Gender-Responsive COVID-19 Recovery in India

Framework of Model OSCs

District Hospital

Social and Development Research and Action Group

www.sadrag.org

Contents

List of abbreviations

CA - Centre Administrator

CEHAT - Centre for Enquiry into Health and Allied Themes

ESP - The Essential Services Package

ET - Evaluation team

GBV - Gender based violence

GBVM - Gender Based Violence Management

KELSA - Kerala State Legal Service Authority

PVI - Intimate Partner Violence

M&E - Monitoring and Evaluation

NCW - National Commission for Women

NFHS - National Family Health Survey

OSC - One Stop Centre

SACTAT - Sexual Assault and Child Abuse Team

CASA - Centres against Sexual Assault

SANE - Sexual Assault Nurse Examiner Programs

UNDP - United Nations Development Programme

UNFPA - United Nations Population Fund

UNODC - United Nations Office on Drugs and Crime

UN Women - United Nations Entity for Gender Equality and the Empowerment of Women

WHO - World Health Organization

Preface

The pandemic of COVID-19 altered every aspect of human life. The humans were caged due to measures taken to slow the spread of virus. The impact on women and girls was devastating. Restricted movement and social isolation measures, predisposed women to violence and abuse at home who managed care work with depleting resources and kept the family fed and contended. The women report that the stress of prolonged isolation and economic hardship led to more frequent and intense bouts of violence from domestic abusers. According to UN Women, "since the outbreak of COVID-19, emerging data and reports from those on the frontlines, have shown that all types of violence against women and girls, particularly domestic violence, has intensified".[1] The unprecedented surge in gender-based violence (GBV) stood out as an urgent threat to safety of women and girls at home. The governments across the globe, had a herculean task of managing the emergency response to COVID-19. The government agencies were pre-occupied with implementing the stricter measures to contain the spread of virus. In the process, the GBV services were deprioritized as the governments had shifted their resources to COVID-19 response action. The movement regulations and lockdowns limited the scope for accessing the GBV prevention and response services.

In India, the GBV response services are provided through the institutional framework of SAKHI-One Stop Centres (OSCs). These centres are run under Mission Shakti, which is a central government integrated women empowerment programme for the safety, security and empowerment of women. OSCs constitute the single window GBV redressal mechanism which facilitates access to an integrated range of services including medical, legal, and psychological support to women survivors of violence. With each district of the country planned to have a functional OSC, there are presently 684 OSCs functioning in the country.[2]

UN Women has implemented a programme titled 'Gender-Responsive COVID-19 Recovery in India' to reduce the disproportionate gender-based risks and negative impact of COVID-19 on women in the most marginalized and vulnerable situations. The twin strategy of the program is to build the capacity of GBV service providers and develop knowledge resources for strengthening of GBV services in the country. One such knowledge resource, is developing a framework on Model OSC and detail the monitoring and evaluation framework of OSCs to assess and evaluate the quality of service provided by them.

This knowledge resource details the concept of Model OSC that has been developed to provide right based survivor centric, gender responsive services to GBV survivors. It has been developed under the program, 'Gender-Responsive COVID-19 Recovery in India', initiated by UN Women to create knowledge on gender responsive processes of accessibility and availability of essential support and redressal services to GBV survivors.

This knowledge resource would not have been possible without the guidance of EVAW team at UN Women, India and the several experts and practitioners working in the domain of gender and GBV. We hope that the Model OSC framework would be used as a referral resource for reviewing the existing SAKHI-OSC model and upgrade its services for GBV prevention and response.

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[1] UN Women, 'The Shadow Pandemic: Violence against women during COVID-19', https://bit.ly/3w2IWwD.
[2] https://sakhi.gov.in/home/osc_live_dashboard

SECTION I – The global genesis of One Stop Model

The GBV prevention and response mechanisms have been devised and implemented in regional and local contexts. The concept of coordinated care approaches, such as one stop centres, was introduced globally in the last twenty to thirty years. Coordinated care refers to GBV survivor services that link sectoral responses within stand-alone programs (where health, psychosocial, police and legal assistance are available in one location), or that link sectoral responses through standardized referral pathways across programs (where health care providers, for example, provide a full array of response services within a health setting and then refer the survivor elsewhere for police and legal assistance) In general, coordinated care models (such as the OSC) seek to optimize a multi-sectoral approach and ensure consistency in the application of core guiding principles in all service delivery efforts (Annexure – I).

Sexual Assault Response Team (SART)

It started in US in 1970s with the core objective of making reporting and medical examination easier for victims and coordinating investigation and support services. It comprised a team of a nurse or doctor, a police officer, and a victim advocate. Typically, SART had its own premises; a victim was escorted there by a police officer or victim advocate. All team members attended the SART office where the victim was interviewed, the medical examination conducted, and support (counselling and referrals) was offered to the victim.

Sexual Assault Referral Centres (SARCs)

These centres were established in United Kingdom in 1986. These are joint ventures between the police and the health sector, with involvement of the voluntary sector. They are usually located in a hospital and provide 24 hours service a day. The victims receive medical care by a specialized health practitioner; receive counselling and legal advice, are interviewed by police, and undergo a forensic examination. The service is available 24 hours a day. The victims may self-refer or be referred by police, but are not obliged to report the assault. They can talk informally to a police officer, before deciding whether to report or not. psychological care for up to 6 months.

The model of One Stop Centres (OSC) was developed as a response to provide an integrated system of support, which are otherwise scattered across different locations, to survivors of violence.[3] It was a response

[3] Olson Rose K., Moreno C.G., Colombini M., 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 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170420/

to the disintegrated nature of the healthcare, police and legal systems which meant that survivors of violence had to often retell their stories of trauma each time they engage with a different service/sector therefore contributing to numerous episodes of re-traumatization. As such, the objectives of the OSC model has been "to increase accessibility, acceptability, quality and multi-sectoral coordination of care in order to reach the ultimate goal of reducing survivor re-traumatization when seeking care".[4]

[4] **One Stop Centres (OSCs), UN Women, 2023** https://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html

SECTION II – One Stop Model: The Indian context

In India, the idea of having One Stop Centres (OSC) emerged from various women and right based organizations which had researched the issue of GBV and addressed it in convergence with health and wellbeing of survivors. The various models that have emerged, have paved the way for a more institutional mechanism for prevention and redressal of GBV.

- **Dilaasa Centre**

Dilaasa Model defines the mechanism of providing comprehensive care and support to GBV survivors through defining the location of such a facility, training mechanism of the functionaries to the mechanism of providing gender sensitive services[5]. Dilaasa represents a redesigned 'one-stop crisis center' (OSCC), with focus on delivering an integrated response to violence against women within the existing roles and responsibilities of health professionals. ***5***

Dilaasa, the first ever One Stop Centre was established at K.B. Bhabha Hospital, at Mumbai in India in 2001. The Centre works for prevention, redressal and providing support to women who visit the hospital and are identified to be GBV survivor. In such cases, women are provided with medical treatment, psychosocial and medico-legal support and crisis intervention services. The provision of services include documentation of history of abuse and collection of evidence in case of sexual violence.

Besides providing direct support to the survivor, Dilaasa crisis intervention center makes people understand the issue of domestic violence within the larger societal context of gendered inequalities and violence. It advocates to recognize domestic violence as a public health concern within the medical context. Dilaasa centre provides right based counseling, emphasizing, the women's right to have a violence free life, saving women from blame and putting the onus of abuse on the perpetrator. It also equips women with the necessary tools and strategies to heal from abuse as well as stop it. An external evaluation of Dilaasa found it to be an evidence-based and sustainable hospital-based model for responding to domestic and sexual violence. This evaluation also highlights that the location of the crisis center in a public hospital enhances accessibility and early detection of VAW, with many women identified within two years of facing abuse 6. ~~The center has established protocols for docu~~mentation of the abuse, its severity, assessment of safety, mental health impact and development of a safety plan.

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5 Padma Bhate-Deosthali, Sangeeta Rege, Poulomi Pal, Subhalakshmi Nandi, Nandita Bhatla & Alpaxee Kashyap, 2018, Role-of-the-Health-Sector-in-Addressing-IPV-in-India: A Synthesis Report, ICRW

6 Hospital based Crisis Centre for Domestic Violence: THE DILAASA MODEL, 2011 https://www.cehat.org/cehat/uploads/files/DilaasaPB.pdf

- **Gauravi centre**

The Gauravi Centre6 was established in Madhya Pradesh in 2014. It was designed as a one-stop shop, where women and girls can access a range of key services when they have experienced sexual and/or domestic violence. It offers the full range of services under one roof that include a helpline, a safe shelter, medical treatment, counselling and legal aid.

Gauravi centre is a shelter and support centre where survivors of sexual and domestic violence can access a suite of services, so that they can recover from trauma and begin to rebuild their lives. Many of the staff members at Gauravi are survivors of violence themselves**.** They often form strong bonds with the women and girls who access the services, keeping in touch for years to come, and providing sensitive, comprehensive care that helps survivors recover from trauma. They counsel women and girls sensitively throughout their experience, from providing a safe, secure place to sleep, to finding a lawyer to represent their case. They help women and girls to recover from their trauma, and achieve the justice they deserve. (Annexure – I)

The Gauravi Centre doesn't just provide aftercare for survivors of violence. It also runs outreach work to break the cycle of violence through gender talks in schools and colleges. They teach women, how to report abuse and what their rights are. They train police officers to ensure, cases are dealt with promptly and sensitively. They work with lawyers to ensure that survivors get justice and perpetrators are held to account.

The Gauravi Centre also runs programmes to help women become financially independent. It runs a program to train women to become auto-rickshaw (tuk-tuk) and bus drivers - a male-dominated profession. They link poor families with government schemes on girls' education.

- **Bhoomika One Stop Crisis Centre**

  Bhoomika, a Gender Based Violence Management (GBVM) Program was started in Kerala in 2009. It was introduced in all 14 districts and seven selected Taluk head quarter hospitals in the state. Bhoomika centres function round the clock to 7:

- Provide social and psychological support to women.
- Sensitize the hospital staff on gender issues.
- Train the hospital staff to identify victims of violence.
- Network with other organisations working on women's issues for mutual support and sharing..

  Situated within the hospital complex, the hospital staff is trained in gender issues and in identifying the women facing domestic violence. The centre provides counselling, medical support and legal aid through Kerala State Legal Service Authority (KELSA). It has provision for temporary shelter for emergency situations. During the period 2012- 2016, 25274 cases were identified, action was taken and follow up of old cases was also done8.

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6 Pandey Madhumita, An Examination of the One Stop Centre – Gauravi in Bhopal, Executive Report, Sheffield Hallam University, 2019 https://shura.shu.ac.uk/28877/1/Research%20Report_Bhopal.pdf

7 Poster: Gender based violence management centre https://nhsrcindia.org/sites/default/files/2021-05/Poster%20-%20Gender%20Based%20Voilence%20Managemnt%20Center%20-%20Bhoomika%20Kerala.pdf

8 Report, Working Group on Medical and Public Health, Thirteenth Five Year Plan (2017-2022), Kerala State Planning Board, Government of Kerala: https://spb.kerala.gov.in/sites/default/files/inline-files/1.14Medical%20and%20Public%20Health%2007052017.pdf

Aman Network

Aman Global Voices for Peace 9 in the Home is a network of international organizations and individuals to end domestic violence. The National Secretariat of the Network is Swayam, a feminist organization based in India. The Aman Network address GBV issues through direct intervention, advocacy, reach and training. The network has members spread over 22 states of the country.

During pandemic, civil society organizations collectively addressed GBV concerns. While there was a limited access to institutional support, they re-strategized the provisioning of support services for survivors of violence. They adopted technology to provide tele-counselling services, set up helplines and trained staff to respond over phone and ways to maintain privacy and confidentiality of survivors. They linked up with front line workers at community level such as ASHA, Anganwadi workers, grassroot women leaders and others engaged in relief work so that they could inform women about the available GBV support services.

9 Responding to Domestic violence during lockdown https://swayam.info/wp-content/uploads/2021/04/AMAN-Network-Response-to-VAW-during-lockdown-2.pdf

- **SAKHI-OSC Model**

The government of India introduced SAKHI-OSCs scheme in 2015. During the 15'h Finance Commission period, 2O2l-22 to 2025-26, this scheme was subsumed under Mission Shakti - an integrated women empowerment programme as umbrella scheme for the safety, security and empowerment of women. The SAKHI-OSCs come under the Sambal scheme of Mission Shakti, which has three categories of services:

- Emergency/immediate services and short term care;
- Care for long-term support; and
- Behaviour Change Communication for dignity and prevention of crime and violence against women

While the former includes support and care for women affected by violence and in distress through immediate services such as dedicated 24 hours helpline and integrated services through SAKHI-OSCs, the latter includes long term support through skill development, entrepreneurship and linkages with support and referral services. Currently, there are 701 operational OSCs across 35 states and union territories in the country.[10]

Post Nirbhaya Case, Justice Verma Committee was formed towards providing recommendations to the government for the prevention of gender based violence. Some of the relevant suggestions came from Partners for Law in Development[1], Lawyers Collective and from Justice Usha Mehra Commission of Enquiry[1]:

1. For the purpose of Reparative Justice, the support services must be integrated for the healing and recovery of the survivor. There be State responsibility to make provisions for medical treatment, psychological care, shelter and income in order to overcome possible destitution and social ostracism.
2. The state must establish Violence against Women Assistance Cells which would be responsible for providing immediate access to quality and free medical attention, psychological counselling, legal aid and other support services as may be required by the victim. These cells should be uniformly available and accessible in urban and rural areas, in zones of peace and conflict.
3. These Cells must provide 24-hour service, including access to interpreters for disabled victims, access to translators for victims who do not speak the local language, transport facilities, access to information about legal aid, compensation schemes and so on.
4. A case worker must be provided for each victim whose case is being investigated or prosecuted. Case workers should inform the victim/survivor in an age-appropriate way about the trial, support the client and listen to her concerns. Case workers should be appointed and employed by the courts and funded through the victim and witness protection programme.

[10] Mission Shakti, Scheme Implementation guidelines, Ministry of Women & Child Development, Govt. of India https://wcd.nic.in/sites/default/files/Mission%20Shakti%20Guidelines%20-%20issued.pdf

SECTION III – Role of One Stop Centres during COVID-19

The rise in incidences of domestic violence was one of the unintended consequences of the COVID-19-induced lockdown which has been termed the shadow pandemic. Ravindran and Shah estimate that in May 2020, increase in domestic violence complaints in red zone districts was 131 per cent higher than green zone districts with fewer restrictions.[11] A submission to OHCHR observes that there were no clear-cut pandemic related advisory/protocol/directives for shelter home admissions which resulted in varied responses.[12] Most shelter homes stopped taking new admissions due to the fear of transmission, remained inactive or allowed admission only when women could produce COVID-negative test results. However, addressing a seminar on 9 April, 2020, the MWCD Minister confirmed that OSCs were functional despite lockdowns.[13] She highlighted that links to the police, NALSA, and medical authorities were maintained during this time. Despite government assurances of the OSCs being functional, ICRW notes that there is an absence of credible data in the public domain which corroborates this. Moreover, the fact that it became incredibly difficult for victims of violence to physically approach OSCs in the midst of a pandemic that put restrictions on mobility leaving them helpless and unsupported remains a bitter truth. The pandemic also challenged the emotional and mental well-being as well as the support abilities of the service providers due to the lack of employee-centric support mechanisms at OSCs. It has particularly been difficult because they are overstretched – the staff dedicate time and labour as additional tasks at OSCs often above and beyond their primary job responsibilities leading to burn-out and time constraints at the workplace.

SECTION IV: Challenges of One Stop Centres

Prior to proposing a model framework for an OSC, it is pertinent to assess the challenges that disrupts seamless efficiency of OSCs. Anecdotal evidence and media reports tell a rather grim story. This section presents the most cited challenges of OSCs and recommend measures to address them.

Challenge 1: **Underutilization of Nirbhaya Funds:** One of the most prominent criticisms have been that large amounts of money released under the Nirbhaya Fund, and earmarked for various schemes, has remained underutilized and the OSCs continue to lack adequate resources.[14] A 2021 Oxfam report which examined the budgetary allocations for services around VAW revealed that budgetary allocations for OSCs have increased between 2018 and 2021 but sees a utilization of approximately 66 per cent of the funds.[15] Therefore, the core objective of OSCs – to provide a gamut of services under one roof – have fallen short of being realized. Stories from the ground reveal that survivors of violence find it hard to access legal, medical and psychological support in OSCs.

[11] Ravindran S. & M.Shah, Unintended consequences of lockdowns: COVID-19 and the shadow pandemic, Working Paper 27562, NBES, Cambridge https://www.nber.org/system/files/working_papers/w27562/w27562.pdf

[12] COVID-19 and the increase of domestic violence against women, Submission by Aman Global Voices for Peace in the Home , https://www.ohchr.org/sites/default/files/2022-01/India-1-aman-globalvoic.docx

[13] India's Policy Response to COVID-19 and the Gendered Impact on Urban Informal Workers in Delhi NCR, ICRW https://www.icrw.org/wp-content/uploads/2022/03/6-_-Gender-Based___230222.pdf

[14] Goyal Ria, One Stop Centres: A well intentioned Scheme gone awry? 2019 https://www.lexquest.in/one-stop-centres-a-well-intentioned-scheme-gone-awry/

[15] Towards Violence Free Lives For Women: Tracking Of Union Budgets (2018-21) For Violence Services https://www.oxfamindia.org/knowledgehub/workingpaper/towards-violence-free-lives-women-tracking-union-budgets-2018-21-violence-services[16] Ibid.

Recommendation 1: There is a need for greater administrative will to ensure just expenditure of the allocated funds to provide the services that the scheme proposes, particularly medical assistance, psycho-social counselling, legal aid and shelter. There is an urgent need to make the approved OSCs functional across India. The network of functional OSCs should be expedited at the earliest.

***Challenge 2**: **Lack of Adequate Space and Safe Location for OSCs**:* Each OSC is supposed to be located within a hospital/medical premise or 2 kms from a hospital/medical facility in the district headquarters to ensure easy accessibility.[16] However, many OSCs operate out of Police Stations or the District Secretariat. The OSC scheme also outlines that the OSC within a hospital premise should have adequate accommodation with separate access having at least 5 rooms and carpet area of 132 square meter that is prominently visible and easily accessible to the women affected by violence. An examination of OSC in one of the capital's leading hospitals – AIIMS found that the OSC was situated in the emergency ward with no sign to show for it. Most of the OSCs operate out of a room and doesn't have adequate space for accommodation. In certain cases where land have been allocated for the construction of OSCs, experts have found that it has been bought far away from a hospital/medical facility in the district headquarters – contrary to the OSC guidelines - which makes easy accessibility a challenge.[17]

There is also an information gap about the location and availability of either private shelters or state-run One Stop Centers and Swadhar Grehs.

Recommendation 2: In continuum with recommendation 1, there is a need for the designated one stop centres to be established as per the rules laid down by the scheme – particularly within the 2 km radius of a medical facility in the district headquarters. Periodical monitoring of the OSCs by designated officers and the publication of accountability reports should be made mandatory to ensure that OSCs are operated according to the established guidelines.

Community based awareness programmes should be initiated under the Social Welfare Department through Anganwadi workers and community outreach volunteers to raise awareness regarding the presence of OSCs, its purpose, and the services that can be availed. The participation of youths from the community as messengers and awareness generators should be encouraged. OSC's should also collaborate and partner with local NGOs and civil-society organizations working on gender-based violence to reach a broader base of the target groups as well as to build capacity.

Challenge 3: Too Bureaucratic System: During pandemic, survivors of violence may be denied admission based on a lack of documentation. They are also stalled when government shelters ask if their arrival is police or court-mandated, even though there is no legal compulsion to seek permission from state

[16] Mission Shakti scheme implementation guidelines 2022 https://wcd.nic.in/schemes/one-stop-centre-scheme-1

[17] Naraharisetty R., How India's infrastructure is ill equipped to help domestic violence survivors escape their marital homes, 2021 https://theswaddle.com/how-indias-infrastructure-is-ill-equipped-to-help-domestic-violence-survivors-escape-their-marital-homes/

authorities before approaching a shelter home. The bureaucratic processes in accessing any support or justice system makes such permissions next to impossible.

Recommendation 3: OSCs should adopt a survivor-centered approach of working. A survivor-centred approach places the human rights, needs and wishes of women and girl survivors at the centre of service delivery. 18 This approach ensures that the environment is conducive to a survivor's recovery. It could mean the immediate prioritization of a survivor's physical and mental well-being at the first point-of-contact above documentation and bureaucratic processes.

Challenge 4: OSCs Lack Trauma- and Violence-informed Support and Care: OSCs also lack trauma- and violence-informed support and care. The Human Rights Watch (HRW) reports that survivors, particularly from marginalized communities, find it difficult to register police complaints.[19] They often suffer humiliation at police stations and hospitals, are still subjected to degrading tests by medical professionals, and feel intimidated and scared when the case reaches the courts. The Domestic Violence Act also mandates state-appointed Protection Officers for every district, whose job it is to respond to women in distress with adequate resources and information. But several of these positions across districts in the country remain vacant, and the ones that are not are sometimes occupied by people without the right training.

Recommendation 4: There is an urgent need to address and eradicate harmful knowledge, attitude and behaviour of support staff. It can be done through rigorous compulsory training of staff at all levels across all services on trauma informed care and OSC operations. OSCs should adopt mechanisms for sustainable knowledge acquisition such as follow-up trainings and evaluation of trainings. The open positions for Protection Officers should be duly filled through the intake of trauma-informed professionals.

[18] Safe consultations with survivors of violence against women and girls, 2022 https://www.unwomen.org/en/digital-library/publications/2022/12/safe-consultations-with-survivors-of-violence-against-women-and girls#:~:text=One%20of%20the%20principles%20underpinning,the%20centre%20of%20service%20delivery.

[19] "Everyone blames me" Barriers to justice and support services for sexual survivors in India, 2017 https://www.hrw.org/report/2017/11/08/everyone-blames-me/barriers-justice-and-support-services-sexual-assault-survivors

Challenge 5: Non-child friendly and challenges in long-term stays: Under the OSC guidelines, the centers can't accommodate boys who are more than 8 years of age with their mothers for temporary shelter. Similarly, he guidelines for Swadher Grehs – where survivors of violence can be moved to from OSCs for a longer stay – has laid down that boys beyond 12 years of age cannot stay in the homes. ICRW notes that such guidelines can create a situation where mothers of young boys will not be able to access these homes for fear of being separated from their children.[20]

Logar and Mustafa write, "This is a form of discrimination and might convey the unintended message that boys are not children but already "dangerous young men".[21]

Recommendation 5: Safety and accommodation of their children is another important aspect that needs to be taken into account while designing environments for survivors of violence.[26] The OSC's should have day-care that can accommodate a wide variety of children's ages and needs. Short-term and long-term residents should be allowed to bring their children who may be in danger. It should accommodate the needs of all female and male children up to the age of eighteen by providing children's counseling and support services. The OSC staff should be trained in child-sensitive and child-friendly interventions.

Challenge 6: Lack of Awareness: There is limited information among the women and people about the existence of the One Stop Centres. The information is provided in the limited capacity due to not enough scope for covering interior places or limitation of OSCs to be present in all the places. The absence on information also delays survivor's access to support especially young women and children. Another challenge that occurs is not having enough number of human resources at the OSCs the outreach activities face challenges. There are times that irrespective of awareness, the distance is a lot to access the OSC or there is no transportation that can reach out to the survivor without causing delay.

Recommendation 6: To ensure awareness among community, the geographic area must be identified in the beginning and over a certain period of time all regions can be covered. Though there is one round of awareness is done but this is required on a regular basis to give reminders and inform new people. Further, the number of workers in the centre are unstable; the priority should be to have appropriate number of people appointed that does not impact awareness activities ensuring people are informed. If there are other challenges, they should be addressed by the government department and/or the implementing organization to find a feasible solution. For the purpose of ensuring transportation access, a vehicle along with the driver should be available.

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20 India's Policy Response to COVID-19 and the Gendered Impact on Urban Informal Workers in Delhi NCR, ICRW https://www.icrw.org/wp-content/uploads/2022/03/6-_-Gender-Based___230222.pdf

21 Logar R. & Ariana Q. Mustafa, Quality guidelines for quality shelters for victims of violence against women and domestic violence, Council of Europe, 2021 https://rm.coe.int/shelter-guideline-eng/1680a24ced

SECTION V: Functional approach of model One Stop Centres

Acknowledging the challenges inherent in current OSCs which risks further harm to survivors of violence this section proposes two functional approaches for the model OSCs.

The overarching approach of the model framework will be survivor-centred. UNICEF construes survivor-centred approach as establishing a relationship with the survivor that promotes their emotional and physical safety, builds trust and helps them to restore some control over their life. It enlists four principles through which this approach can be applied[22]:

i. **Confidentiality:** includes gathering information only on a need-to-know basis or in line with laws and policies, storing any information about the survivor securely and obtaining informed and voluntary consent from the survivor before sharing any information, including in the context of a referral. There could be valid exceptions to confidentiality and those should be made known to the survivors before any information is sought from them.

ii. **Safety:** includes both physical safety and security as well as psychological and emotional safety. It considers the safety needs of survivors, their supporters and providers of care.

iii. **Respect:** Service providers should have a validating, non-judgmental and non-blaming approach, caring about the experience, history and future of the survivors and allowing survivors make their own decisions about care and ensuring that this is valued and upheld.

iv. **Non-discrimination:** indicates that all women have an equal right to the best possible assistance without unfair discrimination on the basis of their gender, disability, ethnicity or tribe, language, religious or political beliefs and status or social class, etc. The target group for the current OSC models are cis-gendered women. As such, the model OSC will cater to the LGBTQI and the gender-non-conforming needs thereby eliminating the risks of exclusion, discrimination or re-victimization.

Another approach has been developed by the UN Women in the form of the Essential Services Package in 2015, which was launched in 2015. It reflects the vital components of coordinated multi-sectoral responses for women and girls who have experienced violence. 23.

The Essential Services Package (ESP) has overlapping principles that underpin the delivery of all essential services and coordination of those services. Those principles include:

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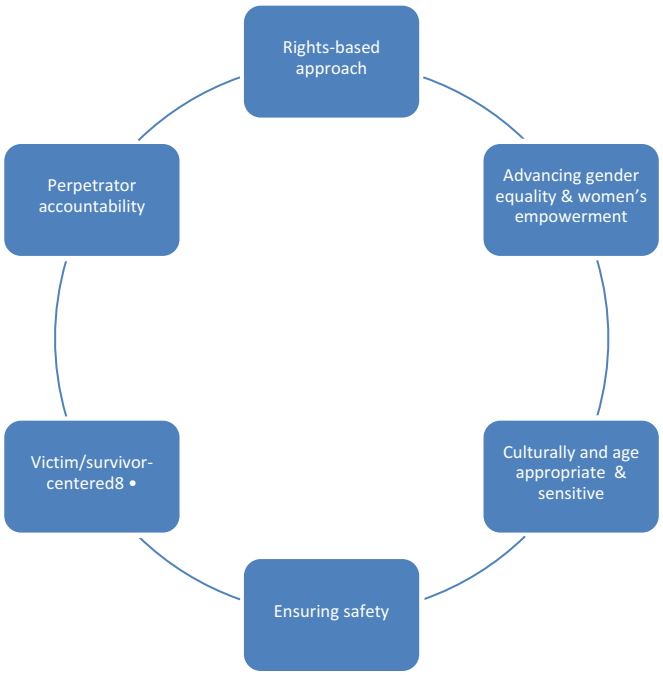
22 Caring for survivors,: A principled approach, UNICEF
https://www.unicef.org/eca/media/15831/file/Module%202.pdf

23 Safe Consultations with survivors of violence against women and girls, UN Women, et al., 2022
https://www.unwomen.org/sites/default/files/2022-12/Safe-consultations-with-survivors-of-violence-against-women-and-girls-en.pdf



In The Essential Services Package (ESP), the provision, coordination and governance of essential health, police, justice and social services can significantly mitigate the consequences that violence has on the well-being, health and safety of women and girls' lives, assist in the recovery and empowerment of women, and stop violence from reoccurring.

SECTION VI: Framework of model One Stop Centres

This section draws from the works of Olson, Moreno and Colombini who examined the effectiveness of implementation and effectiveness of the one stop centre model in low- and middle-income countries including India, to propose a model of OSC.[24] The core objective of the model OSC will be to provide holistic care to survivors of violence without causing further distress.

➢ Location

- The OSC will be situated in the district level public healthcare/hospital facility.
- It will be based in an accessible place with wide doors and ramp if a survivor with physical disability visits the centre.
- The OCS will be preferably on the ground floor in the close vicinity of the emergency room for medical officers and nurses to be available at all hours.
- There will be sign boards in and around the hospital to denote the location of the OSC.

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24 Olson Rose K., Moreno C.G., Colombini M., 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 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170420/

➢ Resources and service delivery

- The OSC will be functional at all hours.
- In terms of infrastructure, OSC will be mandatorily equipped with private rooms to accommodate at least 5 survivors at a time for a short-term and private consultation spaces for survivors. It will have a waiting room, a running kitchen and a clean restroom. The OSC will have sufficient basic medical supplies, facility equipment and survivor comfort items such as clean clothes and sanitary pads. It will have child-friendly spaces for children and adolescents.
- The OSC will house a network of multispectral services such as legal, police, counselling, housing and information booklet on jurisdiction wise contact of Protection Officers, Child Welfare Committees, Police Stations and Shelter Homes by ensuring the presence of staff from the respective services. The roles and responsibilities of each partner will be clearly defined.
- The OSC will have a trauma- and violence- informed team of case workers. To ensure a seamless delivery of services, each survivor will be assigned a case worker to provide information, advice and direct support besides the guidance through the administrative processes.
- The survivors of violence and their children should have the right to stay in the OSCs shelter as long as they need. The OSC staff and survivor will jointly discuss, what kind of support they need and for how long. The survivor's say will be respected and upheld.
- All children, girls upto 18 years and boys up to 14 years, will be allowed to access OSCs shelter. They should get age-appropriate counselling and support when residing in the OSCs or in long-term stays.
- The OSC will have strong documentation and updated data management systems with confidentiality clauses. There would be clear protocols in place to guide the documentation process. The case worker will maintain appropriate case management records through service management information systems and assist in the provision of regular written case studies/reports to the management.
- Health services provided in the OSC are free of cost as per the Criminal Amendment Act 2013. In 2014, the Ministry of Health and Family Welfare issued guidelines for medico-legal care for the survivors of sexual violence. It eliminated the notorious two-finger test. The OSC will ensure that clinical care protocols as per the guidelines, is applied and implemented by the hospitals. The health staff will share information and familiarize survivors with the medical procedures and provide additional health information such as the risk of STI, HIV and pregnancy after sexual assault.
- The OSC will have follow-up services for medical interventions that require repeated visits, referrals or long-term counselling.

➢ Workforce and development

- The OSC will encourage multisector collaboration among the police, legal and medical services, long-term shelters and relevant NGOs through inter-agency update and information sharing meetings. There will be clarity of roles and responsibilities for each sector to minimize risks of confusion among staff on who and how services should be delivered. Day-to-day coordination will be done by the District Programme Officer/Protection Officer appointed under Protection of Women from Domestic Violence Act, 2005.
- The OSC will be adequately staffed after fair and transparent staff recruitment to provide essential services and ensure the presence of female staff such as female police officers and female doctors. The presence of human resource as per the requirement of the OSC will reduce time constraints and burn-out of the staff and shorten the waiting time of those seeking support.
- The OSC staff will have adequate knowledge of services available at the facility. There will also be mandatory

counselling sessions for service providers to ensure their mental and emotional well-being.

- There will be systematic and ongoing gender-sensitive trainings for all staff from all sectors on caring for survivors and encouraging sensitive staff attitudes and behaviors. The curriculum will include awareness of applicable human rights standards and norms; the causes, nature and extent of violence; challenging myths around SGBV; the effects of violence on survivors; and the intersecting needs of survivors.[25]

➢ Funding Support

- The support will cover cost of human resource for effective personal interactions especially with the Counsellor and Case Workers who support women directly at the OSC. The entire team will be the paid staff for sustainability and effective service delivery.
- Funds will be provided for a holistic and fulfilling support to OSC through allocation for regular services like washrooms, shelter facility along with bedding and season specific needs, kitchen, cleaning, clean drinking water, care of the children of woman living or coming to the shelter.

- A dedicated vehicle for OSC will be provided for emergency rescues, late night operations and outreach activities.
- A contingency fund will be provisioned to meet unexpected/unplanned expenses to prevent staff to spend money from their own pockets.

➢ Convergence with Essential Services

- The whole idea behind OSCs is to provide all the services for the woman approaching at the centre itself. Proper guidelines and processes will be established for convergence among departments and service provides including police, healthcare workers, shelter homes and legal advisor etc. to facilitate an institutional convergent response and action.
- Institutional linkages with services like psychiatric care, healthcare providers, government departments of women & child and Mission Poshan Abhiyan will be established for ease of receiving compensation, medical reports, rations, financial support etc.
- Proper guidelines will be established for sharing of resources and facilities with NGOs and other agencies.

SECTION VII: Monitoring and Evaluation

The UN defines monitoring as "the regular and systematic assessment of performance, allowing an understanding of where programmes are in relation to planned results, and enabling the identification of issues requiring decision-making to accelerate progress."[26]

[25] https://www.ohchr.org/sites/default/files/Documents/Publications/PractitionerToolkit/WA2J_Module3.pdf

2 6 https://unsdg.un.org/sites/default/files/UNDG-UNDAF-Companion-Pieces-6-Monitoring-And-Evaluation.pdf
It would be unhealthy to have computer operator or security personnel either to be less paid while their services covers the basic requirements of safety and confidentiality of the woman approaching the centre.
Mission Poshan Abhiyan – for prevention and to reduce Stunting in children and the prevalence of anemia among women and Adolescent Girls in the age group of 15-49 years

On the other hand, they define evaluation as "a systematic and impartial assessment of a policy, programme, strategy or other intervention, to determine its relevance, efficiency, effectiveness, impact and sustainability to support decision-making."[27] Monitoring is ideally undertaken in real-time and feeds into evaluation. UN also incorporates principles of gender equality, women's rights and the empowerment of women. Monitoring and evaluation (M&E) should inform the planning, programme, budgeting, implementation and reporting cycle to improve the institutional relevance and the achievement of results.[28]

- ***Relevance of Monitoring and Evaluation for Effective Functioning of OSCs***

India has a credible evidence base on the proportion of women experiencing various forms of abuse but there is a dearth of evidence on what kinds of strategies are effective in preventing such violence and offering adequate support to victims and survivors. As such, M&E is the only way to assess intervention programmes to gain information on effectiveness and quality of the responses at the service provider, community, and the national levels. M&E will help identify exactly when a programme is on track and when changes are needed. Collecting data and presenting the impact of efforts to prevent violence against women can also be a powerful way to increase political will, support and resources to end such violence.[28] An M&E guide by UN and Path writes, "For initiatives addressing violence against women, monitoring and evaluation is more than a costing or cost-effectiveness exercise. It is a way of ensuring women and girls are able to live their lives free from violence and abuse." [29] It is further important to acknowledge that the process of monitoring is also an aspect of learning where the appropriate methodology be adopted to inquire the gaps. They are extremely relevant when decades old system is applied with the changing laws, unexpected challenges and difference in training needs of the implementers to name a few. Typically, there has to be an internal analysis tool used as a broader analysis tool used as part of decision making towards achievement of the objectives. In the beginning, the evaluation be performed not less once in a quarter since the strategies may require change with change in circumstances.

[27] https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2015/UN-Women-Evaluation-Handbook-en.pdf

[28] Guidance on Monitoring and Evaluation for Programming on Violence against Women and Girls, Guidance Note 3, DFID, 2012 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-

29 RESPECT Women, RESPECT Framework Monitoring and Evaluation (M&E) Guidance, UN Women & WHO, 2020_ https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Monitoring-and-evaluation-guidance-en.pdf

3-monitoring-eval.pdf

The year 2021 saw a 15 per cent increase in crimes against women, reported the National Crime Investigation Bureau. 31.8 per cent of the total cases fell under the "Cruelty by husband or his relatives'' category. The data testifies that violence against women is endemic in India posing as a social and public health challenge which deserves the collective attention and action. Of particular importance is the state's responsibility to exercise due diligence in prevention, protection, prosecution, punishment and provision of adequate redress and establish sustainable and effective interventions while prioritizing the needs of the women affected by violence.[30] The establishment of OSCs by the Government of India can be viewed as an effort to meet that responsibility.

There has been an increasing recognition that women affected by violence have multiple needs which requires the supportive intervention of multiple sectors. As such, multi-sector collaborations that integrate health, legal and psychosocial support services are acknowledged as a best practice intervention. The OSC scheme in India adopts this best practice to facilitate immediate, emergency and non-emergency access to a range of services including medical, legal, psychological and counselling support under one roof to fight against any forms of violence against women. The significance that OSCs play in the lives of those affected by violence became particularly visible during the pandemic when the centres became inaccessible to women. They were either inactive, not admitting newer women irrespective of their COVID-19 status or were admitting women with COVID-negative test reports only. This robbed the women from their chance at escaping violence at home and the only safe space available to them. Therefore, the pandemic reinforced the need for round-the-clock support services for women affected by violence and the role of OSCs in providing such services.

While the first OSC model names Dilaasa was introduced and became functional, monitoring and evaluation process took place in 2010. The evaluation began with looking at its objectives and relevant components where the process went into navigating how the centre is running towards achievement of the objectives, whether the relevant components are included and to what extent efforts are made to achieve expected outcomes. Outcomes are the guiding tools; though the intention is to achieve the outcomes the connection between objectives, components and outcomes is important. All the service providers were interviewed, counseling sessions were supervised, the regularity and themes of training were assessed. Along with that response from government stakeholders including protection officers, hospitals, police were also part of assessing the government focused support 31.

30 Crime against women rose by 15.3% in 2021: NCRB, 2022, https://indianexpress.com/article/india/crime-against women-rose-by-15-3-in-2021-ncrb-8

31 Ravindran T.K. Sundari & Vindhya U., Dilaasa Evaluation report, 2010, https://www.cehat.org/uploads/files/Dilaasa%20evaluation%20report%202010.pdf

- ***Pre-requisites for a well-functioning M&E of the OSCs***

The monitoring and evaluation of OSCs should be undertaken in line with the below guidelines:

- **A separate budget:** The OSC should have a dedicated budget to gather high quality data and integrate M&E design from the very start. DFID's evaluation guidance indicates that an estimate of 1% to 5% of programme expenditure can reasonably be spent on the M&E element of any intervention, depending on the complexity of the project or programme.[32]
- **District Task Force:** The OSC should be overlooked by a task force as an immediate governing body responsible to ensure that the OSC maintains a decided standard of service delivery. The task force will not however intervene in the functioning of the OSC. The District Collector/District Magistrate (DM) should be the Chairperson responsible for oversight, monitoring, coordinating review and course correction of OSCs in the district. There should be regular monitoring of OSCs with mandatory reporting of cases while maintaining the confidentiality to the committee.
- **Integrated Evaluation Team:** The District Task Force should have a dedicated evaluation team (ET) to oversee the monitoring and evaluation from the start. It is important to select evaluators who are experienced in the field of GBV interventions, and are familiar with both qualitative and quantitative methods taking a holistic approach. Ideally at least one team member should have experience in VAWG intervention with firm knowledge of the ethical issues. The Centre Administrator (CA) of the district OSC should be a part of the evaluation team and act as a point of contact/representative of the OSC. A major part of CA's work is to ensure that all related documentation is shared with primary evaluator for an effective assessment. Since CA is also a responsible person for running the OSC, the ethical code of conduct to prevent any biasness should be clarified for CA before beginning the evaluation.
- **Patterns of existing GBV:** The OSC staff should be trained for proper and methodical documentation of cases. This should be analyzed to identify local trends of violence and also identify the effective and efficient violence prevention interventions that can be brought to scale.
- **Categorization of OSC:** The OSCs should be categorized based on cases received and the capacity of the OSC, including how survivors are provided sensitive, effective and information & knowledge based care and support.
- **Contextual methodology:** Methods and tools that maximise active participation and are appropriate to the local context, including the socio-cultural, economic and political context, language and literacy levels should be used. The methodology could be both quantitative and qualitative in nature while method of sampling should be deliberated for adequate results and findings.
- **Ethical Conduct:** The M&E approach should be such that it protects privacy, confidentiality and physical and emotional safety of the women involved and integrate analysis of gender and power relations.

Based on pre-requisites on functioning of OSCs, suitable indicators should be devised on the fundamentals of output, outcome and impact of SAKHI-OSCs functioning. These indicators would create a robust monitoring and evaluation framework that will be practical and replicable to assess the functioning of OSCs across geographies and local eco-systems.

[32] Guidance on Evaluation and Review for DFID staff , 2005
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-3-monitoring-eval.pdf

Annexures

Annexure – I

One Stop Centres in other parts of the world

Name of Response	Originating Country	Originating Sector	Description	Primary Aims
One Stop Centres/ Shops	Originating in Malaysia now in several countries in South Asia and Africa	Usually located in health facilities	One-Stop Centers provide multi-sectoral case management for survivors, including health, welfare, counselling, and legal services in one location. They are linked to police through referral pathways. These crisis centres are typically located in health facilities, including the emergency departments of hospitals, or as stand-alone facilities near a collaborating hospital. These centres can be staffed with specialists 24 hours or can maintain a core group of staff with specialists on call.	1. Make reporting easier for victims 2. Make medical examination easier for victims 3. Coordinate investigation and support services.

[39] https://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html

Rape Crisis Centres	Various	Typically a community-based NGO	These centres are usually NGO-run facilities that provide support to victims (e.g., counselling, telephone helpline) and information about the legal system. Staff and volunteers often participate in multi-disciplinary response to sexual assault such as one-stop shops, SARC, or SART. They may also assist victims during forensic examination or when reporting to police.	1. Assist and support victim 2. Provide information and counselling to victim
Centres Against Sexual Assault (CASA)	Australia	NGO Sector, now linked to multi-sectoral services with autonomy	CASAs provide support to victims (counselling, telephone helpline) and legal information. CASA staff members participate in multi-disciplinary response to sexual assault and in community and professional education. They seek to inform government policy, advocate for law reform, and facilitate research.	Integrate responsesto sexual assault
Sexual Assault Nurse Examiner Programs (SANE)	USA	Health sector	The nurses are specially trainedin examining victims, collecting forensic evidence, and victim care. SANEs not only conduct the forensic examination, they also provide medical care such as pregnancy prevention, STD testing, and referral to counselling. Typically, SANEs are part of a team response to sexual assault	1. Improve collection of forensic evidence 2. Make medical examination easier for victims 3. Provide medical care to victims

			but they also work as specialist nurses in general emergency wards.	
Project Saphire	England	Security/ Police	Project Sapphire was initiated in 2001. It consists of dedicated sexualoffences investigation teams--officers trained in first-response to sexual assault and an inspector whose only duty is the investigation of serious sexual offences. A male or female "chaperone" officer contacts the victim within one hour of reporting. The chaperone is not involved in the investigation but offers support to the victim, organizes the medical examination, contacts support groups, and friends and relatives, and organizes protection for the victim if required. The chaperone is also responsible for keeping the victim informed of the development of the case. An officer is available 24 hours a day. All front desk staff are trained in speaking and responding to victims.	1. Make reporting easier for victims 2. Provide better victim care 3. Improve quality of investigation
Sexual Assault and Child Abuse Team (SACAT)	Australia	Security/ Police	Established in 1988, SACAT is a specialist police unit for sexual assault of adults and children. It aims to minimize further trauma for victims and to increase their confidence to participate in the legal	1. Make reporting easier for victims 2. Improve quality of investigation

			process. Staff members are specially trained in dealing sensitively with victims. Initially located in its own premises, SACAT is now within a suburban police station, which also houses other specialist units. It provides an integrated environment for victims, including a medical suite, bedroom, lounge room, play area for child victims, and an interview room with video-recording facilities. A Sexual Assault Victim Liaison Officer maintains contact with victims, informing them of developments in their case. SACAT detectives receive special training in investigating sexual assault.	
Victim Support Units	Zambia	Security/ Police	Established in 1994, this Unit leads work on gender-based violence. It provides victims with counselling and support in additionto dealing with perpetrators. The units became fully operational in 1998 with presence in every province of the country today.	
Victim Protection Units	East Timor	Security/ Police	These units take complaints and have authority to investigate cases such as rape, attempted rape, domestic violence, child abuse, child neglect,	

			missing persons, paternity and sexual harassment. The Units were established with UN support in 2000 and are found in each of the13 provinces.	

Annexure – II

The Gauravi Model: The support process for survivors

Source: https://shura.shu.ac.uk/28877/1/Research%20Report_Bhopal.pdf