REGIONAL STUDY ON THE IMPLEMENTATION OF A HOLISTIC APPROACH TO CARE FOR VICTIMS AND SURVIVORS OF SEXUAL AND GENDER-BASED VIOLENCE (SGBV) IN ICGLR MEMBER STATES

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dr. Denis Mukwege Foundation

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At the heart of the report are survivors from the Great Lakes Region who contributed their time, perspectives, and recommendations. This report would not have been possible, nor would it have been meaningful without them.

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To operationalise Article 6(9) of the Protocol on the Prevention and Suppression of Sexual Violence Against Women and Children, in February 2014, the ICGLR Regional Training Facility (RTF) was launched. The RTF, based in Kampala, Uganda, provides training for judicial officers, police officers, medical officers, social workers, attorneys and prosecutors on handling SGBV cases and related issues. To date, the RTF has recruited 169 trainers across the 12 ICGLR Member States (MS), including 8 Master Trainers and 161 National Trainers to support implementation of the RTF mandate in the MS. This structure has been instrumental in supporting the development and implementation of the socio-ecological training model in MS and has so far been used to train over 500 professionals on the prevention and management of SGBV cases. The Master Trainers' roles include conducting formative research, developing training curricula, training the National Trainers and monitoring their utilisation of knowledge. On the other hand, the National Trainers are charged with refining general training curricula and course materials, customising the materials to national realities and needs, and cascading training to professionals at the respective national levels.

The **Dr. Denis Mukwege Foundation** is an international human rights organisation, set up in 2016. It supports survivors' demands for a world where sexual violence as a weapon of war is no longer tolerated, and bears consequences for individual perpetrators and states. It works for a future where survivors receive the holistic care and compensation they need to rebuild their lives. It creates opportunities for survivors to speak out and be heard, and where they can organise to create change, influence policies, and demand justice and accountability.

We work closely with Dr. Mukwege's Panzi Hospital and Foundation to transfer and roll out the holistic model of care pioneered at Panzi DRC in other fragile and conflict-affected settings, and to advocate for its adoption as a human rights standard globally. At the global level, we advocate to end impunity, break the silence, and to make the voices of survivors heard. We work with governments and international organisations to strengthen the international norms prohibiting sexual violence.

Panzi Hospital & Panzi Foundation DRC were established in 1999 and 2008 respectively, in Bukavu, Democratic Republic of Congo (DRC) by Dr. Denis Mukwege to provide high quality, specialist reproductive health care services to local populations. Panzi's staff have since accrued extensive experience providing holistic care for tens of thousands of survivors of sexual violence. Recognised as a centre of excellence in providing holistic care to survivors of sexual violence, and particularly survivors of conflict-related sexual violence, Panzi has developed a comprehensive, integrated model of care at Panzi Hospital and Foundation, as well as in rural and urban clinics established in different parts of the DRC, and a mobile clinic to serve remote and vulnerable populations. Panzi implements this holistic model through a **One-Stop Centre approach**. While there are many interpretations of holistic assistance around the world, in the Great Lakes Region, the "Panzi One-Stop Centre model" provides an important case-study for the implementation of holistic care services to survivors of conflict-related sexual violence in a variety of settings.

The Panzi model is particularly unique in its integration of services into a general service provision framework. Practically speaking, this means that services for survivors of sexual violence are integrated into hospitals and local clinics, so that they can receive care alongside other patients suffering from conditions ranging from malaria to obstetric-related gynaecological conditions. This limits risks for the stigmatisation of victims and means that survivors are able to access a wider range of services within the same facility. This integration of **holistic One-Stop Centre care** into an existing system lowers the threshold for victims needing to access a range of services and helps to ensure the sustainability of care for survivors of sexual violence during and after periods of conflict.

INTRODUCTION

TO THE STUDY

On December 15-16, 2011, Member States of the International Conference on the Great Lakes Region (ICGLR) signed the Kampala Declaration, thereby committing to support victims/survivors of Sexual and Gender-Based Violence (SGBV). The Declaration is categorised 'into three sections - dedicated' to Prevention of SGBV; Ending impunity for SGBV; and providing support to the Victims and Survivors of SGBV. This study will majorly focus on category three, that emphasises provision of support to survivors of SGBV and will analyse the three articles, 10, 11 and 12,[1] that emphasise fast tracking of the reconstruction fund, establishment and scaling up of the recovery centres, and establishment and strengthening of income generating activities. Along with other instruments, the Kampala Declaration underlines the centrality and urgency that ICGLR Member States accord to addressing SGBV.

The United Nations Security Council has recognised conflict-related sexual violence as one of the threats to international peace and security (Kirby, 2015; Aroussi, 2011). Resolutions 1325 (2000); 1820 (2008); 1888 (2009); 1960 (2010) were issued by the Security Council to end sexual violence during armed conflict as part of the UN Women, Peace and Security Agenda (Amisi et al., 2018). Conflict-related sexual violence has several devastating consequences for survivors and their communities (Mukwege and Nangini, 2009; Alexandre et al., 2021). This phenomenon can lead to several forms of sexually transmitted diseases and other various gynaecological pathologies, such as fistula and infertility (see Mukwege and Nangini, 2009; Jina and Thomas, 2013). Anxiety, depression and post-traumatic stress disorder (PTSD) are often psychological symptoms associated with sexual violence (Jina and Thomas, 2013). In addition, survivors of sexual violence often face social exclusion and post-abuse stigma (Alexandre and Moke, 2021).

Several studies show that there is a correlation between gender inequality between women and men and sexual violence in times of peace, as well as in times of armed conflict (see Davies & True, 2017). Conflict-related sexual violence cannot, therefore, be dissociated from other forms of gender-based violence. They are exacerbated by the lack of access to both material and intangible resources, such as limited access to education, employment, low representation of women in decision-making bodies, etc. Some studies show that the degree of gender inequality during the peace period is a contributing factor to the upsurge in sexual violence during the period of armed conflict (see Leaterman, 2011).

The fight against SGBV in all its forms and access to care for survivors are among the priorities of the member countries of the International Conference on the Great Lakes Region (ICGLR), as part of their respective and collective commitments for the restoration of peace and security in the region. Despite these commitments and the agreed timeframe for their realisation, over a decade since the Kampala Declaration's adoption, there has been slow and uneven progress in rolling out comprehensive One-Stop Centres in the region.

In a critical effort to improve the provision of holistic care for survivors of SGBV from a right to health perspective, the Panzi and Mukwege Foundations along with the International Conference on the Great Lakes Region Regional Training Facility (ICGLR-RTF) have developed an innovative collaboration supported by funding from GIZ. Within this collaboration, partners are committed, among other things, to undertake evidence-based advocacy to ensure that ICGLR Member States respect their commitments to provide quality holistic care to survivors. As such, the Mukwege Foundation (MF) commissioned this study on the implementation of the holistic care model approach for survivors of SGBV in the Great Lakes region.

1 Article 10 calls for "fast-track the contribution to the ICGLR Special Fund for reconstruction and development so that assistance to victims/survivors is provided in line with Article 6 (8) of the ICGLR Protocol (2006)."

Article 11 of the same Declaration emphasises "Fast track the establishment and scaleup " Recovery Centers" that provide comprehensive services for free medical, psychosocial, forensic, judicial/prosecution services within the next two years of the Summit and special sessions on SGBV. Such centers should be user friendly particularly to women, youth, children, persons with disabilities and men."

Article 12 directs the relevant ministries and public agencies to establish and strengthen income generating programmes and initiatives to support women, especially those in cross boarder trade areas targeting survivors of SGBV.

Background

ICGLR Member States have made addressing SGBV a central objective in the region. This commitment has been elaborated in the Pact on Security, Stability and Development in the Great Lakes Region (2006), Protocol on the Prevention and Suppression of Sexual Violence Against Women and Children (2006), and Kampala Declaration (2011).[2] The provisions of the Kampala Declaration are divided into four sections, namely: prevention of SGBV (Articles 1-6), ending impunity (Articles 7-9), providing support to victims/survivors (Articles 10-12), and the general resolution (Articles 13-19). In Article 11 of the Kampala Declaration, Member States committed to "[f]ast track the establishment and scale up of 'Recovery Centres' that provide comprehensive services of free medical, psychosocial, forensic, judicial/prosecution services within the next two years of this Summit and Special Session on SGBV". Article 11 of the Declaration further provided that Member States would create a "special fund" to provide assistance to victims/survivors. However, the roll-out of recovery centres has been uneven across the region. Although some assessments of the status of implementation of the Kampala Declaration have been conducted,3 to date, no specific comprehensive assessment has been conducted on the implementation of recovery centre engagements.

In a 2012 policy brief, Ndinga-Muvuma[4] suggested that the Kampala Declaration's time-frames were "unrealistic", and it was trying to do too much, too quickly. Twelve years since the Declaration was signed, what progress have Member States made, where are the gaps, who are key actors, what are survivors' views, and how can implementation truly be fast-tracked? These are the main questions the study seeks to answer.

Objectives

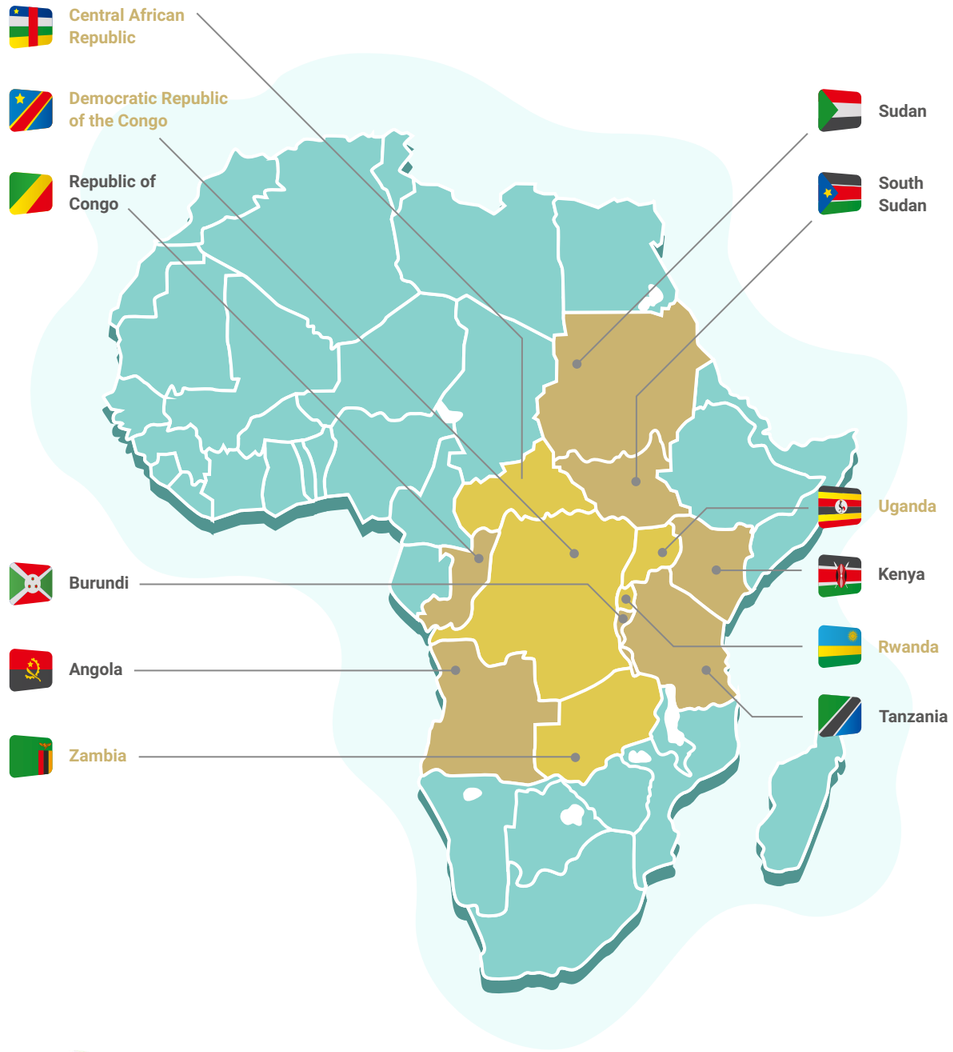
The main objective of the study is to assess the implementation of holistic care (particularly through One-Stop Centres for survivors of SGBV by the 12 ICGLR Member States, with a focus on Burundi, Central African Republic (CAR, Democratic Republic of the Congo (DRC, Rwanda, Uganda, and Zambia. This study will contribute to the evidence base for survivor-centred advocacy to enhance survivors' access to quality holistic assistance in the Great Lakes region.

2 See also: Protocol on the Prevention and Punishment of the Crime of Genocide, War Crimes and Crimes against Humanity and all Forms of Discrimination (2006), Protocol on Democracy and Good Governance (2006), Protocol on the Protection and Assistance to Internally Displaced Persons (2006), and Protocol on Non-Aggression and Mutual Defence in the Great Lakes Region (2006).

3 These include assessments conducted by COCAFEM/GL and the former Isis WICCE in partnership with Akina Mama wa Afrika, and the ICGLR-RTF in partnership with UN Women.

4 Angela Ndinga-Muvumba, "Preventing and Punishing Sexual Violence: The Work of the International Conference of the Great Lakes Region," Policy & Practice Brief, 2012, 1, https://www.accord.org.za/ publication/preventing-punishing-sexual-violence/.

International Conference of Great Lakes Region (ICGLR) Member States



ICGLR Member States

Pilot states focused on in the research

Understanding One-Stop Centres and Holistic Care

The study uses a working definition of holistic care **as care, which incorporates medical, psychological, legal[5], and socio-economic pillars.**[6] Taking this a step further, one-stop centre holistic care is defined as care, in which all four pillars are incorporated under one roof or within a "single system".[7] Even if services are not available in one location, they "coordinate, collaborate, and depend on one another to provide care within a single system".[8] One-stop Centre holistic care reduces re-traumatisation and spares the victim/survivor from having to travel between multiple locations and to recount their story multiple times.[9] While holistic care can most effectively be provided through a One-Stop Centre, which is otherwise referred to in the Kampala Declaration as a "recovery centre", not all so-called "One-Stop Centres" provide holistic care. Rather, some One-Stop Centres do not offer all four pillars of care or do not do so under one roof or within one system. The study's focus on holistic care is based on understandings and prioritisation of such care as articulated by survivors who participated in the research.

5 The legal pillar includes investigation, as well as prosecution of SGBV crimes.

6 Denis Mukwege and Marie Berg, "A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care," PLoS Medicine 13, no. 10 (2016): 13, https://doi.org/10.1371/journal.pmed.1002156.

7 Hôpital GR de Panzi, Panzi Foundation DRC, and Dr. Denis Mukwege Foundation, "Handbook: Holistic Care for Survivors of Sexual Violence in Conflict," 11.

8 Hôpital GR de Panzi, Panzi Foundation DRC, and Dr. Denis Mukwege Foundation, 11.

9 Hôpital GR de Panzi, Panzi Foundation DRC, and Dr. Denis Mukwege Foundation, 12.

Methodology and Scope

This study was conducted by a team of consultants - the regional consultant focusing at the regional level questions and the ICART[10] team ensuring the study takes into account survivors' perspectives on holistic care. The methodology of the studies was qualitative, and the research process was survivor informed.

As part of the Inception Phase of the study, MF team members conducted an in-person focus group discussion (FGD) on 12 October 2021 with six Francophone survivors from three countries based on a protocol and questionnaire developed by the regional consultant in collaboration with the MF team.[11] The FGD sought the survivors' perspectives on the state of delivery of holistic care based on their experiences and that of other survivors, their recommendations for the improvement of care across the region, as well as their ideas on how the study should be conducted. The survivors were given an opportunity to review a draft of their recommendations as compiled by the regional consultant. Their insights and recommendations were incorporated into this report and quotes from the FGD and subsequent interviews are shared throughout the report.

The study involved desk research and virtual and/or phone interviews with 49 key informants at the local, national, and regional levels (See Table 1). Desk research reviewed governmental, ICGLR, academic, non-governmental organisation (NGO), and One-Stop Centre reports and evaluations, research studies, as well as relevant broader literature on the implementation of ICGLR commitments by Member States. In addition to interviews with partners conducted during the Inception Phase, data was collected between 2 November 2021 and 18 January 2022[12] through semi-structured interviews. Key informants included 19 survivors, an ICGLR National Coordinator, RTF National Trainers, One-Stop Centres and other SGBV service providers, NGOs and coalitions working on SGBV, as well as donors and multilateral actors. Although there was only one interview with a National Coordinator, national gender experts provided input into the study during the "Regional Roundtable Meeting on Prevention of Sexual and Gender Based Violence (SGBV) Holistic Care for Victims and Survivors of SGBV in ICGLR Member States" held in Kampala on 27 and 28 January 2022.

The research team also had a specific focus on ensuring that the study remained survivor informed. Survivors were identified through the snowball method and through contacts with local organisations that support survivors, as well as through networks of survivors in the Great Lakes region. The interviews were conducted in Swahili, French, English and other local languages according to the language preference of the survivors, including Lingala, Kinyarwanda, Acholi, Kirundi etc. The ICART team are originally from the Great Lakes region and managed to conduct interviews in several vernacular languages of the region. When a language barrier emerged, translation was often facilitated by available and willing psychosocial assistants, who worked directly with survivors.

While the regional consultant conducted a few interviews with survivors, most interviews were conducted by both ICART team members, one asking open-ended questions and the other taking notes. Each interview lasted between 50 minutes and an hour and thirty minutes depending upon the context of the conversation. In summary, respondents were asked open-ended questions about their needs as survivors, access to holistic care, the impact of holistic care on their lives, and their recommendations to improve holistic care in their respective countries and in the Great Lakes region. Respondents were also asked to provide input into how the study should be conducted, as well as to share their expectations for the research.

While the geographical scope of the study includes all 12 ICGLR Member States, it takes a more in-depth look at six focal Member States, namely Burundi, CAR, the DRC, Rwanda, Uganda, and Zambia. However, coverage was more limited for Rwanda due to fewer interviews with survivors and other actors, as well as for Zambia where no interviews were conducted with survivors.

10 International Centre for Advanced Research and Training (ICART)

11 There was also a plan to hold an FGD in English but due to logistical challenges, it was unable to take place.

12 With a break during the festive season.

To properly exercise the duty of care towards survivors, in addition to compliance with the MF's safeguarding policies, their informed consent was sought before the FGD and interviews. Survivors were not asked about their experience of SGBV. Rather, the FGD and interviews focused on the provision of care. Survivors were made aware that they could opt to terminate the interview at any time, choose to not answer questions they did not seem comfortable answering and that their responses would be treated confidentially.

Additionally, the MF team coordinated with One-Stop Centres or other SGBV providers to speak with survivors who were or had been in their care; arranged to connect survivors with counsellors, social workers, and/or psychologists who would provide psychosocial support if they needed it after an interview; or the research team interviewed survivors who already had a source of psychosocial support.

Semi-Structured Interviews Conducted[13]

Respondents by country

Others

13 For some respondents working at the regional level, the study considered the individual's country of residence rather than country of origin.

Limitations

The study is by no means exhaustive. It has several limitations.

- Small sample size: In addition to the FGD and interviews with partners during the Inception Phase, 49 interviews were conducted. However, from inception, the study was not meant to provide data from a representative sample, but to present a survivor-informed, qualitative assessment of One-Stop Centre care.
- Limited geographical scope: The study's geographical coverage is unbalanced. There is more coverage of the Member States where survivors and other informants came from. Coverage is more limited for non-focal Member States, especially those for whom English and French language materials were not readily available online (i.e., Angola and Sudan).
- Limited interviews with Member States: Another significant gap in the study, due to factors beyond our control, is that almost no interviews were conducted with government institutions. However, input provided by national gender experts at the Regional Roundtable Meeting in January 2022 has been integrated into the report.
- No male or child survivors: Although efforts were made to include male survivors in the FGD and interviews, ultimately none participated. The research also did not include interviews with minors. This would have raised significant ethical issues and there was no clear showing that potential harm to child survivors was outweighed by potential benefits of their participation in the study. As such, both male survivors' and children's perspectives and priorities are not adequately reflected in the report.
- Remote methods: The research was predominantly conducted remotely, which severely limited the ability to conduct real-time assessments of the functionality, accessibility, and quality of care at one-stop centres. The data gathered from desk research and interviews may not adequately reflect One-Stop Centre operations.

Data Analysis Process

For the ICART team, the corpus of data consisted of audio recordings and notes. The audio recordings were listened to several times by the researchers to understand the content of the interviews. A preliminary analysis was made by each researcher immediately after each interview. The regional consultant also analysed data from the focus group discussion, interviews, as well as secondary sources, in order to identify themes that were centred on survivors' experiences and perspectives. The ICART researchers met to discuss together and find consensus on the themes that emerged from their data analysis process. The survivors' original quotes were transcribed and translated into French if/when necessary in order to construct an intelligible discourse of the survivors' experiences and knowledge. A thematic analysis was made to identify themes that emerged from the interviews. The themes were produced through a mapping process and definitions were drawn from the work of Braun & Clarke (2006). Five main themes were identified from the raw data: (1) interdependence of holistic needs among post-abuse survivors, (2) how survivors access care, (3) impact of holistic assistance on survivors' lives, (4) barriers to holistic assistance among survivors of SGBV, and (5) survivor recommendations to improve the holistic model in the Great Lakes region.

Roadmap

The report proceeds first with sections detailing the findings from the focal countries. Except for the Zambia section, each sub-section ends with some of the key recommendations from survivors that were later integrated into the final recommendations. Next, brief findings from the non-focal countries are presented. Although the findings are too rich to summarise at the end, concluding reflections are shared and then followed by the recommendations.

How survivors reported accessing care in the Great Lakes Region

Interviews with survivors revealed that survivors generally access assistance in three preferred ways. In the first case, different NGOs and support structures raise awareness on SGBV issues, in order to identify survivors in need of assistance; as one Ugandan survivor says: “They reached out to me, I didn’t have to look for them.” According to some survivors, it is very important that NGOs and other actors take the initiative to reach out to communities and identify survivors in need of care. A Rwandan survivor explains: "Sometimes survivors are traumatised, they don’t love themselves anymore. Caregivers need to support them instead of waiting for survivors to come to them.” Another Congolese survivor added: “I had no support in the community but by the grace of God, Dr. Mukwege’s team reached out to us.” Survivors stressed the importance of reaching out to those in need of assistance because there are several barriers, including shame, social stigma and lack of information, that prevent them from reaching out to those who could support them. Survivors can be identified and brought to the One-Stop Centres for care or can be treated immediately. For example, in the DRC, the Panzi Foundation has multidisciplinary mobile clinics composed of doctors, nurses, psychologists and lawyers who meet and treat survivors of SGBV in their respective settings.

In the second case, some survivors decide to transcend socio-cultural barriers and seek care themselves. In such a situation, survivors are already self-informed of the available services. As a Congolese survivor puts it: “Being afraid of the diseases associated with rape, I decided to come myself.” It was reported by survivors that knowledge about SGBV and available services developed within communities, generally through in person awareness-raising, radio broadcasts and television programmes.

Finally, in the third case, some survivors are referred by their loved ones, such as friends, family members or other survivors who have already received care. “We learned that other women who went through the same situation were treated at Mukwege’s, and I also decided to go,” says a Congolese survivor. This shows that sharing information between loved ones and community members can facilitate access to care for survivors. National survivors’ movements and networks in different Member States in the region are a force that enables survivors to stand up together for their rights, help others seek care, overcome the stigma of SGBV, and break the silence on sexual violence. Survivors’ movements are therefore an important source of knowledge sharing and advocacy.

BURUNDI

In a joint effort by the Burundian government and various UN agencies, an integrated SGBV centre, called the "Centre Humura", was established in Gitega in 2012.[14] This centre provides medical, psychosocial, and legal services, as well as a shelter.[15] The same year, with funding from the United States Agency for International Development (USAID), the Burundian government worked, among other objectives, to strengthen service provision to victims/survivors in Kayanza and Muyinga provinces through the RESPOND project.[16] Years later, in February 2017, through a World Bank-funded project, the Burundian government established three integrated SGBV centres at district hospitals in Cibitoke, Makamba, and Muyinga, which are in the northwest, south, and northeast of the country, respectively.[17] These centres provide medical and psychosocial services in addition to initiating police investigations and legal processes.[18] Services are provided in one place and are generally free. In 2020, the President inaugurated another Centre Humura in Rumonge.[19]

14 Monica Twesiime Kirya and Laura Nyirinkindi, "Towards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Regional of Africa: A Civil Society Review of the Implementation of the 2011 IC-GLR Kampala Declaration" (Kampala: Isis-WICCE, 2014), 23, https://wipc.org/towards-an-anti-sexual-and- gender-based-violence-norm-in-the-great-lakes-region-of-africa-a-review-of-the-implementation-of-the- 2011-icglr-kampala-declaration/.

15 Kirya and Nyirinkindi, 23; UNDP, "Centre Humura : Plus de 230 Victimes de VBG Ont Déjà Été Prises En Charge" 2012, https://reliefweb.int/report/burundi/centre-humura-plus-de-230-victimes-de-vbg- ont-déjà-été-prises-en-charge.

16 The RESPOND Project/Burundi, "Services for Sexual Violence Survivors in Kayanza and Muyinga Provinces, Burundi" (New York, 2012 https://respond-project.org/archive/files/6/6.2/Study-2011-Services- for-Sexual.pdf.

17 République du Burundi, "Centre Intégré," n.d., http://minisante.bi/bddci/.

18 République du Burundi, "Guide Operationnel Du Centre Integre Pour La Prise En Charge Holistique Des Survivants Des VSBG" n.d., 24, http://minisante.bi/bddci/cside/documents/guide_operationnel_ci.pdff.

19 Presidence Burundi, "Le Chef de l'Etat Présente Le Nouveau Gouverneur de Rumonge" 2020, https://www.presidence.gov.bi/2020/08/27/le-chef-de-letat-presente-le-nouveau-gouverneur-de-rumonge/.

"The care [I received] was not sufficient [...] I felt at risk of breaking."

« Les soins [que j'ai reçu] n'était pas suffisants [...] Je sentais le risque de craquer. »

Survivor from Burundi

"Personally, I think that [...] some services offered by the administration cannot be credible because the administration tends to confront the alleged [perpetrator] and the victim, and sometimes this generates aggression because we are totally misunderstood."

« Personnellement, je pense que... certains services offerts par l'administration ne peuvent pas être crédibles parce que l'administration a tendance à confronter le présumé [bourreau] et la victime et des fois, ça génère de l'agressivité parce qu'on est totalement incomprise. »

Survivor from Burundi

"There are also cultural barriers. There's the cultural aspect that says you should always avoid conflict [and that] silence is an excellent remedy against violence, so you should always keep quiet."

« Le changement de comportements c'est un processus qui ne peut pas s'opérer en une minute, deux minutes. »

Survivor from Burundi

In addition to these five centres, a few institutions or structures at the local and national level seek to provide holistic services to victims/survivors of SGBV. In each province, family and community development centres[20] overseen by the Ministry of National Solidarity, Social Affairs, Human Rights and Gender provide decentralized services. Despite these centres' mandate to provide care to victims/survivors under the medical, psychosocial, and legal pillars, funding and human resource challenges limit their operations.[21] Nevertheless, it is reported that at a minimum, these centres, the National Women's Forum,[22] community networks fighting SGBV,[23] and the Network of women actors for peace and dialogue,[24] provide counselling to victims/survivors and direct them to other services.[25]

Burundian and international NGOs, as well as multilateral actors also play an important role. The Collective of Women's Associations and NGOs of Burundi,[26] Dushirehamwe, Women and Peace Network[27] — which are member collectives of the Concertation of Collectives of Women's Associations in the Great Lakes Region (COCAFEM-GL)[28] — and the Nturengaho Association have come together to collectively provide medical, psychosocial, legal, and socio-economic reintegration services to victims/survivors. From 2010 to 2017, for example, COCAFEM-GL implemented a project to strengthen the provision of holistic care along with its Burundian member collectives and with support from CECI and funding from Global Affairs Canada.[29]

Similarly, Femme Active, the Association of Female Lawyers of Burundi[30], and other partners have formed a referral pathway through which they provide psychosocial, medical, and legal care, as well as socio-economic reintegration to victims/survivors. In a World Bank-funded project through the Ministries of Health, Gender, and Justice, HealthNet TPO formerly worked with Cordaid, and Pathfinder in three provinces to conduct community sensitisation and provided medical, psychosocial, and legal services and socio-economic reintegration to victims/survivors. Unlike the services provided by Femme Active and its partners, the medical, psychosocial, and legal services offered through the HealthNet TPO collaboration were offered in one place. Other international and multilateral actors supporting care provision in Burundi have included, but are not limited to, the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), CARE, Doctors Without Borders (MSF)[31], and International Committee of the Red Cross (ICRC)[32], and the Swiss Agency for Development and Cooperation. Although Humanity & Inclusion formerly provided some support to victims/survivors of SGBV with disabilities, it shut down its country program in 2019.[33]

Started as a project by MSF-Belgium, operation of the Seruka Centre was turned over to a local association in 2009. Seruka offers victims/survivors of SGBV medical, psychological, and legal services 24 hours a day and seven days a week, as well as short-term transitional housing, and a limited amount of socio-economic assistance. It has a presence in Bujumbura and two other provinces. As the first centre of its kind in Burundi, Seruka seeks to build capacity on SGBV in the country and offers training to professionals and academics, including the civil servants who work at the integrated SGBV centres.

20 Centre de Développement Familial et Communautaire
21 The RESPOND Project/Burundi, "Services for Sexual Violence Survivors in Kayanza and Muyinga Provinces, Burundi," 9; COCAFEM-GL and CARE, "Analyse Sur La Participation Politique de La Femme Ainsi Que Sa Protection Contre Les VSBG Dans Les Provinces Cibles Du GEWEPAu Burundi," 2017, 62–63, https://www.careevaluations.org/evaluation/analyse-sur-la-participation-politique-de-la-femme-ainsi-que- sa-protection-contre-les-vsbg-dans-les-provinces-cibles-du-gewep-au-burundi/.
22 Forum National des Femmes
23 Réseaux communautaires de lutte contre les VSBG
24 Réseau des femmes actrices de paix et de dialogues
25 COCAFEM-GL and CARE, "Analyse Sur La Participation Politique de La Femme Ainsi Que Sa Protection Contre Les VSBG Dans Les Provinces Cibles Du GEWEP Au Burundi," 42.
26 Collectif des associations et ONG féminines au Burundi
27 Réseau Femmes et Paix
28 La Concertation des Collectifs des Associations féminines de la région des Grands Lacs
29 CECI, "Combating Violence Against Women (PLUVIF)," accessed February 17, 2022, https://www. ceci.ca/en/projects/combatting-violence-against-women-pluvif.
30 Association des Femmes Juristes du Burundi
31 Médecins sans frontières
32 International Committee of the Red Cross, "ICRC Special Report 2020: Addressing Sexual Violence," 2020, 22–23, https://www.icrc.org/sites/default/files/wysiwyg/Activities/Sexual-violence/icrc_sexual_vio- lence_special_report_2020.pdf.
33 Humanity & Inclusion, "Burundi," n.d., https://www.hi-us.org/burundi.

Survivors' Perspectives

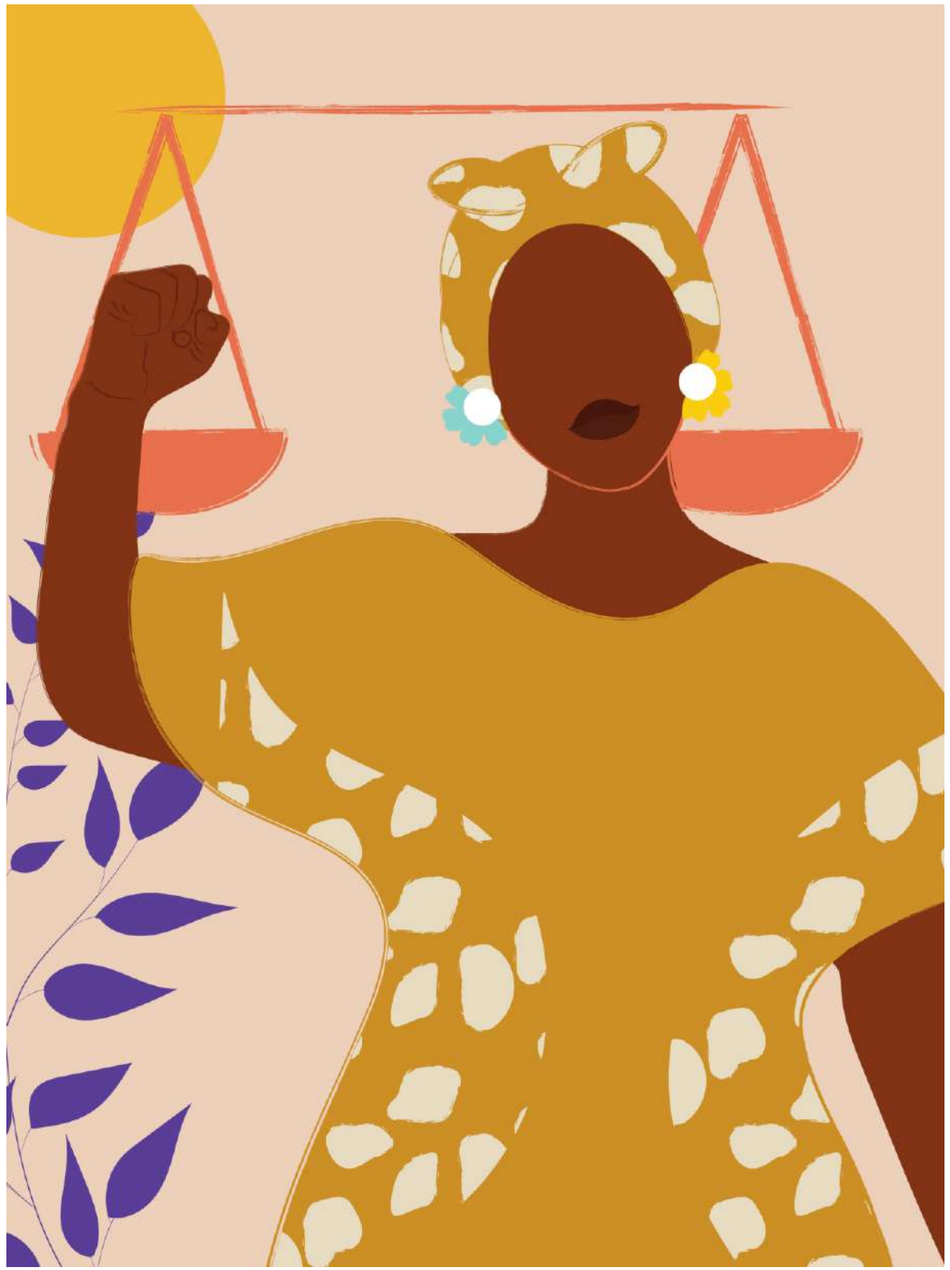
All four of the Burundian survivors interviewed emphasised the importance of holistic care to healing and reclaiming their self-worth. One survivor stressed that despite the violation of intimacy that victims/survivors experienced, the stigma of SGBV, and the precarity in which they often live, having access to all four pillars of care not only enables a victim to recover faster, but is also beneficial to the community. Another survivor echoed this view, indicating that medical, psychosocial, and legal services are critical, and socio-economic reintegration is also a fundamental need. Asked specifically about legal services, one survivor pointed out, "It's positive to punish or provide this [legal] assistance, because the person who is raped, no one understands them. I found legal assistance that understands me and can advocate for me." However, the survivors indicated that there is often a lack of awareness of SGBV centres and accessing them is particularly difficult in rural areas where victims/survivors must travel long distances. A survivor with a disability also highlighted the accessibility challenges she faced, particularly because she had to travel to different locations for services. While some services by NGOs or the government were free, a few survivors indicated that they had to pay for post-exposure prophylaxis (PEP), as well as some other services. Sometimes survivors were unable to find prescribed medicines, even when they had to cover the cost. Moreover, they often faced long waits at centres because of insufficient medical personnel and one survivor expressed concern about privacy, as other patients tried to determine the reason for her visits to a health facility.

Survivors highlighted the stigma of SGBV. They indicated that it can result in a survivor being rendered ineligible for marriage and/or abandoned by his/her family, as was the case for one survivor. In the case of two other survivors, it was through the reintegration process that they were reunited with their families. For all the survivors, this stigma was among the barriers to seeking care. At the same time, they mentioned socio-cultural attitudes towards SGBV as presenting other key challenges. One survivor stated:

> **"The Burundian girl, the Burundian woman must be discreet. So, she cannot reveal everything to anyone whatsoever. [...] This makes the girl keep it to herself. She will think about care when she starts to see the consequences like pregnancy, like [sexually transmitted] infections."**

Survivors also feared being targeted by perpetrators if they went to an SGBV centre and/or took legal action. At the same time, they emphasised family and community efforts to make them reconcile with a perpetrator through mediation, an arranged marriage, or some other out-of-court settlement.

> **"We must think about the safety and protection of the victim. Even if there is legal assistance, the protection of the victim is not really assured. One can win the case but lose their life because they were left alone"**
>
> *"Il faut penser à la sécurité et la protection de la victime. Même s'il y'a l'assistance juridique, vraiment la protection de la victime n'est pas assurée. On peut gagner le procès mais on peut perdre la vie parce qu'on l'a laissé à elle seule."*
>
> **Survivor from Burundi**



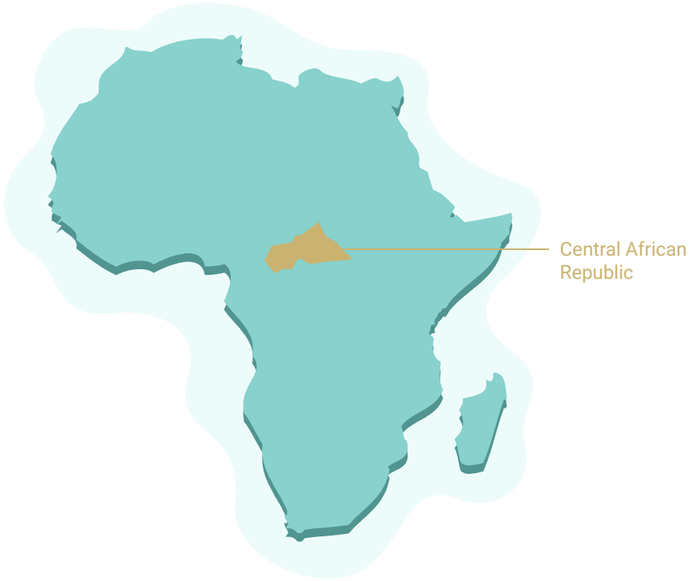
Challenges to the Roll-Out and Operation of One-Stop Centres

Although there are many challenges to the roll-out and operation of One-Stop Centres, including as a result of the legacies of conflict in Burundi, a few key challenges emerged from the research.

- One main challenge was a combination of financial, human resource, material, and technical constraints.
- Difficulties in recruiting, training, and adequately compensating personnel, including specialists; maintaining adequate supplies and equipment; offering all services free of charge; and ensuring the sustainability of services.
- Resource constraints also make it difficult for centres to provide follow-up and longer-term care. For NGOs in particular, project funding cycles and limited scope often placed limitations on provision of holistic care and on ensuring such care's continuity.
- Guaranteeing the security of victims/survivors is a challenge. More broadly, corruption and impunity are big concerns. Survivors saw these concerns, which were also related to the presence of some perpetrators in government offices, as deterrents to accountability. At the same time, there is little awareness in the public and often among local leaders, as well of the laws pertaining to SGBV.
- Informants alluded to the limited budget of the ministry charged with gender and a need for greater political will to provide holistic care. However, we were unable to ascertain how much funding the State allocates to One-Stop Centres and/or holistic care. Although several actors indicated that data on SGBV could facilitate action, data collection is limited and has not been standardised.

Survivors' Key Recommendations

- One-Stop Centres offering free services should be established across Burundi;
- A survivor from Burundi reiterated that "Access to care would be easy if all services are located in one place";
- One-Stop Centre staff should be increased and properly trainedon a continuous basis;
- Although all pillars of holistic care are important, psychosocial care and socio-economic reintegration should be given more prominence than they currently receive;
- Networks of survivors should be created, particularly for survivors in remote areas, so that they can encourage each other;
- Exchanges among survivors in other countries should be facilitated;
- Medications for victims/survivors should be made more readily available;
- Perpetrators of SGBV should be punished;
- Victims/survivors together with their families should be protected when they seek legal recourse;
- Support should be provided not solely to the victim/survivor, but to her family as well;
- The government and donors should fund initiatives to fight SGBV; and
- Through sensitisation, people should be made aware of their rights, the justification and stigmatisation of SGBV should be challenged, and people should be informed about One-Stop Centres.



CENTRAL AFRICAN REPUBLIC

Several national initiatives in CAR aim to provide support to victims/survivors under multiple pillars. Launched in 2017, the Mixed Unit for Rapid Intervention and Suppression of Sexual Violence against Women and Children[34] (UMIRR) is a unit of gendarmes, police officers, and civilians based in Bangui but with a mandate to cover the whole country.[35] With support from various UN agencies and other donors, UMIRR seeks to provide medical, psychosocial, and legal services to victims/survivors. Similarly, the CAR Health System Support and Strengthening Project (SENI) is a four-year project (2019-2022)[36] funded by the World Bank with 18 million USD allocated for a component aimed at strengthening the CAR health system's capacity to address GBV.[37]

34 L'Unité Mixte d'Intervention Rapide et de Répression des violences sexuelles faites aux femmes et aux enfants

35 Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict, "L'UMIRR, Une Unité Pour Faire Face Aux Violences Sexuelles En République Centrafricaine," 2018, https:// www.un.org/sexualviolenceinconflict/lumirr-une-unite-pour-faire-face-aux-violences-sexuelles-en-repub- lique-centrafricaine/.

36 The project was initially designed as a three-year project ending in 2021, but the end date was extended.

37 The World Bank, "Project Appraisal Document on a Proposed IDA Grant in the Amount of SDR 30.7 Million to the Central African Republic for a Health System Support and Strengthening Project (SENI)," 2018, https://documents1.worldbank.org/curated/en/447171538278262488/pdf/CAR-PAD-09102018.pdf; The World Bank, "CAR Health System Support and Strengthening (SENI) Project Implementation Status & Results Report," 2022, https://documents1.worldbank.org/curated/en/099405001042211781/pdf/Disclosable- 0Ve0953000Sequence0No007.pdf.

"First of all, the healthcare facilities are already insufficient. Sometimes there is a lack of equipment for ultrasounds, there is a lack of scanners, there is a lack of everything. So, when a victim has problems and comes to the hospital, they are limited because there are no scanners. There is no other really sophisticated equipment to take good care of their needs. I take the case of the provinces at home where it is already difficult. Everything is flooded by the rebels."

« D'abord les plateaux sanitaires sont déjà insuffisants. Parfois il y'a manque des appareils pour l'échographie, il y a manque de scanners, il y a manque de tout. Donc, quand une victime a des problèmes et elle vient à l'hôpital, ils sont limités parce qu'il n'y a pas de scanners. il n'y a pas des autres appareils vrai- ment sophistiqués pour la mettre à l'aise. Je prends le cas des provinces chez nous ou c'est déjà difficile. Tout est inondé par les rebelles. »

Survivor from CAR

"The lawyers do their job, the attorneys do their job, but as soon as the files are turned over to the government, often the files are said to be missing in action. Often. Quite often. [...] Or we wait a thousand years, there's never a trial."

« Les juristes font leur travail, les avocats font leur travail, mais dès que les dossiers sont remis au gouvernement, souvent on dit que les dossiers sont portés disparus. Souvent. Assez souvent. [...] Ou on attend mille ans, il n'y a jamais procès. »

Survivor from CAR

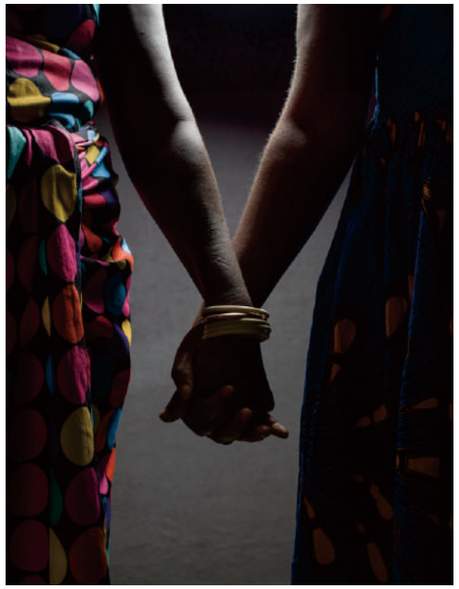
"The cumbersome [legal] process is a new crime against victims."

« La lourde procédure [juridique] est un nouveau crime pour les victimes. »

Survivor from CAR

Local and international non-governmental actors are also actively involved in the provision of care to victims/survivors under various pillars. Responding to the alarming escalation of SGBV in the country, humanitarian actors have been providing medical, psychological, psychosocial, socio-economic, and legal support following the creation of a Humanitarian Fund in August 2021.[38] Other actors who have been involved in providing care to victims/survivors under two or more pillars include, but are not limited to, the following: UNFPA, UNICEF, United Nations Development Program (UNDP), International Rescue Committee, MSF, Tearfund, Central African Red Cross, ICRC, and the African Union in collaboration with Médecins d'Afrique and the Pan African Lawyers Union.[39]

Although many of the projects and initiatives mentioned include One-Stop Centres and a range of referral pathways, there is currently only one operational One-Stop Centre initiative in the country. Project NENGO, an initially four-year consortium project, began in January 2020 and is funded by the French Development Agency [40] (AFD) and the Pierre Fabre Foundation. Through the project, the Pierre Fabre Foundation, the MF, the PF, and the Francophone Institute for Justice and Democracy [41] (IFJD) are providing holistic care to victims/survivors of SGBV in collaboration with a public hospital[42] and the Central African Association of Women Lawyers (AFJC). Drawing from the Panzi holistic care model, the project provides free medical, psychosocial, legal, and socio-economic care to victims and survivors of SGBV, and women and girls with grave gynaecological concerns.



National Trainers and SGBV professionals from CAR have been involved in training sessions that the RTF organised in Bangui to build capacity on care for victims/survivors of SGBV, based on the Regional Integrated Model. National Trainers were trained on the integrated model in April 2021. Subsequently, in November 2021, a workshop was held with stakeholders and another with national and international organisations offering support and emergency assistance to victims/survivors of SGBV.

38 United Nations Office for the Coordination of Humanitarian Affairs, "Gender-Based Violence: A Scourge with Devastating Consequences," 2022, https://reports.unocha.org/en/country/car/card/3wnX- z0h5EQ/.

39 This was a six-month project that ultimately focused primarily on the medical and psychosocial pillars. Union Africaine, "Rapport Final Du Projet d'appui de l'Union Africaine a La Prévention et a La Réponse Aux Violences Sexuelles En République Centrafricaine," 2015, https://www.peaceau.org/uploads/rapport-final-de- l-ua-misac-du-projet-vsbg-rca-juillet-2015-.pdf.

40 Agence française de développement

41 Institut Francophone pour la Justice et la Démocratie

42 Centre Hospitalier Universitaire de l'Amitié Sino-Centrafricaine

Survivors' Perspectives

The four survivors from CAR who were interviewed and the two who participated in the FGD stressed the importance of holistic care for survivors. The interviewees who had benefited from holistic care from Project NENGO credited this care with restoring their physical and mental health, social relations, and economic productivity. "I used to feel guilty and shameful," said one survivor, "I now feel self-worth. I no longer feel guilty, and now I can start collaborating with others."[43] Other survivors shared that although the trauma they had experienced initially left them feeling suicidal, the psychosocial care they received helped them to recover.

However, the survivors noted that services for victims/survivors of SGBV were mainly available in Bangui, which creates hardship for survivors who need to cover the cost of transportation. On arrival, survivors often found long lines. On returning home, they often faced stigma from their families and/or communities. At the same time, most SGBV service providers only provide care under a maximum of two or three pillars.

Survivors indicated that despite the necessary interplay of all four pillars, legal assistance and socio-economic reintegration are rarely provided in CAR. A survivor noted that while there were NGOs like Médecins Sans Frontières and Project Nengo that are implementing holistic care, they only end up providing two or three pillars of support.

Access to justice posed a particular problem for the survivors. They highlighted the challenge of bringing perpetrators, particularly those in government, to justice. Even where perpetrators are not in government, the long delays experienced with court cases and paucity of convictions discouraged survivors. Disheartened by the constraints faced by the government, one survivor suggested that NGOs rather than the government should establish and run One-Stop Centres. Another survivor stated: "Legal assistance is very important. I will be happy to hear one day that a perpetrator has been judged. Even if the court decides that the perpetrator pay me, I will need only one symbolic franc, but I want to see the perpetrator arrested."[44]

> **"My uncle's wife gave me to her little brother as a sex slave for three years. He even impregnated me twice [...] I couldn't talk because I was afraid that if I talked, they would kick me out of the house. I kept this with me until now. I got to a point where I said to myself that there is no point in going to the hospital. There's really no point in going to court. [...] I'd rather accept this. But, thanks to awareness-raising campaigns. Thanks to some NGOs and associations that really pushed me to be here today because if it wasn't for that, I couldn't. [...] If I am here, it means that I dared. We have to help the people who have dared to now talk. [...] We need to help the victims talk in front of people."**
>
> *« La femme de mon oncle m'a donné à son petit frère comme esclave sexuelle pendant 3 ans. Il m'a même enceinté deux fois [...] Je ne pouvais pas parler parce que j'avais peur que quand je parlais, on allait me chas- ser de la maison. J'ai gardé ça sur moi jusqu'à maintenant là. Arrivée à un moment donné, je me suis dit que ça ne sert à rien d'aller à l'hôpital. Ça ne sert à rien vraiment d'aller en justice. [...] Je préfère mieux garder ça. Mais, merci à la sensibilisation. Merci à certains ONGs et associa- tions qui m'ont poussé aujourd'hui vraiment à être la parce que si ce n'était pas à cause de ça, je ne pouvais pas. [...] Si je suis là, ça veut dire que j'ai osé. Il faut aider les gens qui ont osé maintenant à parler. [...] Il faut aider les victimes d'abord à parler devant les gens. »*
>
> **Survivor from CAR**

43 « Avant, je me sentais coupable et honteuse. Maintenant, je me sens valorisée. Je ne me sens plus coupable, et je peux maintenant commencer à collaborer avec les autres. »

44 « L'assistance juridique est très importante. Je serai heureuse d'apprendre un jour qu'un coupable a été jugé. Même si le tribunal décide que le coupable me paie, je n'aurai besoin que d'un franc symbolique, mais je veux que le coupable soit arrêté. »

Challenges to the Roll-Out and Operation of One-Stop Centres

As in other conflict-areas, insecurity in parts of CAR poses a challenge to the operation of One-Stop Centres. At the same time, as one informant suggested, the huge problem of SGBV is interlinked with conflict, psychosocial trauma, and poverty. This makes it both necessary and complicated to design appropriate and sustainable interventions.

Even some basic infrastructure and services that One-Stop Centres require such as a hospital building with a functional design, water, and electricity can be difficult to secure, particularly in rural areas. This raises operational costs and can easily deter establishment of centres. Service providers in the country report challenges faced in recruiting qualified male and female staff members, which further complicate centre operations. For example, there are no trained local psychologists in the country and informants reported having difficulties with identifying female gynaecologists. Developing psychosocial programmes and integrating holistic care training into the curricula of medical and law schools would constitute important steps in addressing SGBV in the country.

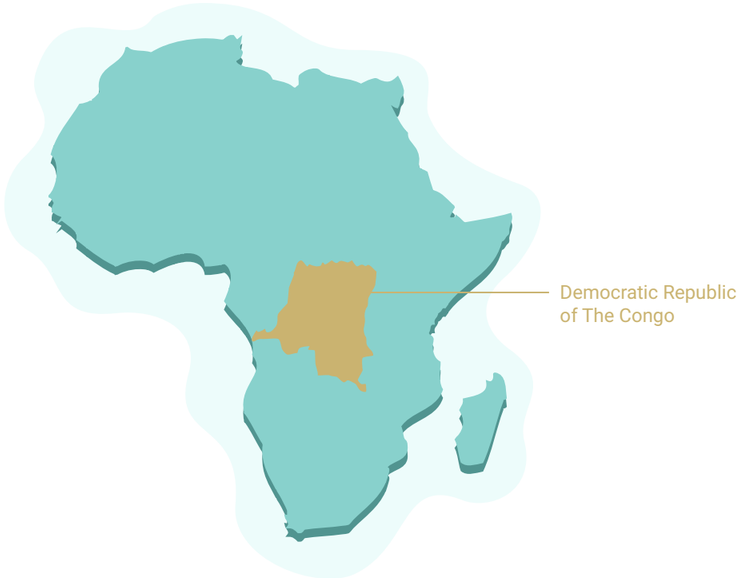
As survivors indicated, the legal pillar presents additional challenges. Despite fairly progressive legislation on SGBV, the application of the law has been problematic. Moreover, the political clout of some perpetrators makes it difficult for victims/survivors to attain justice. As such, there have been few convictions and the legal process tends to be drawn out. While some of the challenges faced by male survivors in accessing quality holistic care are similar to those raised by the female survivors who participated in this study, it is important that One-Stop Centres take additional steps to ensure access to quality care by male survivors. A 2018 report by the All-Survivors Project and other collaborators notes that while violence against men and boys may have increased as insecurity in CAR spread, such violence is not new.[45] Nevertheless, there is insufficient data on male victims/survivors in CAR. According to the report, male survivors faced stigma in speaking out about their experience, which made it difficult for them to seek out even the limited services available in the country. Where they were able to access such services, they often found service providers who lacked the capacity to provide appropriate care. This was particularly the case for boy victim/survivors who had been associated with armed groups.

Sustainability is another barrier to the effective operation of One-Stop Centres. Securing funding from donors in CAR can be challenging in light of what one informant characterised as “donor fatigue”. At the same time, what another informant described as the prevailing “project logic” in the country makes continuous and long-term interventions difficult to undertake.

Survivors' Key Recommendations

- One-Stop Centres with care available in one place, with trained personnel should be established in different parts of CAR;
- Mobile clinics should provide care in remote areas to promote quick recovery, as most support services are concentrated only in Bangui;
- Victims/survivors should be provided with training to conduct income-generating activities and promote their empowerment;
- Perpetrators, including those in high offices, should be punished;
- Reparations should be provided to survivors;
- Housing for survivors in Bangui and in transit should be increased; and
- Mass sensitisation should be conducted to address stigmatisation of victims/survivors as survivors noted that they often face discrimination and social rejection even from their own family.

45 UCLA School of Law The Williams Institute, UCLA School of Law Health & Human Rights Law Project, and All Survivors Project, “‘Je Ne Sais Pas Qui Pourrait Nous Aider’: Les Hommes et Les Garçons Confrontés à La Violence Sexuelle En République Centrafricaine,” 2018, 7, https://allsurvivorsproject.org/ wp-content/uploads/2019/03/French-CAR-Report.pdf.



DEMOCRATIC REPUBLIC OF THE CONGO

The government of DRC adopted a national strategy to combat GBV in 2009 and, most recently, revised it in 2019. One of the components of the strategy is the provision of holistic care to victims/survivors. This includes medical, psychosocial, legal, socio-economic reintegration, and social protection services. This strategy provides an important reference point for SGBV service providers in the country. According to a UN official, there are 13 One-Stop Centres in the DRC with 60% of them based in Eastern DRC.[46] Many of these centres receive support from the World Bank, UN agencies, such as the UNFPA, UN Women, UNICEF, UNDP, and other international donors, including the Canadian, Belgian, Dutch, Swedish, and US governments. Despite the challenges posed by ongoing conflict in some parts of the country, several of the One-Stop Centres manage to offer holistic services to victims/survivors. Nevertheless, given the size of the DRC and magnitude of the problem of SGBV, among other factors, they are still insufficient.

46 Name withheld for confidentiality, online interview, 16 November 2021.

"This person who has been raped has been destroyed in fact. She needs reconstruction and this reconstruction goes in all directions, social, medical, psychological and economic. Often we see that sometimes it is more psychological and medical reconstruction, and economic aspect is left aside."

« Cette personne qui a été violée a été détruite au fait. Elle a besoin d'une reconstruction et cette reconstruction va dans tous les sens, social, médical, psychologique, et économique mais souvent on constate que des fois c'est plus psychologique, médical et l'économique est mis à côté. »

Survivor from DRC

"If the psychologist is not around [...] to comfort him/her, to show the importance of frequenting the center, [the victim] gives up and falls back to his/her original state. We have had many cases.
[...] Some of them die when they would not have died if there had truly been good follow-up by the support worker, but because of a lack of means [they die]."

« Si le psychologue n'est pas à côté [...] pour la consoler, pour montrer l'importance de la fréquentation du centre, [la victime] lâche et elle retombe dans son état initial. Nous avons eu beaucoup de cas.
[...] Il y'en a qui meurt, alors qu'elle ne devrait pas mourir s'il y avait vraiment un suivi bien de la part de l'accompagnateur ou de l'accompagnatrice, mais par manque de moyen [elle meurt].

Survivor from the DRC

"When it's a rape case, there is a slowdown in the legal system that facilitates corruption, and this discourages the victim's family."

« Lorsque c'est le cas de viol, il y a un ralentissement dans le système juridique pour qu'il y ait maintenant corruption et ça décourage la famille de la victime. »

Survivor from the DRC

Under the "Tupinge Ubakaji" project (2014-2017) financed by Canada and implemented in Eastern DRC, six integrated multisectoral centres[47] were set up at Gesom Hospital (Beni), Kyeshero Hospital (Beni), Kyeshero Hospital (Goma) at Oicha Hospital (all in North Kivu), as well as in Luvungi (South Kivu) and Aru (Ituri).[48] The centres provide medical, psychosocial, legal, and socio-economic care to victims/survivors. Building on lessons learned from these centres, the UNDP, UNFPA, and UN Joint Human Rights Office are implementing the JAD[49] project together with the Ministry of Gender, Family Affairs and Children. This project also receives support from Canada. JAD aims to strengthen the provision of holistic care in the existing centres and establish three new centres in Kinshasa and two in Kasaï-Central.[50] Several national and international NGOs also support the provision of holistic care in DRC. The international Christian organisation HEAL Africa, for example, runs a referral hospital in North Kivu, as well as health centres in the province and in Maniema. Through these facilities and community development programs, the organisation provides medical care (including fistula repair), psychosocial, and socio-economic support to victims/survivors in addition to working with their families to facilitate their reintegration. Female Solidarity for Peace and Integral Development (SOFEPADI)[51] provides care to victims/survivors under all four pillars through its branches in Beni, Bunia, and Kinshasa. As in Burundi, COCAFEM-GL partnered with five other coalitions or networks in DRC[52] to strengthen the provision of holistic care through a 2010-2017 project. Other actors in DRC that have provided care under two or more pillars or supported its provision include the ICRC, International Medical Corps, Red Cross Society of the DRC, Oxfam, Maison de la Femme, among others.

Panzi General Referral Hospital, which 2018 Nobel Peace Prize laureate Dr. Denis Mukwege founded in 1999, is one of the best-known One-Stop Centres in the DRC and Africa as a whole. Using what has become known as the "Panzi model", the Bukavu-based hospital offers free medical, psychosocial, legal, and socio-economic care to victims of SGBV and women and girls suffering from grave gynaecological problems. Its work is animated by the following definition of a One-Stop Centre: "a holistic, person-centred care model that treats sexually, bodily, and mentally harmed women as dignified persons having major needs but also being valuable resources for their own healing and society".[53] In addition to the services provided at Panzi Hospital in Bukavu and Kinshasa, a model adapted for rural areas is used in Mulamba and Bulenga.[54] Within a five-year project, for which the Congolese government received funding from the World Bank,[55] the Fonds Social de la RDC (Social Fund of the DRC) is working with the Panzi Foundation and other partners to support the provision of holistic care in four provinces, namely North and South Kivu, Maniema, and Tanganyika. There are plans to expand this collaboration to Kinshasa and Ituri as well. Through the project, which will continue for at least two more years, victims/survivors are provided with all four pillars of care.

The Panzi model has informed ICGLR commitments regarding One-Stop Centres and, more recently, was combined with the RTF's socio-ecological model to create the Regional Integrated Model used within the ICTLR-RTF's regional SGBV training programme.[56] Following a Training of Trainers (ToT) session on the integrated model in March 2021, National Trainers from the DRC contributed to a training session on SGBV that brought together customary chiefs, religious leaders, lawyers and judges, along with some NGO representatives. The session was organised by the RTF with support from GIZ. The trainer's plan, once additional fundraising has been conducted, is to continue to undertake other training initiatives for professionals who provide care to victim/survivors.

47 Centres Intégrés de Services Multisectoriels

48 "Programme Conjoint de Lutte Contres Les Violences Basées Sur Le Genre: Justice, Autonomisation et Dignité Des Femmes et Des Filles En République Démocratique Du Congo « JAD »," 2018, 20, https:// www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiJ24-

49 Lutte contre les VBG: Justice, Autonomisation et Dignité des Femmes et des Filles en République Démocratique du Congo

50 HEAL Africa, "HEAL Africa," 2022, https://healafrica.org/; RAINN, "Sexual Violence in Six African Nations: A Call for Investment," 2021, 27, https://www.rainn.org/sites/default/files/Finalized Africa Re- port.11.4.21.pdf.

51 Solidarité Féminine Pour la Paix et le Développement

52 Collectif des Associations Féminines pour le Développement, Coalition des Femmes pour la Paix et le Développement, Conseil Des Organisations Des Femmes Agissant en Synergie, Comité national Femme et Développement, Union des Femmes Congolaises pour le Développement

53 Mukwege and Berg, "A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Demo- cratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care," 5.

54 Mukwege and Berg, 3

55 Projet de Prévention et Réponse aux VBG

56 Regional Training Facility of the International Conference of the Great Lakes Region, Panzi Foun- dation DRC, and Dr. Denis Mukwege Foundation, "Integrated Training Model for SGBV Professionals and Trainers: Great Lakes Region," 2020.

Survivors' Perspectives

Four survivors from the DRC who were interviewed attributed their ability to overcome their experience to holistic care. Emphasising the interdependence of the four pillars, they indicated that holistic care enabled them to gain back their self-esteem, find the will to live, and develop some autonomy. One survivor indicated that having access to all four pillars of care in one place facilitated a faster recovery. "If I did not get medical assistance, I could not be alive today," another survivor stated, "I had difficulty sitting. I could not have an appetite. I wanted to die […]". For another survivor, improving her physical and psychosocial well-being made people more accepting of and respectful towards her.

All of the survivors interviewed received care from Panzi Hospital.

Nevertheless, these survivors, who participated in the FGD, recognised that not all survivors in their country have access to holistic care. It is often difficult for them to get to One-Stop Centres because of distance, insecurity in certain parts of the country, possible lack of information about the centres, and the deterrent effect of shame and stigma. At the same time, holistic services are not available throughout the country. In some cases, centres misleadingly present themselves as One-Stop Centres.

> **"I have had a gynaecological problem since I was raped and every time I bleed—sometimes I can bleed for a month […]—and every time I go to the hospital, they give me medicines and when they send me to the pharmacy, it's to buy medicine for a hundred thousand and more and it's always the same thing that happens. So, I often manage with generics. […] Often I am forced to self-medicate, buy the medication on the side of the road to take and then stop, because I don't have the money to go to the hospital all the time to buy the medication they prescribe."**
>
> *« J'ai un problème gynécologique depuis que j'ai été violée et à chaque fois quand je saigne—parfois je peux saigner pendant un mois […] —et à ch- aque fois que je vais à l'hôpital on me donne les médicaments et quand on m'envoie à la pharmacie, c'est pour acheter les médicaments pour cent et quelques milles et c'est toujours la même chose qui arrive. Donc, je me débrouille souvent avec les génériques. […] Souvent je suis obligée de faire l'automédication, acheter les médicaments au bord de la route pour pren- dre et puis arrêter parce que je n'ai pas l'argent pour aller tout le temps à l'hôpital acheter les médications qu'on me donne. »*
>
> **Survivor from DRC**

As an FGD participant put it, "There are signs in some hospitals that say 'One-Stop Centre', but when you get there or when you bring survivors there, it is not a One-Stop Centre. It is limited. One wonders whether they don't have funding."[57] A FGD participant contended that some centres try unsuccessfully to simply "copy and paste" what Panzi is doing.

Survivors also decried the quality of care provided in some facilities and the challenges faced getting medicines and specialised care. One survivor shared, "One doesn't get quality care. [...] It's been almost 20 years since I was raped, and I'm still being treated. There are problems, problems, problems."[58]

Access to justice also poses a significant problem for survivors. They not only complained about the slowness of the legal process, but also raised concerns about victims'/survivors' security and about the possibility of a fair trial, particularly where members of armed groups are involved. As one survivor recounted - "For the cases of armed groups, even in the foreign groups there are names that are known, and these people are known. But how will you have the strength and courage to denounce them when you have denounced nationals, and nothing has been done? Must you still denounce the foreigners?[59]"

Survivors often fear reprisals by perpetrators. They fear not only for themselves, but for their families as well. As a result, they are often either forced by circumstances or urged by others to reach amicable settlements with perpetrators. "Let us take the example of civil rape. [...] The perpetrator has money in his pocket. The victim's family has nothing. Should we go to court, where the perpetrator will bribe his way to get out and come after the victim's family? Or should we make out-of-court settlements? Today, we suffer from out-of-court settlements because it is our justice system that causes this, that encourages this. When we do sensitisation on this point, we are not heard.[60]"

57 « Il y a les pancartes dans les hôpitaux ou on écrit 'one-stop centre', mais quand vous y arrivez ou lor- sque vous y amenez des survivantes, ce n'est pas le one-stop centre. Ils sont limités. On se demande si on n'a pas de financement. »

58 « On ne reçoit pas les soins de qualité. […] Ça fait presque 20 ans que j'ai été violée, et on me soigne toujours. Il y a des problèmes des problèmes, des problèmes. »

59 « Pour les cas de groupes armés, mêmes dans les groupes étrangers il y'a des noms qui sont connus et ces personnes sont connus. Mais comment tu auras la force et le courage de dénoncer alors que lorsque tu as dénoncé pour les nationaux rien n'a été fait. Faut-il encore dénoncer les étrangers? »

60 « Prenons l'exemple du viol civil. […] Le bourreau a son argent dans sa poche. La famille de la victime n'a rien. Faut-il aller à la justice ou le bourreau va corrompre pour [se] libérer et pour venir s'attaquer à la famille de la victime ? Ou faut-il faire les arrangements à l'amiable ? Aujourd'hui, nous souffrons des ar- rangements à l'amiable parce que c'est notre justice qui cause ça, qui encourage ça. Lorsque nous faisons des sensibilisations sur ce point-là, nous ne sommes pas entendus. »

Challenges to the Roll-Out and Operation of One-Stop Centres

- As mentioned by survivors, the insecurity created by the conflict in the areas, notably in eastern DRC, where the majority of One-Stop Centres operate, presents a significant challenge to the centres.
- Like other centres in the region, the centres in the DRC also face challenges with maintaining trained personnel, having adequate medical supplies and equipment, and ensuring the continuity and sustainability of interventions.
- Although various informants noted some political will to address SGBV, they also alluded to the State's limited gender budget and the lack of a specific budget line for One-Stop Centres, as a reflection of the need for the State to further prioritise the fight against SGBV.
- One-Stop Centres also face challenges providing legal services due to the slow pace of cases, corruption, and failures in the grant or payment of reparations. Mobile courts that operate with support from international actors are helping alleviate some delays in the system. Unfortunately, even where cases may arrive at judgment, it was reported that non- enforcement of judgments presents another problem. Nevertheless, survivors are often discouraged from even filing cases by fears of security, stigma and marginalisation, and/or due to sociocultural norms that are mobilised in support of out-of-court settlements or other amicable arrangements. The fact that members of the public often lack information about laws pertaining to SGBV further compounds the problems.
- A 2019 evaluation of UN SGBV activities implemented in DRC between 2005 and 2017 suggested that multisectoral approaches are not necessarily holistic.[61] According to the evaluation, while the medical pillar often received the largest amount of funding, psychosocial and socio-economic reintegration were often sidelined, thereby threatening the interrelationships among all four pillars, which collectively contribute to both individual healing and changes in sociocultural norms and practices.[62]
- The presence of many actors providing SGBV services in DRC lends itself to some coordination challenges. Despite the existence of various coordination mechanisms and groups at both the local and provincial levels, such challenges remain.
- Coordination of data collection is also a problem. Moreover, there's a danger that the limited or non-existent monitoring and evaluation mechanisms within coordination bodies leave actors insufficiently aware, not only of any harm caused by their interventions[63] but of the interplay between the potential harms and benefits of interventions.

61 Alexandra Vasseur et al., "Evaluation Conjointe Des Programmes de Lutte Contre Les Violences Sexuelles En République Démocratique Du Congo 2005-2017" (Rome, 2019), 12, https://www.humanita- rianresponse.info/en/operations/democratic-republic-congo/document/rd-congo-sous-cluster-vbg-rapport-dé- valuation.

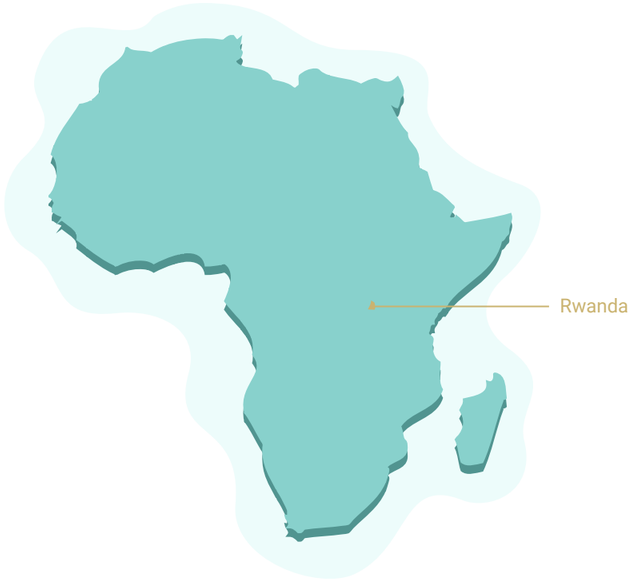
62 Vasseur et al., 12, 130.

63 Vasseur et al., 132.

Survivors' Key Recommendations

- Survivors should be provided with free and secure transportation to One-Stop Centres;
- Survivors should be given the opportunity to choose the care they want;
- One-Stop Centre staff in both rural and urban areas should be adequately trained to address survivors' needs;
- More One-Stop Centres should be established in the DRC and additional mobile clinics should strengthen service provision in remote areas;
- Survivors should have better access to legal aid and legal procedures should be just;
- Socio-economic assistance is important and empowering for survivors journey towards healing - "socio-economic assistance changed my life, of course I received medical and pyschosocial support, but famine continued to threaten my family - socio-economic assistance helped me overcome it and become self-reliant;"[64]
- Shortages of medicines in One-Stop Centres should be addressed;
- Equipment and infrastructure should be improved at hospitals that provide care to survivors;
- The victim and the victim's family must be protected before, during, and after trial(s);
- Efforts must be made to ensure justice when perpetrators are in high offices in the national government, UN missions, or are foreign troops;
- Victims/survivors should be encouraged to break their silence on sexual violence in conflict and not be stigmatised further by communities.

64 «l 'assistance socioéconomique a changé ma vie, bien sûre j'ai reçu le soutien médical et psychosocial mais la famine continuait à menacer ma famille, l'assistance socioéconomique m'a aidée à vaincre la famine et à être autonome.»



RWANDA

Rwanda is well-known and well-regarded for having established Isange One-Stop Centres prior to the Kampala Declaration. In fact, in 2012, Rwanda received the UN Public Service Award in recognition of its promotion of gender-responsive, public-service delivery through the Isange centres.[65] The first centre was established at the Kacyiru Police Hospital in Kigali in 2009 and operated under the Rwanda National Police. It provided free medical, psychosocial, and legal care, as well as police services. Eight other centres were opened soon after, and there are now 44 Isange One-Stop Centres in Rwanda. Seeking to ensure uniformity of services, the police launched a standard operating procedure manual in 2016.[66]

65 "Rwanda Received UN Award for Anti-GBV Campaign," Hope Magazine, 2012, http://www.hope-mag.com/index.php?com=news&option=read&ca=1&a=367#:~:text=The award dubbed "Promoting Gender,operates under Rwanda National Police.&text=The Center is part of,campaign against Gender Based Violence.; Kirya and Nyirinkindi, To- wards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Regional of Africa: A Civil Society Review of the Implementation of the 2011 ICGLR Kampala Declara- tion, 55.

66 Rwanda National Police, "Standard Operating Procedure Manual for Isange One Stop Centres Launched," 2016, https://police.gov.rw/media-archives/news-detail/?tx_news_pi1%5Bnews%5D=3758&tx_news_pi1%5Bcontroller%5D=News&tx_news_pi1%5Bac-tion%5D=detail&cHash=c8f4491fb175ff5efcb3a4ca1a81ccaf.

"In Rwanda, the government has done everything possible to support the survivors. The survivors are treated for free. [...] Also, we have decentralised. That goes for the health side. [...] [But,] on the socio-economic side, there is no way to support all the survivors. We are taking it step by step."

« Au Rwanda, le gouvernement à fait tout ce qui est possible d'entretenir les survivants et survivantes. Les survivants se font soigner gratuitement. [...] Aussi, on a décentralisé. Ça va du côté santé. [...][Mais,] du côté socioéconomique, il n'y a pas de possibilité d'entretenir tous les survivants. On fait des pas à pas. »

Survivor from Rwanda

"My advice is not to stay silent but to talk—either the victims/the survivors, or other people of goodwill—to talk in order to stop [the violence]."

« Je peux donner conseil de ne pas garder silence. De parler, soit les victimes/ les survivant(e)s, soit d'autres personnes de bon coeur, de parler pour arrêter [les violences]. »

Survivor from Rwanda

Although various NGOs offer SGBV services, it is unclear whether there are other One-Stop Centres in Rwanda. Rwandan NGO Haguruka seems to come close, but does not offer all the services in one place. It offers legal, psychological care, and short-term shelter (although the shelters are not yet fully operational), while working with partners to provide socio-economic support through referrals. Haguruka operates four centres in four provinces and has created a network of 416 volunteer paralegals, who provide legal advice and orientation in each of the country's sectors (i.e. local administrative units).

The ToT for National Trainers under the partnership between RTF, Panzi and MF - for Rwanda took place in November 2020. One of the recommendations of the session was that future training activities be expanded to not only target the professionals who provide care under each of the four pillars, but to civil society organisations (CSOs) including faith-based organisations, private sector actors, and the media.

Survivors' Perspectives

Due to various constraints, only two survivors from Rwanda were interviewed for this study. One of them also participated in the FGD. Although neither survivor had been a beneficiary of holistic care from a One-Stop Centre, both described the pillars as interrelated and essential to healing. One survivor recounted how after receiving psychosocial care, she was able to think, take steps towards financially supporting her family, and, ultimately, become a counsellor. The other survivor also indicated that receiving medical and psychosocial care helped her find self-love again and take up her responsibility to take care of herself and her family. Both indicated that the psychosocial care they received helped restore their social relations. To be noted that the survivor explained that 'psychosocial care results in reconciliation with oneself, with one's family, and with one's community - I started with myself, then with my children and then with my community - before I could share or talk to anyone else'.

The survivors pointed out that many victims/survivors do not seek care for diverse reasons. These include their lack of knowledge about if services are available, if they are - then where to go, the distance they must cover to reach One-Stop Centres, the lack of awareness of their rights, or lack of self-confidence. One survivor stated that she was initially afraid to seek assistance, but was directed to a centre by an acquaintance.

Socio-cultural norms that are used to suggest that victims/survivors should remain silent present another obstacle. In some cases, victims and/or survivors may fear reprisals, and may lack confidence in the judicial system.

> **"As women, we are taught (or we learn) to remain silent. Many people do not know the concept of gender-based violence, some things are culturally accepted, but are incompatible with human rights."**

Challenges to the Roll-Out and Operation of One-Stop Centres

Although the progress Rwanda has made in establishing Isange centres is notable, the demand for the services remains high and there is still need to further scale-up service provision. Sometimes victims/survivors must travel long distances to get to the centres. In other cases, they lack awareness of the services. In a 2019 household-based survey conducted by the Ministry of Gender and Family Promotion, 16% of respondents indicated that they were aware of Isange One-Stop Centres.[67] Interestingly, more men were aware of them than women.[68] The survey further revealed that additional reasons victims/survivors did not seek care were: distance to centres, stigma (which was heightened for male survivors), and fear of exposure.[69]

Another reason raised by an informant in the current study, was due to socio-cultural norms that were used to justify certain forms of violence even where they were prohibited by law. The Rwandan household survey found that limited awareness of the law also contributed to failure to seek care. Moreover, the survey seems to suggest that victims/survivors unwittingly destroyed evidence, because they had not been informed about key aspects of evidence preservation. According to the survey, victims'/survivors' limited understanding of evidence preservation led to difficulty in putting together a strong legal case, which victims/survivors tended to interpret as a demonstration of One-Stop Centres' unwillingness to seek justice. As such, this served as an additional deterrent to reporting cases.[70] Among household survey respondents, 50% of survivors who formally reported did so to local leaders, while 30% reported to the police and most survivors did not formally report at all and had their cases dealt with within the family.[71]

An underlying challenge revealed by the Rwandan Ministry of Gender's study was that Isange centres have not been fully integrated into the structure of hosting hospitals.[72] This contributes to a range of difficulties, including limited funding, limited staff members, inability to offer 24-hour services, and limited provision of socio-economic reintegration.[73] Limited staff sometimes mean that victims/survivors have to go to other offices, such as the Ministry of Justice, to seek services.[74] One informant in the current study further suggested that coordination of data collection from One-Stop Centres could be improved. More broadly, the informant also noted that while some steps have been taken in this regard, there is room for even greater coordination between various stakeholders.

Like in other parts of the region, sustainability also presents a challenge in Rwanda. Both the Isange centres and other NGO initiatives have benefited from international donor funding at some point. However, as the survivor from Burundi noted above, given the time it takes to see positive change as a result of SGBV initiatives, funding constraints not only cause the problems described the Ministry, but, more broadly, hamper progress in combatting SGBV.

67 Ministry of Gender and Family Promotion Republic of Rwanda, "Final Report on the Study on Knowledge, Attitude and Practices on GBV, Perceived Root Causes and IOSC Service Delivery" (Kigali, 2019), 69, https://www.migeprof.gov.rw/fileadmin/user_upload/Migeprof/Publications/Reports/Final_Re- port_on_GBV_perceived_root_causes_and_IOSC_service_delivery-July2019.pdf.
68 Republic of Rwanda, 69.
69 Republic of Rwanda, 77.
70 Republic of Rwanda, 77.
71 Republic of Rwanda, 92.
72 Republic of Rwanda, 78.
73 Republic of Rwanda, 77–78.
74 Republic of Rwanda, 77.

Survivors' Key Recommendations

- The legal and socio-economic reintegration pillars should be strengthened, so that One-Stop Centres provide holistic care;
- Victims/survivors should be encouraged to speak out;
- Victims/survivors should be given justice, including compensation - “justice gives peace to the heart”- as a survivor beautifully explained;
- Legal assistance should be provided to survivors during the investigation process and in courts. They should also be interconnected. A survivor recounted receiving legal assistance at the prosecutor's office and psychophysical assistance elsewhere;
- Victims/survivors should be provided with safe spaces where they can support and learn from each other,
- The public should be sensitised about human rights, SGBV, and One-Stop Centers; and
- Sensitisation initiatives should be led by survivors.

UGANDA

Although Uganda is reported to have piloted One-Stop Centres in five districts several years ago, these centres are not operational.[75] In fact, the research suggests that there are currently no One-Stop Centres in Uganda. However, it was reported that the Ugandan government partners with CSOs and development partners operate 21 GBV shelters in keeping with the Guidelines for Establishment and Management of GBV Shelters, which were revised in 2021. These shelters operate within a referral system, through which survivors are provided with medical, psychosocial, legal, and socio-economic support. Through these pathways, various donors, civil society, and governmental actors play an important role in coordinating service provision for victims/survivors. However, the shelters should not be mistaken for One-Stop Centres.

The lack of One-Stop Centres was one of the challenges highlighted during the ToT for Ugandan National Trainers, which took place in November 2020.[76] As a result, National Trainers committed, among other activities, to conduct a stakeholder mapping.[77] The mapping indicates that there are at least 64 SGBV service providers in Uganda. However, few of the providers identified provide services in rural areas and the majority offer psychosocial and legal services.[78] Further, apart from conducting the mapping, the RTF National Trainers supported the police to develop the SGBV curriculum and incorporated the Integrated Model. Additionally, in collaboration with the RTF, the trainers have conducted one training at the Police School and two departmental trainings.

75 Kirya and Nyirinkindi, Towards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Regional of Africa: A Civil Society Review of the Implementation of the 2011 ICGLR Kampala Decla- ration, 80.

76 Hon. Dora C. Kanabahita Byamukama, ASP Francis Ogweng, and Nina Asiimwe Byarugaba, "Re- port on Stakeholder Mapping of Sexual and Gender Based Violence and Training Needs Assessment of Sexual and Gender Based Violence Service Mechanisms and Providers," 2021, 1.

77 Byamukama, Ogweng, and Byarugaba, 2.

78 Byamukama, Ogweng, and Byarugaba, 4.

"[Holistic care] is a set or a series of actions that are done, that are aimed at addressing several aspects of violations that have affected someone."

Survivor from Uganda

"At the time [I was violated], even up to now, holistic care is not available."

Survivor from Uganda

"In most cases, the person ends up giving up because of the corruption that has taken place, and the case has been withdrawn or [they] say the file is lost."

Survivor from Uganda

"If there is a group that wants to support survivors, they should come directly to survivors and not go through the government."

Survivor from Uganda

Some non-governmental service providers also try to offer holistic care through referral pathways. The Centre for Domestic Violence Prevention (CEDOVIP), for example, coordinates a network of referral points: organisations, institutions, and individuals with shared core values who provide services to survivors of SGBV. Through the network, survivors can be provided with medical, legal, psychosocial, economic empowerment and shelter services. Network members share knowledge and support each other's capacity building. Most, but not all, of the services are free but they are not provided in one place or within one system. While members try to complement each other's work and CEDOVIP tries to keep its Referral Directory updated, high staff turnover and organisational change sometimes leave coverage gaps. UGANET, another NGO, operates a shelter in Kampala with support from UN Women. At the centre, survivors of SGBV and of human trafficking are assisted in accessing medical, legal, psychosocial, and economic support through a referral pathway.[79] ActionAid International Uganda, CEDOVIP, MIFUMI, and Uganda Women's Network are other NGOs that have operated shelters that provide victims/survivors with referrals for care under two or more pillars.

79 UN Women, "Rising Woman Shelter and Wellness Centre Provides Refuge to Survivors of Violence and Trafficking," 2021, https://africa.unwomen.org/en/news-and-events/stories/2021/06/feature-story--ris-ing-woman-shelter-and-wellness-centre-provides-refuge-to-survivors.

Survivors' Perspectives

Despite not having received holistic care through a One-Stop Centre, the three Ugandan survivors who were interviewed stressed the importance of all four pillars of holistic care to survivors' wellbeing. One survivor indicated that through holistic care, a survivor can be restored physically, socially, psychosocially, and economically. At the same time, she emphasised that holistic care tries to ensure that a survivor is safe. Another survivor recounted: "After getting the psychosocial support, I was relieved of the burden of thinking every time of the child I bore in captivity, who did not come home and thinking of my friends who are not yet back."

Restoring the survivors' well-being then made it easier for them to restart their lives. Asked about the care she received, one of the survivors indicated that it was transformative, adding, "Without it, I wouldn't be talking to you." The survivors mentioned that while either medical or psychosocial support are provided by the government and some NGOs, legal support and socio-economic reintegration are more difficult to access. Survivors are not often aware of the facilities that are available and often do not receive much support from community members. Rather, according to the survivors interviewed, the community tends to blame and shame survivors, particularly when they are seen moving back and forth from a clinic or centre. Although victims/survivors are often taught that it is shameful to talk about SGBV and might not want their experience known, through such movements, community members can discover that they are victims/survivors.

Moreover, survivors spoke about the difficulty of getting legal assistance. Not only do survivors find it challenging to find a lawyer, but to also pay their fees. Moreover, they feared the impact of corruption on legal cases. One survivor stated:

> **"You may go to the police, then the police may end up talking with the perpetrator. They go and bribe the medical personnel, the case ends up dying, you follow in vain. That's another challenge that we have. Most of the sexual offenses here, they have never succeeded. I don't know whether there are any that really succeeded, and the perpetrator was apprehended."**

Survivors also tried not to be discouraged by Parliament's failure, since 2014, to pass a bill on reparations for victims/survivors following a petition by a small community-based organisation. One of the survivors suggested that the government does not think victims/survivors are important and does not value them. She also expressed concern about children who were born as a result of rape but were too old to remain with their parents, lacked financial resources, and could not buy land.

Other challenges survivors raised had to do with the cost, duration, and quality of care. They often faced difficulty paying for transport to get to centres; for medical services at the hospital and/or medications; and/or for counselling services. This was particularly challenging for one survivor who had been rejected by her family and was seeking financial assistance from the government. Although one of the survivors' rated the quality of psychosocial care she had received as mediocre, she indicated that had it been provided for a longer period, she would have given it a higher rating. Another survivor revealed that although she had a bullet wound, she was yet to receive medical care. She mentioned that many people had promised to provide medical support and had even recorded her contact details, but she was still waiting.

Challenges to the Roll-Out and Operation of One-Stop Centres

As indicated by an informant, the lack of a funding strategy for a One-Stop Centre is a key obstacle. Not only would funding need to cover the cost of running a One-Stop Centre, but it would need to be sustainable.

Much like in other contexts in the region, the government does not seem to have a budget allocation for such centres, and it was difficult to ascertain how much money is, more broadly, allocated to SGBV. One informant contended that the government has left One-Stop Centres to NGOs. Undoubtedly, shelters are filling an important gap. However, they also present challenges. It was reported that shelters predominantly serve women and children rather than men. Additionally, victims/survivors can only stay in a shelter for a maximum of one month. Although the government has reportedly sought to place shelters as close to other service providers as possible, victims/survivors must still travel between different locations and are likely to have to recount their story multiple times.

The difficulty of properly training and maintaining staff is another obstacle to the roll-out and smooth operation of One-Stop Centres. It is highly likely that the high staff turnover witnessed in SGBV service providers will be seen within a One-Stop Centre. The secondary trauma and burnout sometimes experienced by SGBV providers not only affects them and the organisation (e.g. through high staff turnover), but also affects the quality of care they provide to the victim/survivor.

Victim blaming, the stigma associated with support, and other patriarchal attitudes that breed resistance to talking about and addressing SGBV, can hinder victims'/survivors' use of One-Stop Centres. This renders the magnitude of the SGBV problem less visible and makes it difficult to make a compelling case to the government to establish and maintain One-Stop Centres.

There are many obstacles to developing a strong legal pillar. Not only does the public often lack information about SGBV laws and policies,[80] but implementation is often insufficient. As survivors described, corruption further complicates the pursuit of justice. Furthermore, poor coordination within the Justice, Law and Order Sector makes it difficult for victims/survivors to navigate. A 2017 report of the Ugandan Judiciary's Case Backlog Reduction Committee admits that efforts to improve coordination are ongoing.[81] Additional barriers are created by the lack of adequate witness and victim protection laws, and lack of a legal framework on reparations for victims.[82]

80 Byamukama, Ogweng, and Byarugaba, "Report on Stakeholder Mapping of Sexual and Gender Based Violence and Training Needs Assessment of Sexual and Gender Based Violence Service Mechanisms and Providers," 2.

81 Judiciary of Uganda, "A Report of the Case Backlog Reduction Committee," 2017, 37, http://judi- ciary.go.ug/files/downloads/case backlog Report final.pdf.

82 Byamukama, Ogweng, and Byarugaba, "Report on Stakeholder Mapping of Sexual and Gender Based Violence and Training Needs Assessment of Sexual and Gender Based Violence Service Mechanisms and Providers," 1.

Survivors' Key Recommendations

- User-friendly, free One-Stop Centres with adequately trained staff should be established throughout Uganda;
- Except where a hotline is set up, victims/survivors should be provided with free transportation to One-Stop Centres;
- Corruption in the legal system should be addressed, so that victims/survivors can access justice for free and without fear of negative repercussions for them; and
- Perpetrators of SGBV should be convicted.

ZAMBIA

This study is limited in its analysis of Zambia, as Zambian survivors were not included in the research process. Nevertheless, interviews with RTF Trainers and other actors, as well as desk research form the basis for this section.

There are an estimated 50 One-Stop Centres in Zambia. However, many of them do not provide holistic care as defined within this study, because the socio-economic pillar is often missing. Between 2005 and 2011, CARE with funding from the USAID and the European Union (EU) - established One-Stop Centres that offered medical, psychosocial, and legal support.[83] CARE first established two-pilot centres outside of hospital facilities in Lusaka and Chipata, then followed this with six hospital-based facilities in other parts of the country.[84]

In April 2018, the US Ambassador to Zambia handed over 16 One-Stop Centres to the Ministry of Health.[85] The centres had been established within USAID's Stamping Out and Preventing Gender-Based Violence (STOP GBV) programme, funded by the US President's Emergency Plan for AIDS Relief (PEPFAR) and United Kingdom's Department for International Development. In addition to providing medical, psychosocial, and legal services to survivors, the project developed an electronic Gender-Based Violence Information System (GBV IMS) in partnership with the National Central Statistics Office.[86]

83 Care, "CARE Gender & Empowerment One-Stop Model of Support for Survivors of Gender-Based Violence: Lessons from CARE Zambia," 2013, 3, https://1library.net/document/zljx45gy-gender-empower- ment-support-survivors-gender-violence-lessons-zambia.html.

84 Care, 2–3.

85 US Embassy in Zambia, "Ministry of Health to Integrate U.S.-Funded One-Stop Centers into Fight Against GBV," 2018, https://zm.usembassy.gov/anti-gbv/.

86 US Embassy in Zambia.

As described by an informant, donors tend to focus on particular geographical areas. In Lusaka, the Centre for Disease Control funds the University Teaching Hospital (UTH), which provides medical and psychosocial care to victims/survivors of child sexual abuse and adult victims of rape. The UTH has become a key institution for training on response to child sexual abuse. Meanwhile, PEPFAR Zambia supports One-Stop Centres that provide medical and psychosocial care in the South.[87] The European Union (EU) supports One-Stop Centres in Luapula and Northern Province.[88] It is unclear whether they offer holistic care services.

Through the current USAID's Stop GBV Project (2018-2023), the Zambian Centre for Communication Programmes (ZCCP) is supporting 28 One-Stop Centres from 7 provinces, namely Eastern, Lusaka, Central, Copperbelt, Southern, Western, and North-Western. The centres provide medical, psychosocial, and legal services, and refer victims/survivors to other service providers that offer additional services like education support. The Ministry of Health has adopted GBV indicators developed by ZCCP, these indicators are captured live through the GBV IMIS developed in the earlier phase of the project, and now being rolled out by the government at the national level.

Challenges to the Roll-Out and Operation of One-Stop Centres

While most of the One-Stop Centres in Zambia do not seem to provide care services under all four pillars, several of them provide care under three pillars (i.e., medical, psychosocial, and legal), while also seeking to provide some socio-economic assistance to survivors through referrals to actors working in the area. At the same time, even though psychosocial services are often provided, one informant emphasised that the general public is unaware of the importance of such care.

One-Stop Centres also faced difficulty securing sufficient space and equipment. The lack of facilities, like a forensic lab for DNA, led to delays that could hurt court cases. The high cost of training staff members presented another challenge, despite the high risk of turnover. Like informants in CAR, the ZCCP viewed integration of holistic care training at the tertiary and professional or continuing education levels, as a potential solution. The COVID-19 pandemic also resulted in staff shortages, as some staff members were redeployed by the government.

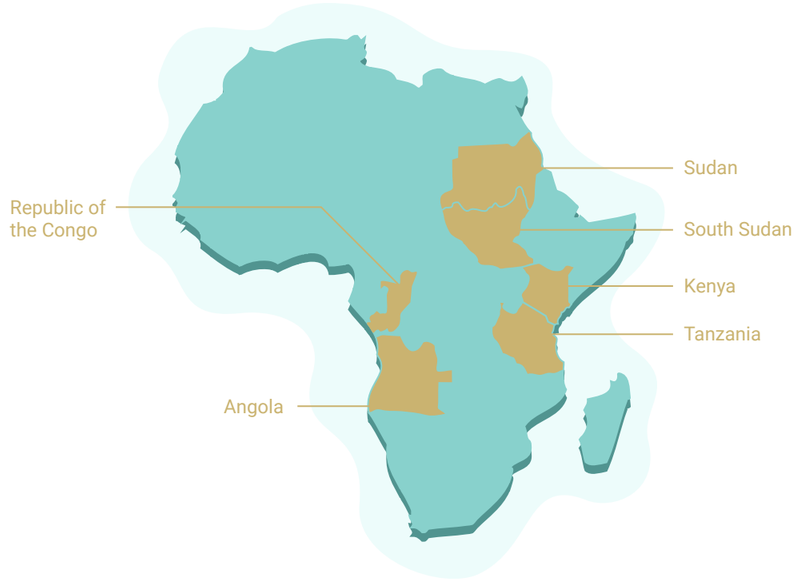
Much like other parts of the region, victims/survivors in Zambia may opt not to seek care because of the way sociocultural norms are used to justify certain forms of SGBV. Contradictions between statutory law and "customary" practices further complicate victims'/survivors' efforts to seek recourse.

The One-Stop Centres in Zambia all relied on international donor funding at one point. It is not clear whether the government has a budget line for One-Stop Centres and how much it allocates to SGBV more broadly. As elsewhere in the region, limited project terms pose a threat to the impact and sustainability of the services. One informant added that there seemed to be a "silent competition" among donors, who were trying to "outdo each other" in the Zambian context. In the informant's view, this dynamic resulted in duplication, rather than cooperation.

The centres often reportedly struggle to provide quality care to survivors. A primary concern was delays in administering PEP and emergency services. Sometimes this was due to the distance victim/survivors had to travel, and their inability to afford transport. UTH also found that children often did not return for PEP reviews. Since the ZCCP is not running the One-Stop Centres but is supporting staff members who are on the government payroll, it faces some challenges maintaining standards across multiple provinces.

87 PEPFAR Zambia, "PEPFAR Zambia Country Operational Plan 2021 Strategic Direction Summary," 2021, 48, https://www.state.gov/wp-content/uploads/2021/09/Zambia_SDS_Final-Public_Aug-11-2021.pdf.

88 Delegation of the European Union to Zambia and COMESA, "Zambia and the EU," 2016, https://eeas.europa.eu/delegations/zambia_pl/1857/Zambia and the EU.



Non-Focal Countries

Much of this section of the report is based on desk research, with the exception of the sections on Kenya and Tanzania, which were also informed by three and one interview(s), respectively. As such, the section focuses primarily on identifying whether or not One-Stop Centres have been established in the non-focal countries and whether they provide holistic care.

ANGOLA

In Angola, the Ministry of Social Action, Family and Women's Promotion has established a network of free Family Counselling Centres that offer legal services to women, as well as care facilities.[89] In collaboration with the Organisation of Angolan Women, the government has also set up shelters for victims/survivors of domestic violence in at least five provinces, namely "Cabinda (1 shelter), Uíge (6 shelters), Cando Cubango (1 shelter), Huambo (1 shelter) and in Luanda (1 shelter)".[90] A 2019 ICGLR-RTF and UN Women report classifies the network of care centres as recovery centres.[91] However, it has been difficult to conclusively determine whether these are indeed One-Stop Centres and whether they offer holistic care to victims/survivors of SGBV.

89 Republic of Angola, "Sixth and Seventh Report on the African Charter on Human and Peoples 'Rights and Initial Report on the Protocol on the Rights of Women in Africa 2011-2016," 2017, para. 30, https://www.achpr.org/public/Document/file/English/angola_periodic_report_6th_2011_2016_eng.pdf.

90 Republic of Angola, para. 36.

91 Hon. Dora C. Kanabahita Byamukama, "An Updated Report on the Implementation of the Kampala Declaration on Sexual and Gender Based Violence by International Conference on the Great Lakes Region Member States," 2019, 44.

98 Jill Keesbury et al., "A Review and Evaluation of Multi-Sectoral Response Services ('One-Stop Centers') for Gender-Based Violence in Kenya and Zambia" (Nairobi, 2012), 7.

93 Gender Violence Recovery Centre, "About Us," 2020, https://gvrc.or.ke/about-us/.

94 Gender Violence Recovery Centre; Coalition on Violence Against Women, "Access to Justice and Women's Rights Initiative," n.d., https://covaw.or.ke/access-to-justice-and-womens-rights/.

95 Wangu Kanja Foundation, "Wangu Kanja Foundation," 2016, https://wangukanjafoundation.org/.

96 Coalition on Violence Against Women, "Access to Justice and Women's Rights Initiative."

97 National Police Service, "POLICARE Policy" (Nairobi, 2021), 1.

98 RAINN, "Sexual Violence in Six African Nations: A Call for Investment," 10.

99 RAINN, 11.

KENYA

There are at least 10 public and private Gender Violence Recovery Centres (GVRCs) or Gender Based Violence Recovery Centres (GBVRCs) in Kenya, which primarily provide medical and psychosocial care to victims/survivors. They occasionally provide legal aid as well, but this is generally through "off-site referrals".[92] The first such centre was established in March 2001 as a non-profit charitable trust of Nairobi Women's Hospital.[93] Since then, this GVRC has been used as a model to establish similar centres in other parts of the country. These include the following:

- Centre for Assault and Recovery (CARE) at Moi Teaching and Referral Centre in Eldoret;
- Coast General Hospital Recovery Centre in Mombasa;
- Gender Based Violence Recovery Centre (GBVRC) at Kenyatta National Hospital in Nairobi;
- Taita Taveta District Hospital;
- Biafra Clinic in Eastleigh Nairobi;
- Mbagathi District Hospital in Nairobi; and
- Makueni County Hospital Gender Based Violence Recovery Centre (GBVRC);
- Rift Valley Provincial General Hospital in Nakuru; and
- Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu.[94]

Although services at these centres are predominantly free, victims/survivors usually have to pay an administrative cost to open their file. Reflecting on the services these and other centres provide, one informant suggested that if holistic care requires inclusion of all four pillars of care, "then there is no holistic care in Kenya".

Nevertheless, some NGOs try to collaboratively offer holistic care. The Wangu Kanja Foundation, for example, offers medical care through the GVRC at Nairobi Women's, as well as psychosocial care, legal aid, and financial freedom programmes.[95] The Foundation was started by a survivor of SGBV and convenes the Survivors of Sexual Violence in Kenya Network. Similarly, the Coalition on Violence Against Women works with several G(B)VRCs to provide medical, legal, and psychosocial care to victims/survivors of SGBV.[96] However, this care is not provided in one place or within a single system.

Inspired by the Rwandan Isange One-Stop Centres, the Kenya National Police Service launched the POLICARE (for "police that care")[97] initiative on 13 October 2021. This initiative aims to establish One-Stop Centres across the country, which offer medical, psychosocial, legal, and forensic services to victims/survivors of SGBV. Although special GBV courts have not yet been established in Kenya, the initiative also seeks to have a GBV court on site at each of the centres. Unlike the Isange, centres will not be based at hospitals, but will be hosted by the police. Medical personnel may be seconded to the centres, and they plan to have an ambulance available to transport victims/survivors to hospitals as needed. While there are currently no plans to have a socio-economic component on site, the centres will enlist the support of partners, including UN agencies and NGOs, in order to provide this care to victims/survivors off-site. The centres will be non-residential, but will work with safe houses to provide some accommodation to victims/survivors.

Many of the challenges faced by One-Stop Centres in other parts of the region are also experienced or anticipated in Kenya. Victims/survivors may not be aware of the services or may opt not to use them for a range of reasons. At the same time, funding and personnel constraints make it difficult for some of the G(B)VRCs to offer 24-hour services.[98] The centres also experience shortages in medical supplies and lack some of the equipment necessary to provide quality services to victims/survivors. Limitations within the DNA management infrastructure, for example, make it difficult for the G(B)VRCs and other SGBV service providers to use forensic evidence to identify and convict perpetrators in sexual assault cases.[99] Data management is also a challenge, resulting in little documentation of SGBV cases and an inability to track them through the legal system.

POLICARE is currently relying on development partners for funding and planning to recruit volunteers to provide services during its initial phase of operation. However, the expectation is that the centres will be supported by a budget allocation for the National Police Service. It is impossible to predict what that budget allocation may be, particularly since it is unclear how much the Kenyan government currently allocates to SGBV. The amount of funding POLICARE Centres will receive, and the source(s) of this funding will be a significant determinant of the initiative's sustainability.

Although there are many actors providing SGBV services, there is limited coordination at the national and, more so, at the county levels. One informant suggested that within the mix of State and non-State actors, "people are not talking to each other. Everyone is doing their own thing."

REPUBLIC OF CONGO

In the early 2000s, Médecins Sans Frontières supported the establishment of centres offering medical, psychological, and social assistance to victims/survivors of SGBV in the Republic of Congo.[100] The centres are based at hospitals in Makélékélé and Talangai. However, MSF withdrew from the country in 2005. With support from the EU, the NGO AZUR Développement also established centres offering medical, psychosocial, and legal care in Brazzaville and, more recently, in Bouenza.[101] AZUR established a similar centre in Pointe-Noire in 2014 with support from the French Embassy in Congo.[102] The ICGLR-RTF and UN Women report that care units for victims/survivors of SGBV have also been established at integrated health centres in Likouala, Bouemba, Makotipoko, and Madibou, as well as at the hospital in Bacongo.[103] However, it is not clear what services these units provide and whether they provide holistic care.

SOUTH SUDAN

The UNFPA provides support to 11 family protection centres that provide medical, psychological and legal care to victims/survivors of SGBV in Juba, Bor, Kapoeta, Malakal, Maluankon, Rumbek, Torit, Wau and Yambio.[104] The Ministry for Gender, Child and Social Welfare supports the centres with a range of donors, including the UN Trust Fund to End Violence Against Women, Sweden, Canada, Swiss Agency for Development Cooperation, and the Netherlands.[105] The centres are run by different organisations, including the International Rescue Committee (Juba, Malakal, and Rumbek) and Strategic Initiative for the Women in the Horn of Africa (Wau).

SUDAN

A 2014 CSO review of progress implementing the Kampala Declaration suggested that the low amount of government spending on health led to limited provision of services to victims/survivors in Sudan.[106] Unfortunately, like the ICGLR-RTF and UN Women's more recent report on implementation of the Declaration,[107] this study was unable to find information on the status of the roll-out of One-Stop Centres in Sudan. It was reported that NGOs confidentially operate One-Stop Centres in order to protect the victims/survivors.

100 Véronique Goblet, "Lutte et Réponse Aux Violences Sexuelles En République Du Congo: Analyse de Situation," n.d., 30.

101 Programme concerté pluri acteurs Congo, "Azur DEV Lance Un Guichet Unique d'assistance Aux Jeunes Filles Dans La Bouenza," 2020, https://pcpacongo.org/2020/12/26/azur-dev-lance-un-guichet- unique-dassistance-aux-jeunes-filles-dans-la-bouenza/.

102 Programme concerté pluri acteurs Congo.

103 Byamukama, "An Updated Report on the Implementation of the Kampala Declaration on Sexual and Gender Based Violence by International Conference on the Great Lakes Region Member States," 44.

104 United Nations Population Fund and United Nations Development Programme, "One Stop Centre: Rolling Out Provision of Integrated Gender-Based Violence (GBV) Response Services in South Sudan," 2020, 3–4, https://mptf.undp.org/document/download/23930; USAID, "USAID/South Sudan Gender-Based Violence Prevention and Response Roadmap," 2019, 86, https://pdf.usaid.gov/pdf_docs/PA00WB3K.pdf. civil society organisations, national and international NGOs, and other donors.

105 USAID, "USAID/South Sudan Gender-Based Violence Prevention and Response Roadmap," 86.civ- il society organizations, national and international NGOs, and other donors

106 Kirya and Nyirinkindi, Towards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Regional of Africa: A Civil Society Review of the Implementation of the 2011 ICGLR Kampala Decla- ration, 69.

107 Byamukama, "An Updated Report on the Implementation of the Kampala Declaration on Sexual and Gender Based Violence by International Conference on the Great Lakes Region Member States," 45.

TANZANIA

There are at least 15 One-Stop Centres in Tanzania. The first centre was established in 2011, at Mnazi Moja Hospital in Zanzibar. Through a partnership between several government ministries and institutions, Zanzibar Female Lawyers Association, Legal Service Centre, Save the Children, United Nation Children's Fund (UNICEF), UNFPA, and the Danish International Development Agency, the centre offers free medical, psychosocial, and legal care to victims/survivors of SGBV.[108] Since then, seven additional centres have been set up in Tanzania Mainland, at Amana Hospital in Dar es Salaam Region, as well as in the regions of Hai, Mbeya, Iringa, Simiyu, Mwanza, and Shinyanga.[109] Another six centres were established in Zanzibar hospitals, including Kivunge, Makunduchi, Chake Chake, Wete, Micheweni, and Mkoani.[110] In February 2019, together with implementing partner Children's Dignity Forum, the UNFPA opened another One-Stop Centre at Mwananyamala Hospital in Dar es Salaam.[111] This centre offers medical, psychosocial care, and legal care.[112]

Despite the availability of these services, barriers to victims'/survivors' use, include lack of awareness of the services, shame and stigma, sociocultural norms mobilised to justify violence, and distance. Even where victims/survivors use the services, the informant indicated that people lack information about evidence preservation, resulting in late reporting. Survivors often faced difficulty covering the cost of transportation and medical supplies.[113] Moreover, poverty and long delays in court cases contributed to perpetrators negotiating with victims/survivors outside of court. According to the informant, although there are some safe houses in Tanzania, they are not enough to meet the need.

108 UNFPA, "One Stop Centre for Survivors of Violence Opens in Zanzibar," 2011, https://www.unfpa. org/news/one-stop-centre-survivors-violence-opens-zanzibar.

109 CEDAW, "Committee on the Elimination of Discrimination against Women List of Issues in Rela- tion to the Seventh and Eighth Periodic Reports of the United Republic of Tanzania: Replies of the United Republic of Tanzania to the List of Issues," 2016, para. 13, https://tbinternet.ohchr.org/Treaties/CEDAW/ Shared Documents/TZA/CEDAW_C_TZA_Q_7-8_Add-1_23034_E.pdf.

110 CEDAW, para. 13; "Why New Government in Zanzibar Vows to Stop Gender-Based Violence," Daily News, 2020, https://www.dailynews.co.tz/news/2020-11-245fbd1de0aee8e.aspx.

111 UNFPA, "Annual Report 2018," 2018, 40, https://tanzania.unfpa.org/sites/default/files/pub-pdf/ AR_2018_Tanzania_medres_7march2.pdf; UNFPA, "One Stop Centres: Facilitating Comprehensive and Ethical Care for Survivors of Gender-Based Violence," 2019, https://tanzania.unfpa.org/en/news/ one-stop-centres-facilitating-comprehensive-and-ethical-care-survivors-gender-based-violence.

112 UNFPA, "One Stop Centres: Facilitating Comprehensive and Ethical Care for Survivors of Gen-der-Based Violence."

113 RAINN, "Sexual Violence in Six African Nations: A Call for Investment," viii.

Concluding Reflections

The majority of ICLGR Member States missed the 2014 deadline for "fast track[ing]" the rollout of One-Stop Centres offering free, comprehensive, and user-friendly services to victims/survivors of SGBV. However, in the last decade, ICGLR Member States have shown increased commitment to addressing SGBV through laws and policies, national action plans, public sensitisation campaigns, like the Zero Tolerance Campaign,[114] and other initiatives. To date, there are reportedly One-Stop Centres operating in all of Member States with the possible exceptions of Sudan - where there was insufficient information to confirm the status of One-Stop Centres - and Uganda. Nevertheless, the coverage of these centres is limited and does not respond to the actual need.

Throughout the region, NGOs have been key actors in the realisation of this Kampala Declaration commitment, often partnering with the government, UN agencies, and/or international donors to set up centres. Although this role has been critical, NGO reliance on external funding limits the number, geographical coverage, and holistic scope of One-Stop Centres, while narrowing the timeframe for care and posing a huge threat to sustainability. This has contributed to what one informant referred to as the "projectisation" of SGBV, which hampers real progress in this area.

> **"Something good is coming, but not [as] fast as we had hoped for before. Ten years are done. Maybe in the near [future] we are going to get something for ourselves, so we should be patient."**
>
> **Survivor from Uganda**

> **"We're fighting the consequences. We should really try to look at how to fight the cause."**
>
> *« On est en train de se battre contre les conséquences. Il faudrait vraiment voir comment se battre contre la cause. »*
>
> **Survivor from DRC**

> **"Exchanging testimonies teaches lessons. X country has advanced. We must help the others advance. We gain knowledge from it."**
>
> *« Les échanges de témoignages donnent des leçons. Tel pays a avancé. Nous devons faire avancer les autres. On en retire des connaissances. »*
>
> **Survivor from Rwanda**

114 Byamukama, "An Updated Report on the Implementation of the Kampala Declaration on Sexual and Gender Based Violence by International Conference on the Great Lakes Region Member States," 32–33.

While all the centres identified offer a package that includes two or three of the pillars of holistic care, only One-Stop Centres identified in CAR and the DRC offer holistic care, meaning that they offer all four pillars of care in one place or within one system. Although some of the Isange Centres in Rwanda may offer some socio-economic reintegration care, the findings suggest that even where it is available, this **care tends to be limited in scope.** The failure to provide holistic care poses a grave threat to survivors' recovery, as well as to the broader well-being of the community. Survivors who participated in the study, urge the creation of more One-Stop Centres with services available in a central space, providing holistic care across the region. This is especially relevant, as the interviews with survivors recognise the interdependence of needs when receiving care.

Different quotes and real-life instances revealed through the study demonstrate that for the body to heal, or for a patient to feel mentally strong enough to undergo complex surgery, pyschological needs must be addressed. Furthermore, in order to fully heal and practice self-reliance, concerns about livelihood and financial security must be alleviated. Similarly, as was evident throughout the different countries analised in the study, seeking justice and bearing processes of police reporting, and testifying in court was important to work further towards gaining justice. While for most survivors, going through these different stages of care proved to be a difficult process, it was possible with the presence of a strong support network and availability of free and dignified services.

Although Member States in the region may allocate funding to provide certain services to victims/survivors, financing is a key concern, given the impact of the COVID-19 pandemic, conflicts in some Member States, and the resource constraints all Member States face, as low- or lower-middle income States. However, as one informant put it, "They don't have money for these issues, but they have money for fighter jets!" Regardless of the cost, One-Stop Centres do not seem to be a priority for many of the Member States. An informant from Burundi estimated the operational costs of a One-Stop Centre to be about 30,700 USD per year, while an informant from the DRC estimated that the costs of setting up and running a centre would be between 300,000 and 400,000 USD. A 2012 Population Council study looking at One-Stop Centres in Kenya and Zambia, projected the cost for an NGO to set up and manage a One-Stop Centre (either hospital-based or stand-alone) as between 35,719 and 46,069 USD per year.[115] Salary costs to run such a centre were estimated to range between 24.7 and 26.1 USD per survivor per year.[116] It was also estimated that salaries would run at about 31.9 per survivor per year for a hospital-based and hospital-owned One-Stop Centre. However, it was and remains difficult to estimate start-up costs for such a facility because of its full integration within the hospital.[117] In 2016, a study by the Kenya National Gender and Equality Commission projected the mean cost of a One-Stop Centre at a first referral public hospital in the country to be about 502 USD per survivor, with legal costs making up the highest percentage of costs (i.e. 75 percent).[118] Although further study of the cost of One-Stop Centres, and consideration of how quality, holistic services can be provided at an affordable cost might inform Member State budgetary allocations, States that have not already done so, should prioritise One-Stop Centres by creating a specific budget line for them and allocating resources.

Survivors expressed many shared concerns, and similar challenges faced in the roll-out and operation of One-Stop Centres echoed from one focal Member State to the next. For example, survivor's testimonies demonstrated that geographical distance and lack of means of travel are key obstacles for survivors accessing care. Survivors in the region noted that most of the One-Stop Centres are located in the major cities of their countries and operate less/or not in rural areas where SGBV rates still remain very high. As such, a Congolese survivor says: "The services are far away in the city, while there are many survivors in the villages." Survivors called for One-Stop shops to be built in all rural areas of the Great Lakes countries, in view of the scale and magnitude of the problem in remote corners of these countries. Bringing care closer to survivors was seen as a priority of priorities. In addition, the lack of information on the what-where-how of available services, social stigma attached to SGBV, and non-transparent procedures were also seen as additional obstacles by survivors in accessing their right to holistic care.

Survivors noted that it is not just the presence of One-Stop Centres, but also **the environment that is created in these spaces** that can encourage more survivors to break the silence on sexual violence and access care. They appreciated the confidentiality, warm welcome, and dignity survivors experienced in the One-Stop Centres. This becomes especially important when survivors are coming from an environment of stigmatisation and isolation. In addition to reinforcing respect and dignity of survivors in care settings, survivors that were interviewed through this study also appreciated receiving free access to care, whether this takes the form of receiving PEP kits[119] and other medicines, receiving free food and accommodation for the days spent in medical treatment, access to free psychological support etc.

There is **great potential for learning and collaboration across borders.** Key lessons must be learned from survivors, who often felt marginalised from processes purportedly aimed to serve them. One survivor warned, "We work on projects, but they don't have an impact on the person themselves. And that's the big challenge, that donors understand that it's not every project that can impact the life of a victim."[120]

Coordination of activities and monitoring progress are two important aspects that the ICGLR should enhance. Informants suggested two different possibilities for better coordination at the regional level. One was that the ICGLR Gender Directorate be strengthened, in order to facilitate coordination of regional care activities. Another was the creation of a special rapporteur with a coordination mandate. Also, given the multiple levels and areas of reporting within various regional economic communities and the African Union (AU), one informant recommended that the ICGLR work with the AU, in order for Member States' reports at the continental level to include reporting on the Kampala Declaration. Regardless of how the ICGLR proceeds, the findings suggest that focus should be on facilitating concrete action. As one informant contended, "We are killing ourselves with action plans!" Study participants made it clear that yet another regional action plan is not required.

115 Keesbury et al., "A Review and Evaluation of Multi-Sectoral Response Services ('One-Stop Cen- ters') for Gender-Based Violence in Kenya and Zambia," 28.

116 Keesbury et al., 28.

117 Keesbury et al., 28.

118 National Gender Equality Commission, "Gender-Based Violence in Kenya: The Cost of Providing Services," 2016, 31, https://www.ngeckenya.org/Downloads/GBV Costing Study-THE COST of PROVID- ING SERVICES.pdf.

119 Post-Exposure Prophylaxis. PEP is a short term anti-retroviral treatment that reduces the likelihood of HIV infection after exposure of HIV-infect blood or sexual contact with an HIV positive person.

120 « Nous faisons des projets mais qui n'impacte pas sur la personne elle-même. Et c'est ça le grand défi, que les bailleurs de fond comprennent que ce n'est pas tout projet qui peut impacter sur la vie de victime. »

Recommendations

Overarching Recommendations:

- ICGLR Member States should adopt a definition of and commitment to holistic care that includes medical, psychological, legal, and socio-economic pillars, and respects victims'/survivors' right to choose what care they need;
- Survivor organisations and movements should be provided with financial, technical, and/or logistical support, so that they can lead initiatives to improve the provision of holistic care in the region;
- ICLGR Member States should create and observe a new deadline for fast-tracking the creation of accessible (i.e., free, survivor-friendly, 24-hour, regional, locally-tailored) One-Stop Centres with adequate equipment, as well as motivated and trained personnel who offer quality, long-term support to victims/survivors of SGBV; and
- Project partners should collaborate with One-Stop Centres, survivors, and other stakeholders to create a platform through which One-Stop Centres can share challenges faced, best practices, and lessons learned.

Additional Recommendations:

- ICGLR Member States should adopt the Regional Integrated Training Model for SGBV, adapt it to their contexts, and integrate it into professional training and other relevant tertiary education programs (e.g., medicine, law, nursing, psychosocial programs and training of police recruits);
- Make sufficient line budget allocations to relevant Ministries to support the establishment and operation of One-Stop Centres that provide quality holistic care;
- Undertake, routinely update and disseminate a mapping of all One-Stop Centres, which includes each centre's location, services, geographical coverage, challenges, and annual budget;
- Undertake and routinely update a mapping of SGBV providers who provide care under two or more pillars;
- Strengthen legal and judicial assistance for survivors, ending a culture of impunity in their countries. Survivors from different countries stressed that as long as perpetrators are not arrested and convicted, SGBV will continue;
- If they have not already done so, create and provide adequate funding to a mechanism charged with coordinating the provision of care to victims/survivors of SGBV at the national level;
- Work with survivors to design and establish a program to provide reparations[121];
- Annually document and periodically report on their budgetary allocation for One-Stop Centres and contributions to the Special Fund, in addition to collecting user data on One-Stop Centres and income generation initiatives;
- Develop standard operating procedures for One-Stop Centres in collaboration with other stakeholders, based on the Regional Integrated Model; and
- Develop national SGBV data management systems in collaboration with other stake-holders.

ICGLR MS should:

- Strengthen its Gender Directorate, so that it can facilitate learning from survivors, One-Stop Centres, and other SGBV service providers;
- Create a special mechanism or revamp an existing institution to facilitate coordination of regional holistic care activities;
- Create a mechanism through which Member States periodically report on implementation of the Kampala Declaration.

121 This draws on the recommendations made at the November 2021 Survivors' Hearing on Reparations held in Kinshasa.

ICGLR-RTF, Mukwege Foundation, and/or Panzi Foundation should:

- Provide additional financial support and build the fundraising capacity of Master and National Trainers, in order to cascade the training across the region;
- Support exchange visits between SEMA Network members and other survivors in the region;
- Share the results of this report with all the actors who contributed to the study, in addition to producing a simplified version of the report and disseminating it to the grassroots with support from survivor networks, community-based organisations, and other actors;
- Promote the sharing of experiences and best practices between different countries of the Great Lakes Region in terms of prevention and response to SGBV.

One-Stop Centres should:

- Contribute to the national data management system by monitoring the number of survivors served, type of violence involved, types of care provided, number of court cases, number of convictions, and other data;
- Undergo routine evaluations under each pillar of the holistic model to assess the extent to which they are meeting victims/survivors' needs; and
- Continuously provide training, as well as psychosocial support to staff.

Donors should:

- Provide core support and flexible funding to ensure that local and regional grantees can cover the cost of longer-term, holistic One-Stop Centre projects;
- Ensure that NGO One-Stop Centre projects incorporate the transfer of competency to relevant government actors, in order to facilitate sustainability;
- Make the funding application process user-friendly to facilitate funding of grassroots survivor initiatives;
- Include self and collective care for service providers in the budgeting for One-Stop Centre and other SGBV-provider grantees; and
- Harmonise funding procedures in order to collaboratively support One-Stop Centres.

All Actors should:

- Ensure that survivors are placed at the centre of initiatives to improve the provision of care;
- Provide financial, technical, and/or logistical support to survivor organisations and movements, so that they can lead holistic care initiatives in the region;
- Foster experience sharing and mentorship through One-Stop Centre exchange and monitoring visits which include policy makers;
- Work to improve the provision of care and the coordination of services among all 4 pillars (medical, psychological, legal, and socio-economic), while paying particular attention to the notable weakness of the legal and socio-economic pillars across the region;
- Support the translation of SGBV laws and policies into local languages;
- Provide mobile care and clinics in hard to reach settings;
- Conduct and/or support community sensitisation on SGBV across the region, which involves traditional and religious leaders, tackles the stigma associated with SGBV, engages everyone including men and boys, and promotes holistic care for victims/survivors; and
- Conduct community-based, participatory research in order to better understand how to promote peace and stability.

> **"We have a saying: 'Two are better than one'."**
> *"L'union fait la force." "Unity creates strength."*
> **Survivor from Uganda**

> **"Listen to me and then take actions based on my recommendations."**
> *« Écoutez-moi et prenez des mesures en fonction de mes recommandations. »*
> **Survivor from DRC**

> **"As a result of this study, [a] survivor would like to see something tangible affecting his/her life."**
> **Survivor from Rwanda**

List of Abbreviations and Acronyms

AU	African Union
AFD	Agence Française de Développement (French Development Agency)
AFJC	Association des Femmes Juriste de Centrafrique (Central African Association of Women Lawyers)
CAR	Central African Republic
CEDOVIP	Centre for Domestic Violence Prevention
COCAFEM/GL	La Concertation des Collectifs des Associations Féminines de la Région des Grands Lacs (Concertation of Collectives of Women's Associations in the Great Lakes Region)
CRSV	Conflict-Related Sexual Violence
CSO	Civil Society Organisation
DRC	Democratic Republic of the Congo
FGD	Focus Group Discussion
FNF	Forum National des Femmes
GBV IMS	Gender Based Violence Information System
G(B)VRC	Gender (Based) Violence Recovery Centre
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HIV	Human Immunodeficiency Virus
ICART	International Center for Advanced Research and Training
ICGLR	International Conference on the Great Lakes Region
ICRC	International Committee of the Red Cross
IFJD	Institut Francophone pour la Justice et la Démocratie (Francophone Institute for Justice and Democracy)
MF	Dr. Denis Mukwege Foundation
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Fund for AIDS Relief
PF	Panzi Foundation
RTF	Regional Training Facility
SEMA	Global Network of Victims and Survivors to End Wartime Sexual Violence
SENI	CAR Health System Support & Strengthening
SGBV	Sexual and Gender-Based Violence
SOFEPADI	Solidarité Féminine Pour la Paix et le Développement (Female Solidarity for Peace and Integral Development)
STI	Sexually Transmitted Infection
ToT	Training of Trainers
UMIRR	L'Unité Mixte d'Intervention Rapide et de Répression des Violences Sexuelles faites aux Femmes et aux Enfants/ Mixed Unit for Rapid Intervention and Suppression of Sexual Violence against Women and Children
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
UTH	University Teaching Hospital
USD	United States Dollars
ZCCP	Zambia Centre for Communications Programmes

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