‘One Stop Centres’ and State Accountability for Sexual Violence: Comparing Integration Models In Kenya And South Africa

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INTRODUCTION

Comprehensive responses to sexual violence that integrate, at a basic – health, legal and psychosocial support services – are widely accepted as best practice. Disjointed efforts among the relevant sectors compromise health care, causes secondary victimization and attrition of cases from the justice system. While the popular ‘One Stop Centre’ (OSC) approach providing services under one roof has increasingly gained traction in Africa, there is a dearth of evidence on how these models can operate effectively and sustainably in low-resource settings (Keesbury, Onyango-Ouma, 2012).

In this study I seek to understand how integration approaches in Kenya (Gender Based Violence Recovery Centres) and South Africa (Thuthuzela Care Centres) contribute to fulfilment of State Obligations to address sexual violence against women. The few existing evaluations of inter-sectoral approaches have largely construed *effectiveness* solely on the basis of meeting immediate health needs or legal outcomes. To include broader considerations, I assess how the models contribute to fulfilment of State obligations to Prevent, Protect, Prosecute Punish and Provide adequate reparations for sexual violence,-5Ps, (Abdul Azizi and Moussa 2014).

Understanding how each stakeholder as a ‘node’ within the inter-sectoral networks operate to influence the orientation of the approaches, is critical in assessing whether victims needs and rights remain at the centre of the integration processes. Linking the OSC approach to State accountability for sexual violence as gives imperative for State-led approach to establishing and scaling-up sustainable models.

OBJECTIVES

To understand how integration approaches in Kenya and South Africa contribute to the fulfillment State obligations to Prevent, Protect, Prosecute, Punish and Provide adequate redress/reparations for sexual violence.

METHODS

8 sites, 63 key informants, 4 FGDs, 34 victims

Study areas and site selection: Both Kenya and South Africa are leading the continent in integrating sexual violence interventions. The Courts in both countries have developed jurisprudence on the due diligence obligations of States to prevent and respond to sexual violence. Sites in rural, peri-urban and rural settings were selected and matched into comparable pairs in terms of structure, facilities and locality.

Study participants: service providers such as police, health workers, prosecutors, case managers, social workers, NGOs providing services at the centers and victims of sexual violence supported through the Centres

METHODS

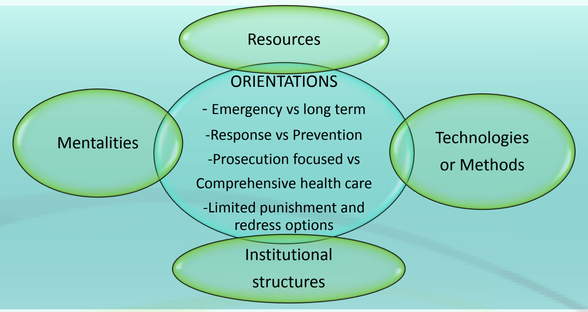
Summary of sites showing selection and categories

Description	Services		Kenya	South Africa
Well facilitated, Urban setting	Public facility	• Specialized medical services, collection and preservation of forensic evidence • Counselling &psychosocial services • Legal aid through referral or case managers • Awareness creation activities.	Kenyatta National Hospital-GBVRC	Karl Bremer Heideveld TCC (GF Jooste)
	Private facility		Nairobi Women’s GVRC	None
Reasonably facilitated peri- setting urban	• Medical care and psychosocial support. • Legal aid is provided through referral. • Awareness campaign activities		Nakuru PGH GBVRC	Worcester TCC
Basic services, rural setting	• Basic clinical services integrated through main facility • Dependent on general facility clinical staff for medical services • Counselling by part time counsellors		Kitale District GRC	Atlantis-Wesfleur TCC

FINDINGS

Orientations Matter

Depending on the specific resources, mentalities (ways of thinking), technologies (or methods), and institutional structures (that mobilize resources) of each *player* within the integration approaches; whether State or Non-State, the integration approaches adopt certain orientations which cause them to prioritize certain outcomes more than others.



***‘I felt safe but afraid’* –Victim in FGD**

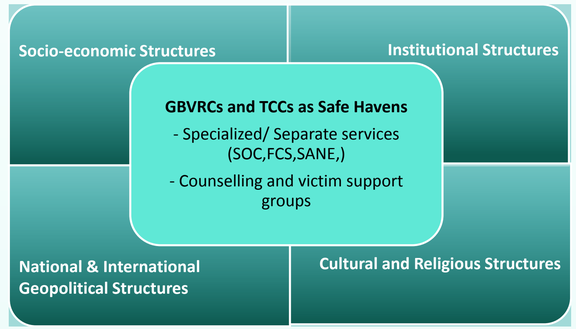
In this quote the participant expresses the consequence of disconnected health and legal interventions to rape, and the challenge of lacking shelters. While she received long-term psychosocial care that helped her deal with the rape trauma, she remained afraid because the court case was never resolved. She had no information of the case status.

DISCUSSION AND CONCLUSIONS

Models orientated towards enhancing criminal justice system outcomes increase conviction rates, but may compromise holistic long term health care. Models orientated towards comprehensive health (including psychosocial care) offer long-term support but may compromise investment towards legal outcomes that a victim may want. A model that fulfils the 5Ps of State obligations is one that would integrate both approaches.

Safe havens within flawed structures

The integration models display immense creativity in galvanizing the capacities of a range of stakeholders including paralegals, community health workers, volunteer counselors and social workers to overcome challenges of low-resource settings. Ultimately the centers operate as safe heavens within flawed legal, social,, political, and economic structures that embed the systems and institutions within which they operate.



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