie Cluver, 'Improving Positive Parenting Skills and Reducing Harsh and Abusive Parenting in Low-and Middle-Income Countries: A Systematic Review' (2013) 14 *Prevention Science* 352, 353.



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Investing in children, their health, protection and wellbeing is about securing the future and sustainability of our societies. A strong child protection system with intervention tools like the One-Stop Centre model contributes the children's rights to grow up free of violence – which we, at the IPU, support.

Martin Chungong, Secretary General of the Inter-Parliamentary Union



Every child has the right to grow up without violence and to develop to their full potential. I would like to see every country with strong child protection systems acting to prevent and respond to cases of child abuse, neglect, and harm. The One-Stop Centres as an intervention tool providing holistic multidisciplinary services under one roof, are desperately needed to support and respond to young survivors of violence. With this brochure we hope to inspire key stakeholders to further enhancing their child protection systems.

Janina Özen-Otto, Founder of the Ana Kwa Ana Foundation
and Ambassador of the World Future Council