ASSESSMENT REPORT ON ONE STOP SERVICE CENTERS FOR VICTIMS OF VIOLENCE IN MONGOLIA

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Abbreviations

AGH	Aimag General Hospital
GBV:	Gender Based Violence
FH:	Forensic Hospital
HIV:	Human Immunodeficiency Virus
LCDV:	Law on Combating Domestic Violence
MDT:	Multi-Disciplinary Team
MOH:	Ministry of Health
MOJHA:	Ministry of Justice and Home Affairs
MOSWL:	Ministry of Social Welfare and Labor
MOSW	Ministry of Social Welfare (former MOSWL)
NGO:	Non-Governmental Organization
NCAV:	National Center against Violence
OSSC:	One Stop Service Center
PEP:	Post-Exposure Prophylaxis
PHC:	Primary Health Care
PO:	Police Office
SDC:	Swiss Agency for Development and Cooperation
SDHC:	Sukhbaatar District Health Center
STI:	Sexually Transmitted Infection
TH:	Trauma Hospital
UBCPD:	Ulaanbaatar City Police Department
UN:	United Nations
UNDP:	United Nations Development Programme
UNFPA:	United Nations Population Fund
WHO:	World Health Organization

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EXECUTIVE SUMMARY

This summary presents the key findings of the assessment of UNFPA supported one-stop service centers (OSSCs) and shelters for survivors of gender-based violence (GBV) operating in Mongolia. The assessment was designed to assess the relevance, effectiveness, efficiency, and sustainability of services provided by existing OSSCs and their implementation of the United Nations Essential Services Package (UN ESP). The assessment was conducted in four geographical areas: Ulaanbaatar (the capital city), Bayankhongor, Gobi-Altai, and Zavkhan aimags in June and July 2017. The key findings of the assessment were as follows:

A. Relevance: Mongolia has comprehensive legislation and a policy framework addressing GBV including the provision of essential services to survivors of domestic and sexual violence. The revised Law on Combating Domestic Violence (LCDV) which was approved in December 2016 and became effective in February 2017, defines the duties and responsibilities of the health, justice and social sectors, the police, non-governmental organizations (NGOs) and other service providers in the delivery and coordination of multi-sectoral services for GBV response. The assessment found these services to be aligned with the Essential Services identified in the UN ESP Guidelines.

Mongolia's national response to GBV is addressed in several complementary pieces of legislation. The LCDV indicates that "the one-stop service provision unit (OSSC) can work under hospital, governmental agencies and NGOs, and shall provide essential services free of charge, regardless of the victim/survivor's residence." The Health Law mandates that the State shall provide free (government subsidized) health services to survivors. The National Programme on Domestic Violence, the Mid-term Strategy to implement the Gender Equality Law, and the National Program on Gender Equality further mandate that OSSCs will be scaled up across the country.

At present, there are three distinct types of OSSC models in Mongolia: The first is a health facility-based model where some or all of the OSSC's management and operations are integrated into the health facility's administration. The second is an OSSC that is owned and fully integrated into the police department and based out of a local police office, such as in Zavkhan. The third is an independent OSSC managed by a local NGO and financed by the local government, such as in Bayankhongor.

All models had strengths and weaknesses as the first point of care for GBV survivors. For example, the health facility-based OSSCs provided easy access to the broadest range of health and psychological services. However, this model had weaker links to the legal and justice systems. The police-based OSSC was

strongest in terms of safety, legal, policing and psychosocial services but the provision of health care remains a challenge. The NGO OSSC offered a wider range of essential services including safety, psychosocial and legal support, but the health care provision was also challenging. Coordination with other sectors and agencies was weak across all OSSC models. Multi-sectoral collaboration and coordination should be strengthened to ensure the provision of quality essential services in line with the UN ESP Guidelines.

B. Effectiveness: The assessment found that OSSCs have made significant progress since the approach was first introduced in Mongolia in 2009. The OSSCs have served over 5,000 victims in the last 5 years. Of these, approximately 2,000 women and children benefitted from safe accommodation and other essential services including health care, psychosocial and policing/legal support and child services. Between 30 and 35 percent of service users were children under 16 years of age. The data also showed that the number of clients who received services in 2016 had increased at least threefold since 2012. This increase is attributed to the expansion of OSSCs into select aimag centers. The OSSC within Ulaanbaatar's trauma hospital served the highest number of survivors with a significant increase in recent years, with 900 clients served in 2016 alone.

Positive changes were also apparent at the individual level. The majority of clients interviewed were more confident, had gained coping skills, improved self-esteem, and were well informed about their rights to live free from violence. These results were most evident among the clients of the OSSC run by an NGO and the shelter run by the National Center against Violence (NCAV).

While it was difficult to assess the final outcome of services provided by the OSSCs due to a lack of documentation, several positive long-term health and legal outcomes were evident. For example: staff members shared a number of examples of clients whose perpetrators were apprehended by the police, taken to court, and convicted, as well as examples of incidents that were successfully resolved privately.

Overall, the findings illustrated that the OSSCs play a critical role by increasing the effectiveness of essential multi-sectoral services. However, OSSC service provision needs to be strengthened to ensure that all necessary essential services are accessible, rights-based, victim-centered, and provided in an integrated way, as per UN ESP guidelines.

C. Efficiency: At the time of the assessment, OSSCs were financed from various sources including the local government, health facilities and the police department. Since there is no specific national budget line for OSSCs, costs tend to be integrated into the limited budgets of their host organizations. As a result, existing OSSCs were mostly underfunded. However, this problem will be addressed if the provisions within the LCDV that call for state financing of OSSCs are put into place.

The assessment revealed several positive examples of local investment into OSSCs as well as alternative funding options. For example, Zavkhan aimag's local government invested 139.5 million tugriks into the construction of an excellent OSSC facility within its police department. Conversely, Bayankhongor aimag's local government mobilized 167 million tugriks to construct their OSSC facility from the Grassroots Programme of the Japanese Embassy in Mongolia. Currently, Bayankhongor's OSSC, which is managed by a local NGO, is financed by the local government and 43.7 million tugriks were allocated to the OSSC for 2017. UN agencies also supported the furnishing and the procurement of supplies for OSSCs.

According to the Social Welfare Law, an accredited NGO that provides services to survivors of violence can be reimbursed from the Social Welfare Fund for costs spent on protection, food and other basic provisions up to 26,000 tugrik per person per day. However, as noted, only one OSSC in Mongolia is currently run by an NGO.

The assessment found that generally, OSSCs were inadequately staffed to deliver all essential services 24 hours per day and 7 days per week, as is mandated in the LCDV. There is also a wide variation in human resources across facilities. For example, the shelter at the Ulaanbaatar City Police Department (UBCPD) had 22 full time staff, while the OSSCs based in the aimag general hospital of Gobi-Altai and the Forensic Hospital had only one part-time staff person. Moreover, the Zavkhan OSSC had no dedicated full-time staff, but rather OSSC functions were integrated into the duties of police officers.

For the most part, the assessment found that the OSSCs' activities and services were managed by a few dedicated staff members, with a very limited budget and in collaboration with partners. It was evident that OSSCs used their limited financial and human resources in an efficient way and to the best of their abilities.

D. Sustainability: The assessment identified several positive developments regarding the sustainability of OSSC services. These include: progressive legal changes for state financing of OSSC operations and services, as well as several effective examples of institutionalization and integration. International agencies also demonstrated a continued commitment to scale up OSSCs and shelters across the country. The assessment also identified some potential risks that could negatively influence the sustainability of OSSCs. These include: the vulnerability of stand-alone OSSCs operating outside of a health facility or other government structure due to a lack of staffing and financing. Overall, the assessment found that the sustainability of services provided by the OSSC can be ensured if all relevant sectors successfully implement the LCDV, particularly those provisions that pertain to OSSC financing, operations and services.

E. The ability of the OSSCs to effectively implement the UN ESP Guidelines

It is important that OSSCs in Mongolia meet international standards for the provision of services to survivors. This assessment examined the OSSCs' ability to effectively implement the UN ESP according to the six principles and nine common characteristics of quality essential services identified therein.

Principles and characteristics: The UN ESP identifies six principles that underpin quality essential services for survivors of GBV: A rights based approach; Advancing gender equality and women's empowerment; culturally and age appropriate and sensitive; Victim/survivor centered approach; Safety is paramount; and Perpetrator accountability. The assessment found that these six principles were well reflected in Mongolia's overall response to GBV. For instance, the common principles articulated within the LCDV and the updated National Guideline on OSSCs for all activities and services undertaken in response to violence (maintaining victims' safety, privacy and confidentiality; a rights-based, victim-centered, non-discriminatory and non-judgmental approach in service provision; and respect for the rights, dignity and interests of survivors, particularly children and persons with disability) closely parallel UN ESP guidelines. While the assessment found that these principles were well reflected in OSSC service delivery, key stakeholders' awareness and knowledge could be further improved.

The OSSCs and shelter's implementation of the nine common characteristics of essential services identified in the UN ESP (availability, accessibility, adaptability, appropriateness, prioritize safety, informed consent and confidentiality, data collection and information management, effective communication and linking with other sectors and agencies through referral and coordination) are discussed below.

Availability: The LCDV defines seven types of essential services for survivors: (i) safety/protective, (ii) health, (iii) psychological, (iv) legal, (v) social (vi) child protection and (vii) follow-up or referral. These seven services types align with 28 services identified in the UN ESP Guidelines. The assessment conducted a snapshot review of the availability of the 28 UN ESP services and found that all were available in the non-governmental organization's (NGO) OSSC, Police Office's (PO) OSSC and the National Center Against Violence (NCAV) and Ulaanbaatar City Police Department's (UBCPD) shelters (either on-site or by referral) and 70-90% of services were available within health facility-based OSSCs. However, an in-depth review revealed some gaps and areas for further improvements (see details in Table 8).

Accessibility: Overall, essential services provided by OSSCs were physically accessible and free of charge for survivors. However, accessibility remained a challenge for women and girls living in rural areas as a result of geographic

and transportation barriers. A review of OSSC data showed that, outside of the Trauma Hospital OSSC, the average number of monthly visitors was low, with only 10-15 new clients seeking services. Conversely, there was a higher demand for services in Ulaanbaatar, as evidenced by an increase in the number of crisis phone calls received by police (10,403 calls in 2016).

Adaptability: OSSCs provided services according to the individual needs of survivors based on a situation assessment undertaken by police and a social worker, with particular attention to safety. According to clients interviewed, protective services and psychological counseling were the most needed and most important services received at the OSSC. These two essential services are also prioritized in the standards for OSSC service provision.

Appropriateness: It was evident that OSSC service providers made all possible efforts to deliver services that addressed the individual needs of survivors, respected their dignity and confidentiality, and minimized secondary victimization. This was also confirmed during client interviews. However, despite these efforts it was found that survivors did have to undergo repeated interviews with social workers and police.

Prioritize safety: The safety of survivors is paramount in the delivery of OSSC services. National Standards approved by the National Standard Authority establish the general and specific safety requirements for OSSCs. Most OSSCs and shelters had 2 to 8 well-furnished, safe accommodation for between 2 and 30 clients. OSSCs also provided basic provisions including food, underwear, toiletries, kitchen facilities, television, and toys for children, and books. Clients interviewed were happy with the level of safety, food, living conditions, staff attitudes and services provided by the OSSCs.

Informed consent and confidentiality: OSSCs and shelters produced the required documentation to inform consent and guarantee confidentiality during activities observed during the assessment including interviews and situation assessments. Those clients interviewed were happy with the level of privacy and confidentiality maintained by the OSSCs.

Data collection and information management: While OSSCs and shelters collected basic data, the quality of the data was inadequate. Data collection forms were not standardized and were overly long. At the time of the assessment, service statistics were not integrated into the information management systems of health facilities or the police department. Overall, OSSCs' data collection and information management needs strengthening.

Linking with other sectors and agencies through referral and coordination: Local multi-sectoral coordination mechanisms were established and functional in the three aimags visited during the assessment. Despite changes to local authority following political shifts, decision-makers demonstrated continued commitment to the OSSCs. At the community level, multi-disciplinary teams

(MDTs) are legally mandated to coordinate the provision of essential services for survivors in their communities. MDTs are composed of professionals from different sectors (i.e. pscychological, social, legal, health, and protection) that collaborate together to provide services to the victims/ survivors of GBV/ DV. At the time of the assessment, some MDTs were more experienced than others as several were only established after the enforcement of the LCDV. Despite some challenges, overall, the MDT approach worked to create linkages across sectors.

Referral services were generally effective, but they should be strengthened to provide easier, centralized access to all essential services. For example, some OSSCs faced challenges in facilitating secure referrals for survivors.

F. Recommendations

The assessment proposes the following recommendations based on the "Fundamental Elements" as structured in the UN ESP Guidelines:

- *Provide comprehensive legislation and legal framework* that works with all the different sectors; health, justice/ police and social to develop and implement the National Standards or Guidelines in accordance with the UN ESP Guidelines.
- *Strengthening governance oversight and accountability* in order to effectively coordinate the essential services provided by the OSSCs, and to provide guidance for community-based MDTs. This can be done by X.
- *Ensuring the human resources and trainings are adequate* to deliver and coordinate the essential service package guidelines among the MDTs through the OSSCs. Also, the jobs are professionalized to meet international standards in providing sufficient support to victims of domestic violence.
- *Secure sufficient resources and finance* in order to provide the provisions of safe accommodation, private counselling, and 24/7 services. It is recommended that a costing exercise should be conducted for the different OSSC models that can be used for evidence-based budgets and cost-benefit analyses (to justify scale-up and to demonstrate adherence to international standards). This should also take into consideration the commitment of the local authorities to ensure national ownership.
- *Enhancing the monitoring and evaluation* systems by reviewing and revising the existing data collection forms used by the OSSCs to harmonize them with international best practices. Moreover, it is important to bolster the staff's capacity to ensure quality and consistency of skills and performance through proper monitoring and evaluation systems.

The assessment concluded that the OSSCs play a vital role in their communities by providing greater access to quality essential services for survivors of GBV. The OSSCs enable the victims to access services under one roof, without the inconvenience of commuting to multiple locations to seek help or services. Therefore, it provides greater accessibility through a victim-centered approach and avoids, the re-traumatization of victims. However, the OSSC service provisions should still be strengthened to ensure that all necessary services are provided in an integrated manner, and fully aligned with international standards such as the UN ESP.

1. BACKGROUND

The Government of Mongolia has demonstrated a strong commitment to GBV prevention and response, but domestic and sexual violence remains a major problem in the country. According to some studies, one in five women reported have experienced physical violence in their lifetime. For the first time in Mongolia's history, a nationwide survey on GBV is being conducted by the National Statistics Office (NSO). The survey's final results will establish the prevalence and nature of GBV in Mongolia and is expected to be shared in 2018.

A literature review confirmed OSSCs as the international best practice in service provision for survivors of violence, serving as the first point of contact to access quality multi-disciplinary services, including protection, health care, legal/police and psychosocial services.

In Mongolia, the first three OSSCs were established in Ulaanbaatar in 2009 by order of the Ministers of Health (MOH), Justice and Home Affaires (MOJHA) and Social Welfare and Labor (MOSWL) with support from UNFPA, UNDP and WHO. At the time, OSSCs were established to provide medical, psychosocial and legal support services to survivors in a single location.

Before 2009, GBV protection services were operated by the National Center against Violence (NCAV), an NGO, with assistance from international and UN agencies specializing in support and services to survivors of violence.

UNFPA, UNDP and WHO provided financial and technical support to establish the first OSSCs in Ulaanbaatar, including supplying medical equipment and furniture, developing technical guidelines and protocols, and training service providers.

From 2012 to 2016, three more OSSCs were established in the aimag centers of Bayankhongor, Gobi-Altai, and Zavkhan as part of UNFPA's fifth country programme. In 2017, it is expected that 10 more OSSC sites will be identified based on the results of the nationwide GBV prevalence survey. The survey was initiated as part of the UNFPA project titled "Combating Gender-Based Violence in Mongolia" co-funded by the Swiss Agency for Development and Cooperation (SDC), the Government of Mongolia, and UNFPA. Therefore, it is important to determine the successes, challenges, and lessons learned from existing OSSCs in order to identify gaps and incorporate best practices into the new OSSCs.

As of June 2017, there were six UNFPA-supported OSSCs operating in Mongolia. UNFPA also works closely with two independent shelters – one operated by NCAV and another by the Ulaanbaatar City Police Department (UBCPD) (Table 1).

Table 1. OSSCs and shelters operating in Mongolia with UNFPA support

	Name	Year established	Scope and Location (short name)	Work hours
1	One-stop service center	2009	Two rooms in the reception area of the National Trauma Hospital in Bayangol district of Ulaanbaatar (TH OSSC)	24 hours 7 days a week
2	One-stop service center	2009	Three small rooms in the outpatient clinic of the Forensic Hospital in Sukhbaatar district of Ulaanbaatar (FH OSSC)	Monday to Friday 8 am to 5 pm
3	One-stop service center	2009	Three separate rooms in the entrance area of the health center of Sukhbaatar district of Ulaanbaatar (SDHC OSSC)	Monday to Friday 8 am to 5 pm
4	One-stop service center	2014	With a separate side entrance in the mental health department building of the aimag general hospital of Gobi-altai aimag (AGH OSSC)	Monday to Friday 8 am to 5 pm
5	One-stop service center	2016	In a separate building between the aimag police and the general hospital of Bayankhongor aimag (NGO OSSC)	24 hours when client(s) present
6	One stop service center	2013	In a separate location next to the police department of Zavkhan aimag (PO OSSC)	24 hours when client(s) present
7	NCAV shelter	1995	Attached to an apartment building with a separate entrance; in Bayangol district of Ulaanbaatar (NCAV Shelter)	24 hours 7 days a week
8	UBCPD Shelter	2014	In a separate building located 3 km away from the center of Khan-uul district, Ulaanbaatar (UBCPO shelter)	24 hours 7 days a week

2. ASSESSMENT OBJECTIVES AND METHODOLOGY

2.1 Assessment objectives

The objectives of the assessment were as follows:

- To undertake a desk review of the 2009 MOH report and its findings, and the annual programmatic reports of existing OSSCs;
- To assess the relevance, capabilities, efficiency, effectiveness and sustainability of services provided by OSSCs;
- To assess OSSCs' ability to effectively implement the United Nations Essential Services Package Guidelines and identify any gaps;
- To identify key challenges, best practices and lessons learned;
- To assess to what extent improvements were made since the 2009 assessment; and
- To recommend additional areas for improvement for OSSCs to meet international standards.

The overall assessment approach was participatory, consultative, gender and human rights-oriented, and culturally sensitive.

2.2 Assessment process

The inception phase was focused on designing the assessment framework, methodology and instruments in consultation with the UNFPA GBV project team and preparing for the field study.

A desk review of international literature on the OSSC model, existing laws, national policies and programmes, and OSSC reports was carried out in line with the UN ESP Guidelines.

A field study took place with the UNFPA team in Bayankhongor, Gobi-altai and Zavkhan aimags from 14-24 June, 2017 and in Ulaanbaatar from 26-30 June, 2017. These sites were selected because of the locations of UNFPA supported OSSCs and shelters. The field mission included site visits, case studies, interviews, focus group discussions and stakeholder meetings at existing OSSCs and shelters using the pre-prepared methodologies for the assessment which was consultated with UNFPA Mongolia CO. Stakeholder then provided, feedback and comments during the time of the assessment.

2.4 Assessment methodology

Data collection methods: The assessment used a range of descriptive

and comparative approaches, as well as qualitative and quantitative methods for data collection. However, the assessment relied primarily on qualitative methods including: 36 in-depth interviews with key informants, 6 focus group discussions and multi-sectoral stakeholder meetings, and 8 case studies across existing OSSCs and shelters in selected sites.

The following assessment tools were developed: an OSSC case study tool, interview questionnaires for OSSC staff and survivors, and a compendium for the focus group discussions.

Data processing and analysis: Descriptive and comparative approaches were used for data processing and analysis. Data gathered from case studies, interviews and focus group discussions were grouped by common themes and key questions established in the assessment framework. OSSCs' ability to effectively implement the UN ESP Guidelines was also examined.

2.5 Limitations and ethical considerations

This assessment had several limitations. First, the revised LCDV was recently passed and implementation was in its infancy. While some national guidelines for implementation were released, others were still being developed and some partners were not fully informed about updated or new regulations. Second, the scope of this assessment was focused on services and functions of the existing OSSCs, not the full range of Essential Services to be provided by the health, social service, police and justice sectors.

Ethical considerations: The privacy and confidentiality of survivors and stakeholders was a foremost consideration of this assessment, and the following measures were taken:

- To guarantee the privacy and confidentiality of all information, the names of victims and OSSC staff members and other key informants were not disclosed;
- Interviewers obtained informed consent from all respondents
- The consultant obtained all required authorizations before undertaking fieldwork; and
- The consultant took into consideration survivor and stakeholder security and their emotional and psychological state/ well-being when conducting interviews based on the pre-developed methodology.

3. KEY FINDINGS FROM THE ASSESSMENT

Key findings from the assessment are presented in the following two sections: section 3.1 examines the relevance, effectiveness, efficiency and sustainability of services provided by existing OSSCs; and section 3.2 examines OSSCs' ability to effectively implement the UN ESP Guidelines.

3.1. Relevance, effectiveness, efficiency and sustainability

A. Relevance

A review of the national legislation and policy documents related to GBV showed that the OSSC approach is highly relevant and in line with national priorities. This relevance is confirmed by the integration of OSSCs into laws, national policies and programmes. For example, the National Programme on Domestic Violence, the Mid-term Strategy to implement the Gender Equality Law and the current National Program on Gender Equality all stipulate that one-stop services be established and that OSSCs be scaled up across the country.

The national response to GBV is manifested through the implementation and enforcement of the LCDV that was approved by Parliament in December 2016 and put into force in February 2017. Through the LCDV, domestic violence is criminalized for the first time in Mongolia. The LCDV also legally recognizes the OSSC approach and defines it as "the activity to provide medical and other essential services defined by this law at one location by a hospital, governmental or non-governmental organizations for a short term period."[1]

Following the LCDV, the MOH, MOJHA and MOSWL established guidelines on OSSC service provision and financing. The guidelines state that "the OSSCs should provide essential services for victims in collaboration with other organizations and specialists at a single location, free of charge, for 24 hours, regardless of the victim/survivor' residence[2].

According to the LCDV, OSSCs can operate within a hospital, governmental or non-governmental organization.[3] In line with this, the assessment found three existing models of OSSCs in Mongolia:

A) Health model type that includes several sub-categories as OSSCs operate out of facilities at different levels within the health system. Current examples include: hospital-based OSSCs at the National Trauma Hospital (TH OSSC) and in the Forensic Hospital (FH OSSC); district

1 Article 5.1.3, the LCDV

2 Guideline on OSSC' service provision and financing, Section 2 and 3; Annex of the joint order # A/80, A/132, A/60 of the MOH, MOJHA, MOSP, 6 April, 2017

3 Atricle 36.1, the LCDV

health centre-based OSSCs as in the Sukhbaatar District Health Center (SDHC OSSC) and an aimag general hospital OSSC as is in Gobi-Altai aimag (AGH OSSC).

B) Police model: the second type of OSSC operates within or adjacent to a police office as in Zavkhan aimag (PO OSSC).

X) NGO model: the third type is a stand-alone OSSC managed by an NGO in partnership with the local government as in Bayankhongor aimag (NGO OSSC).

The strengths and weaknesses of the different models are examined and summarized in Table 2 below.

Table 2 Strengths and weaknesses of OSSC models

Strengths	Weaknesses
A. **Health model**	
(a) **Specialized hospital-based model: TH OSSC**	
• Access to specialized medical care (trauma/ emergency care) within the hospital 24 hours per day and 7 days a week (24/7); • Four full-time social workers and a part-time medical doctor work 24/7 and provide essential health, protective services and psychological counselling on site; • Links with police services; • Functions as a public health unit within the hospital; • The hospital provides staff salaries, food and other basic supplies for clients.	• Quality of services, including adherence to survivor-centered care, needs improvement (e.g., safe room is not client-friendly and there is no separate room for counselling); • Some barriers in linking and referrals to legal services; • Weak links with the community MDTs.
(b) **Specialized hospital-based model: FH OSSC**	
• Access to a full range of forensic examination and services; • Strong linkages with justice channels because the hospital functions under the MOJHA; • Has three small rooms for medical examinations, counselling and protection.	• Links with other essential services (referrals) exist, but could be strengthened more; • Needs more full-time staff available to enhance the ability to provide safe space overnight; has access to some food; but no toiletry; • Confidentiality and privacy need improvement as the OSSC is located within an open outpatient area; • Management support needs to be strengthened and there are budget constraints; • No coordination or links with MDTs.

(c) **District health center-based model: SDHC OSSC**	
• Access to a wide range of health care services within the facility; • Well-trained, full-time social worker provides basic psychological counselling and protective services on-site; • Has three well equipped, comfortable rooms for private counselling, protection of clients, and medical examinations; • Potential to link to primary health care workers within the health center; • Opportunity for close collaboration with police, judicial entities, and social services in the district.	• Limited staffing (2 social workers were employed until 2014, then reduced to one due to budgetary constraints); • Closed on Saturdays and Sundays; • No dedicated budget; • Management support needs to be strengthened; • Weak link with legal, police and social services; • Weak coordination and collaboration with MDTs.
(d) **Aimag general hospital-based model: AGH OSSC in Gobi-Altai**	
• Access to a wide range of health care services within the facility 24/7; • A part time health worker provides basic psychological counselling and protective services on site during the day; • Has five well equipped rooms for medical examinations, private counselling and protection; • Potential to link to the primary health care workers within the hospital; • Opportunity for close collaboration with local multi-sectoral stakeholders.	• Inadequate staffing; • Closed on Saturdays and Sundays; • Weak link with legal and police services; • Weak coordination and collaboration with MDTs; • Management support needs to be strengthened; • No dedicated budget; • High turnover of personnel at both the decision-making and operational level.

B. **The police-based OSSC model: PO OSSC in Zavkhan**	
• Access to a full range of essential legal and police services; • Functions integrated into routine activities of the police officer dedicated to DV and child abuse cases and a psychologist; • Strong protective services, basic psychological and legal counselling on-site and referrals to health care services; • A toll-free hotline operating 24/7; • Has a separate facility that is well-equipped, with sufficient, comfortable rooms for private counselling and protection of clients; • Local government has allocated a budget for OSSC operations; • Police department covers maintenance costs, food and basic provisions for clients; • High commitment and support from local decision makers and police management; • Community police officers work closely with other community workers; • Potential collaboration with other organizations for provision of other essential services.	• Dual responsibilities of staff may affect quality of services; • Considerations related to survivor-centered approach and confidentiality: According to the LCDV, the police take on the legal responsibility to conduct on-site security risk assessment. Based on the assessed risk level, police are obligated to take survivors to an OSSC or shelter or leave them under the supervision of the victim's relatives[4]. Based on the procedures, police officers offer protective service and take victims to the OSSC in most cases. Therefore, based on the above scenario, some victims may not feel comfortable going to a police OSSC because they are afraid the perpetrator may also be at the same police station, also the police station may not provide welcoming environment as it does not feel like a home or shelter; • Some barriers in provision of referral to health care services.
C. **Stand-alone NGO OSSC model: NGO OSSC in Bayankhongor**	
• Offers a wider range of essential services (protective, psychosocial and legal services on-site and referral to health care) 24/7; • Employs four full-time social workers and a psychologist, as well as a part-time legal specialist; • Has a separate facility with well-equipped, sufficient, comfortable rooms for medical examinations, private counselling and protection; • Good partnership with local government including financing; a memorandum of understanding outlines official collaboration with local government, police and social welfare agencies; • Strong reputation among local stakeholders; • Leads the technical arm of the MDT and provides training; • Strong leadership and technical competence among coordinators and staff; • Good links with MDTs, strong community outreach and follow up.	• Long-term sustainability is dependent on government financing (Note: The support provided by external donors for this OSSC and government/NGO partnership might not be readily available everywhere) • Some barriers in the provision of referrals to health care for clients

[4]Atricle 25.4.1, the LCDV

The above analysis illustrates that health facility-based OSSCs provide the broadest range of health and psychological services for survivors. However, their linkage to the legal and justice systems is weak. The PO OSSC offers the best protective services, as well as access to legal and psychosocial services but the provision of health care remains a challenge. The NGO OSSC offers a wider range of essential services but also struggles with referrals to health care services.

In general, coordination with other sectors and agencies was weak across all models. The weaknesses are attributed to: a low level of commitment from implementing agencies, as well as structural barriers to institutionalization (integration of OSSC services into the regular functions of the organizations).

Stakeholders articulated their perception that the PO OSSC and the NGO OSSC were well-suited to their local contexts and provided a coordinated service to survivors. For health-facility based OSSCs, stakeholders voiced concerns about client protection, staffing and budgets.

Stakeholders' opinions on the relevance of the existing OSSCs

"From our experience, police-based OSSC model works well in our situation. Its advantage is that the victim comes under the state protection; the victim will be able to receive a range of services such as psychological, social and legal support in a single location. It is also cost-effective, because civil servants will provide services under their routine activities" (Key informant, Zavkhan).

"The police station is the most suitable location for OSSC because the police have a legal obligation to ensure safety protection of victims. Therefore, I strongly supported this option since the establishment of the OSSC. Health facilities can work together to provide health care for the victims" (Key informant, Zavkhan).

"The model which was managed by non-governmental organization and financed by the local government looks like a well-suited option. This is a good example of task shifting among state and non-governmental organizations"(Key informant, Bayankhongor)

"I think that this model is well-suited to the local context, particularly having OSSCs together with shelter seems like a more suitable option in aimag. State organizations work in a wide range of areas, but NGOs work can be more focused" (Key informant, Bayankhongor)

"The health center is a suitable place, because the victims can obtain a wide range of health care services in one location. The only issue is the staff and budget, but other things work, so if there are at least two staff members, we can work more effectively" (Key informant, UB).

"The OSSC in our hospital did not work well because one-stop service center is currently not included into the National Standard for the General Hospital and health centers; therefore, it is not possible to address its staffing and budget" (Key informant, Gobi-Altai).

Overall, OSSCs were well aligned with national policies and priorities. Each OSSC model had strengths and weaknesses for the provision of quality essential services in accordance with the UN ESP Guidelines. If the relevant authorities take appropriate action to address the identified weaknesses, all OSSC models can function more effectively in their local context.

B. Effectiveness

The assessment found that the OSSCs have made a lot of progress since 2009, when the OSSC approach was first introduced in Mongolia. The data collected through review of the OSSC' and shelters' reports showed that the OSSCs reached over 5,000 victims of violence, mostly women and girls in the last 5 years providing various services including crisis counseling, health information and linking with essential health, legal/policing and social services.

Out of the 5,000 victims, approximately, 2,000 women and children affected by domestic and sexual violence were provided with safe accommodation, and at the same time, they received essential health, psychosocial and legal/policing services in the OSSCs and shelters for the short and medium time of period - up to 3 months in the shelters. (see Table 3). About 30-35 % of clients were children under the age of 16. Table 3 shows that the number of clients who received services in OSSCs in 2016 was increased at least 3 times as compared to 2012.[5] This increase is primarily attributed to the expansion of OSSCs to aimag centers. The TH OSSC has the highest number of visitors and has experienced a significant increase in clients in recent years. This OSSC has 2-3 new visitors per day and as a result, sometimes lacks the physical and human resource capacity to serve all clients.

Table 3: Number of clients who received services in OSSCs and shelters, 2012-2016

OSSCs and shelters	Number of clients who received services						Number of clients who stayed in OSSCs or shelters					
	2012	2013	2014	2015	2016	Total	2012	2013	2014	2015	2016	Total
TH OSSC	334	350	431	792	962	2869	52	49	86	106	125	418
SDHC OSSC	172	181	115	56	91	615	56	69	45	22	26	218
FH OSSC	-	-	-	-	75	75	-	-	-	-	-	0
AGH OSSC	-	-	110	87	84	281	-	-	16	24	24	64
PO OSSC	-	-	183	215	145	543	-	-	38	56	82	176
NGO OSSC*	-	-	-	-	170	170	-	-	-	-	41	41
NCAV shelter	-	-	-	-	-	-	145	129	106	69	114	563
UBCPD shelter	-	-	305	540	287	1132	-	-	88	201	216	505
Total	506	531	1144	1690	1814	5685	253	247	379	478	628	1985

Source: Data collected by the consultant from the review of the OSSCs' and shelters' annual and other reports.

Note* NGO OSSC opened in October 2016; this data covers the period from October 2016 to June 2017.

[5]Annual reports of the OSSC and data provided by the OSSCs

A breakdown of essential services provided was only available from the PO OSSC (see Table 4).

Table 4 Number of clients by type of service received (PO OSSC), 2014-2016

Type of services provided	Number of clients	Coverage (%)
Total number of survivors of DV/GBV who sought services	204	100.0
Legal and police services	204	100.0
Basic psychological counseling	204	100.0
Protective services	204	100.0
Referral to health care	153	75.0
Child protection services	42	20.5
Social welfare assistance	18	8.8
Referred to MDT, and other services	183	89.7

Source: Report on OSSC for domestic and sexual violence in Zavkhan, 2014-2017, Aimag police department, L. Ulziijargal

As a complement to the quantitative results shown above, interviews revealed that positive changes were apparent at the individual level among OSSC and shelter clients. The majority of clients interviewed were observed to be confident, had gained coping skills and improved self-esteem, and were well informed about their rights to live free from violence. Those results were most apparent among clients of the NGO OSSC and the NCAV shelter.

Survivor responses

"Before, I did not know where to contact, but I get very good support here and it feels like something big has been lifted off my back" (Survivor, NGO OSSC).

"Before, I could not talk with people as I was very shy, but now I can look right in the eyes and say what I want very clearly. I started to gain confidence in changing myself for the better" (Survivor, NGO OSSC).

"At first I did not know where to contact as I slept in the school fence then the next day morning approached to the violence center. Now, I always take the necessities such as bus money and clothes to take them with me. I come here for advices when need. (NCAV shelter client)

It was difficult to assess the final outcomes of services provided by OSSCs due to a lack of documentation; however, some positive long-term health and legal outcomes were evident. For example: staff members shared examples of cases of perpetrators who were apprehended by the police, taken to court, and convicted. The police officers who were interviewed also noted that since the enforcement of the LCDV, the number of cases being investigated and referred to the court system has increased. Furthermore, the assessment revealed that several cases were already being processed through the criminal justice system.

The findings showed that OSSCs are helping to provide greater access to

essential, multi- services to survivors of violence. At the same time, OSSC services can be strengthened further to improve accessibility, integration, and alignment with UN ESP Guidelines.

C. Efficiency

This assessment could not perform a cost-effectiveness analysis of OSSC services because of a lack of comprehensive and standardized financial data. Table 5 shows financial information including standard start-up costs for new OSSCs, as well as overall budgets and allocation to salaries, where available.

Table 5 Selected financial resources allocated for and used by the OSSCs and shelters

Investment and regular budget	Local budget	State budget	Embassy of Japan	UNFPA	UNDP	WHO
1. Financial investment made for infrastructure of selected OSSCs (thousand tugriks)						
(i) Start-up cost of NGO OSSC in Bayankhongor (infrastructure, furniture, equipment, training,2012-2015)	20,000	-	167,000	80,000	-	-
(ii) Start-up cost of PO OSSC in Zavkhan (infrastructure, furniture, equipment, training, 2012-2014)	139,506	-	-	38,700	-	-
(iii) Start-up cost of AGH OSSC in Gobi-Altai (renovation, furniture, equipment, supplies, training, 2012-2013)	20,000	-	-	40,000	-	-
(iii) Start-up cost of TH OSSC, FH OSSC, SDHC OSSC (equipment, furniture, training, 2009-2016)		7,200		48,500	16,000	17,500
2. 2017 budget allocated for selected OSSCs (thousand tugriks)						
(i) NGO OSSC	43,700					
(ii) PO OSSC	1,000					
(iii) UBCPD shelter	X					
3. Salaries paid by the organizations in 2016 (thousand tugriks)						
TH OSSC		50,000				9,200
AGH OSSC		6,200				
SDHC OSSC		6,720				

Source: Data collected by national consultant from various sources

At the time of the assessment, OSSCs were financed from various sources including the budgets of local governments, health facilities or the police department. Since there is no national budget line for OSSCs, health facilities and police departments manage OSSC salaries and other costs within their limited budgets. As a result, the assessment found that most OSSCs were underfunded, however this is expected to be resolved through the full implementation of the LCDV, which mandates state financing for OSSCs.

The assessment revealed several examples of internal and external investment into OSSCs. For example, the local government of Zavkhan aimag invested 139.5 million tugriks for the construction of an excellent OSSC facility under its police department. Furthermore, the local government of Bayankhongor aimag mobilized 167 million tugriks from a Japanese Grassroots Programme for the construction of its OSSC. In addition, the local government finances the NGO OSSC and allocated 43.7 million tugriks from the aimag budget for 2017. OSSCs were also supported by UN agencies for furnishings and the procurement of supplies.

According to the LCDV, an accredited NGO that provides services to survivors of violence can be reimbursed from the Social Welfare Fund for costs spent on protection, food and other basic provisions up to 26,000 tugrik per person per day. However, OSSCs run by government organizations are ineligible and currently only the NCAV shelter has accessed financial contributions from this fund. At the time of the assessment, the NGO OSSC in Bayankhongor aimag was seeking accreditation in order to access this financial support.

The assessment found that, in most cases, OSSCs operated thanks to the hard work of a few dedicated staff members in collaboration with other partners on a very limited budget.

A general weakness among OSSCs was staffing. Table 6 shows the wide variation in human resources among OSSCs and shelters. While the UBCPD shelter has 22 full time staff on-site, the AGH OSSC and FH OSSC have only one part-time staff and the PO OSSC does not have any full-time, dedicated staff.

Table 6 Human resources in the existing OSSCs and shelters, 2017

Human resources	TH OSSC	SDHC OSSC	FH OSSC	NGO OSSC	AGH OSSC	PO OSSC	NCAV shelter	UBCPD Sheller
1. **Full time staff stationed at the OSSCs and shelters**								
• Coordinator/ manager				1			1	1
• Medical doctor								1
• Health worker (feldsher)	1							
• Social worker	4	1		3			2	3
• Legal specialist							1	

• Psychologist				1			1	4
• Administrative/ service staff				1			1	5
• Security officer								4
• Police officer								4
2. **Part-time staff with other responsibilities in the organization**								
• Coordinator	1							
• Legal specialist				1		1		
• Psychologist			1			1		
• Social worker					1			
• Assistant						1		

Source: Data collected by national consultant from different sources

The interviews confirmed that the majority of OSSC and shelter staff have participated in ad hoc on-the-job trainings on GBV and service provision for survivors. These trainings covered topics including basic knowledge about GBV, general counseling, privacy and confidentiality issues, risk assessment and situation assessment techniques. However, social workers interviewed felt that their skills were insufficient to address the psychological crises of the survivors and to empower clients. As a result, they indicated a desire for additional training, as well as tools and techniques in order to improve their counseling and empowerment sessions. Service providers interviewed were not familiar with UN ESP Guidelines.

The majority of OSSC staff interviewed reported having job satisfaction. However, some social workers felt that managers did not understand or undervalued their work. Key stakeholders cited high turnover rates of trained staff as one of the greatest challenges affecting the quality of services across OSSCs and shelters. Staff also reinforced the importance of continuous sensitization and targeted advocacy for senior managers.

While the institutionalization and integration of OSSCs into host organizations was highlighted as an important strength, the potential negative effects on service quality is also acknowledged. For example, police officers responsible for OSSCs in addition to their regular activities voiced their concern that "sometimes we cannot focus on victims in the OSSC due to workload and urgent matters related to other responsibilities."

The assessment concluded that OSSCs were underfunded and had inadequate human resources to provide essential services with 24/7 accessibility as mandated by the LCDV. However, the assessment also found that OSSCs used their limited financial and human resources in an efficient way and to the best of their abilities.

D. Sustainability

This section looks at the sustainability of existing OSSCs and shelters in the long term, identifying progress made to date and potential risks.

Progress made to date:

- *Progressive legal changes towards sustainability:* The OSSC approach is addressed in the through several pieces of legislation that define the obligations of relevant sectors, service providers and NGOs. This provides a strong legal basis to justify OSSC budget allocation and staffing and facilitates the involvement of civil society organizations.
- *Increased recognition of the OSSC approach at all levels:* In recent years, the OSSC approach has gained more recognition at all levels across sectors. For instance, the MOJHA, the General Police Board and some local governments have already made significant contributions to OSSCs and shelters and are increasingly taking on leadership roles to ensure the functioning and sustainability of OSSCs.
- *Setting national standards and regulations for OSSCs:* The National Standard of Shelters was endorsed by the National Standard Authority and a draft National Standard for OSSCs is being developed in accordance with the LCDV. Several new guidelines on OSSC operations, services and financing are being developed and others are already in place. These standards and guidelines will ensure the integration of OSSCs into the structures, staffing and budgets of existing organizations and facilities.
- *Enhanced participation:* Multi-sectoral collaboration is facilitated through the MDT, along with the legal obligations of each relevant sector, to ensure the sustainability and coordination of essential services.
- *Institutionalization:* While not without its limitations, the PO OSSC provides a good example of institutionalization through the integration of functions into the regular activities of officers for sustainability.
- *Continued commitment of international agencies:* International and UN agencies such as UNFPA, SDC and ADB have already shown their commitment to working in partnership with the government to scale up OSSCs and shelters across the country. Support is primarily provided in the form of technical and financial support as well as capacity building.
- *Increased demand for services:* Planned mandatory reporting is expected to generate an increased demand for OSSCs that will also increase accessibility and utilization of OSSCs by survivors.

Potential risks:

- *Continued lack of institutionalization:* If OSSCs continue to operate as stand-alone or unofficial units within health facilities and other organizations, there will be continued problems with staffing and financing.
- *Budget constraints:* In 2016, the government cut the 2017 budget for all sectors at all levels due to reduced external investment and government revenue. This type of constraint may negatively impact the implementation of the OSSC approach going forward. For example, although a local government approved 70 million tugrik for the NGO OSSC in 2016, this figure was reduced to 36 million for 2017 because of budget cuts.
- *Unstable assistance for NGO OSSCs and shelters:* This assessment found that the stand-alone NGO OSSC model had many strengths, however their success and long-term sustainability is dependent on continued financial support from the government or external partners.

Overall, significant progress has been made to ensure the sustainability of OSSCs and shelters. If government authorities and relevant sectors successfully implement the LCDV, particularly regulations related to OSSC financing, operations and services, there should be no major challenge to ensure the future sustainability of OSSC services.

3.2 OSSC implementation of the UN Essential Services Package

The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence ("the Programme") was launched in 2016 by UN Women, UNFPA, WHO, UNDP and UNODC. The Programme identified the essential services to be provided by the health, social service, police and justice sectors (the "Essential Services"), as well as guidelines for the coordination of Essential Services and the governance of coordination mechanisms (the Coordination Guidelines). Taken together, these elements constitute the "Essential Services Package (ESP)."[6]

This assessment aimed to assess OSSCs' ability to effectively implement the ESP, which reflect the common principles and characteristics of quality essential services. The findings are presented according to the UN ESP's Overall Framework Diagram (Chart 1).

A. Principles

The UN ESP Guidelines identify six overlapping principles that underpin the delivery of all essential services and the coordination of those services (Chart

[6] Module 1, Overview and Introduction, Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines

1). It was found that these principles are well reflected in Mongolia's overall response to GBV.

Chart 1. Essential Services Package: Overall Framework Diagram

Principles	A rights based approach	Advancing gender equality and women's empowerment	Culturally and age appropriate and sensitive
	Victim/survivor centered approach	Safety is paramount	Perpetrator accountability

Common characteristics	Availability	Accessibility
	Adaptability	Appropriateness
	Prioritize safety	Informed consent and confidentiality
	Data collection and information management	Effective communication
	Linking with other sectors and agencies through referral and coordination	

Source: Module 1, Overview and Introduction, Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines

Mongolia's Constitution, the Law on Gender Equality and other related legal acts affirm the fundamental rights of all citizens as put forward in the United Nations Declaration of Human Rights and other international human rights and gender equity instruments. These overlapping legislations are foundational elements of a rights-based approach and serve to advance gender equality and women's empowerment in the response to GBV, including quality essential services for survivors of violence.

More specifically, the LCDV and the updated Guideline on OSSCs identified a set of common principles that underpin GBV response and service provision including: maintaining victims' safety, privacy and confidentiality; a rights-based, victim-centered, nondiscriminatory and non-judgmental approach to service provision; and respect for the rights, dignity and interests of victims, particularly children and persons with disabilities.[7] [8]

During the field assessment, it was found that OSSCs abided by these overriding principles in delivering services. However, service providers and key stakeholders' awareness and knowledge of these principles could be improved to further strengthen the quality of essential services.

B. Common characteristics of quality essential services

UN ESP Guidelines define nine common characteristics of quality essential services for survivors (Chart 1). This section will discuss the findings related to

[7] Article 4: Principles of activities to combat with domestic violence, the LCDV

[8] Section 1.3: Principles of OSSC' activities, Guidelines on OSSC' services and financing, Joint order # A/80, A/132, A/60 of the MOH, MOJHA, MOSP, 6 April, 2017

these characteristics in the OSSCs' delivery of essential services.

(a) Availability: The LCDV defined seven types of essential services to be provided for survivors of violence: (i) protective, (ii) health, (iii) psychological, (iv) legal and (v) social services, (vi) child protection and (vii) referral to any other necessary services.[9] These essential services are closely aligned with the Essential Services and activities defined in the UN ESP guidelines. A review of the availability of 28 essential health, justice and policing and social services to be provided for survivors according to the UN ESP guidelines indicated that all services were generally available in the NGO and PO OSSC as well as the NCAV and UBCPO shelters (either on-site or by referral). Health facility-based OSSCs were able to offer 70 to 90% of services (see Table 7).

Table 7. Availability of essential services defined in the UN ESP guidelines in the OSSCs

Essential services	TH OSSC	FH OSSC	SDHC OSSC	AGH OSSC	NGO OSSC	PO OSSC	NCAV shelter	UBCPO shelter
One. Essential Health Services								
1.1 Identification of survivors	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
1.2 First line support	On-site	On-site	On-site	On-site	Referral	Referral	Referral	On-site
1.3 Care of injuries and urgent medical issues	On-site	Referral	On-site	On-site	Referral	Referral	Referral	On-site
1.4 Sexual assault examination and care	Referral	On-site	Referral	Referral	Referral	Referral	Referral	Referral
1.5 Mental health assessment and care	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
1.6 Documentation (Medico-Legal)	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
Two. Essential Justice and Policing Services								
2.1 Prevention	No	No	Yes	No	Yes	Yes	No	Yes

[9] Article 33.1 (33.1.1-33.1.7) Type of services to be provided for the victims, the LCDV

2.2 Initial Contact	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2.3 Investigation	Link	Link	No	No	Link	On-site	Link	On-site
2.4-2.11 Essential services to be provided by police, justice sectors	Link	Link	No	No	Link	On-site	Link	On-site
Three. Essential Social Services								
3.1 Crisis information	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
3.2 Crisis counseling	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
3.3 Help lines	On-site	No	On-site	On-site	On-site	On-site	On-site	On-site
3.4 Safe and secure accommodation	Yes	No	Yes	No	Yes	Yes	Yes	Yes
3.5 Material and financial aid	Link	No	No	No	Link	Link	Link	Link
3.6 Creation, recovery, replacement of ID documents	Link	No	No	No	Link	Link	Link	Link
3.7 Legal and rights information and advice	Link	Link	Link	Link	On-site	On-site	On-site	On-site
3.8 Psychosocial support and counseling	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site
3.9 Child-focused services for any child victims	On-site	On-site	On-site	On-site	On-site	On-site	On-site	On-site

3.10 Community IEC and community outreach	No	No	On-site	No	On-site	On-site	On-site	No
3.11 Assistance towards economic independence, recovery and autonomy	Link	No	No	No	Link	Link	Link	Link

However, a more in-depth review of key activities identified in the UN ESP Guidelines (as a sub-set of each essential service) revealed some gaps and areas for improvement. These are detailed in Table 8 below along with proposed key actions.

Table 8 Gaps in specific key activities identified in the UN ESP

Gaps identified	Proposed key actions
One. ESSENTIAL HEALTH SERVICES	
Essential service: 1. Identification of survivors	
1.1 Information	
A lack of user-friendly, well developed, accurate information in the OSSCs and health facilities	Ensure availability of written information on intimate partner/ non-partner violence and sexual assault in OSSCs and healthcare settings in the form of posters, pamphlets and/ or leaflets
1.2 Identification of women experiencing intimate partner violence	
No written protocol; health care workers are not yet trained on identification of survivors	Put in place a protocol/standard operating procedure for the identification of women/ persons experiencing intimate partner violence; Revise the existing situation assessment form in accordance with the guidance set out in the WHO Clinical Handbook; "Universal screening" or "routine enquiry" methods should not be utilized.
Essential service: 2. First line support	
2.1 Women- centered care	
Some OSSCs do not have counseling rooms and/or full-time counselor/social workers, and there is no standard in protocol	Protocol /standard operating procedure should include the core principles of women-centered care. The PO OSSC needs to have at least one full-time female social worker. All OSSCs should have a counseling room.

2.2 Mandatory reporting	
Health service providers are obligated to report incidents of violence.	According to the Guidelines, mandatory reporting of violence against women to the police by health service providers is not recommended.
Essential service: 3. Care of injuries and urgent medical issues	
3.1 History and examination	
Current forms to gather client history does not meet the international standard	According to the WHO Clinical Handbook, the clinical protocol should include specifics of the client's history, including past intakes and instances of GBV and sexual violence. Recommended to develop the standard client history form according to the WHO Clinical Handbook.
3.2 Emergency treatment	
Only the TH OSSC has a health specialist on-site	All OSSCs should have medical specialists on-call or on-site and should have standardized arrangements for emergency transportation.
Essential service: 4. Sexual assault examination and care	
4.1 Complete history	
OSSCs lack capacity	Protocol / standard operating procedure should include forensic services according to WHO Clinical Handbook
4.2 Emergency contraception for survivors of sexual assault	
No information or related services on emergency contraception	Information on emergency contraceptives, PEP kits, and supplies should be available in OSSCs; clinical protocol should include information about emergency contraception. If there is pregnancy as a result of rape, survivor should be offered counselling services, in accordance with national law and the WHO Clinical Handbook.
4.3 HIV post-exposure prophylaxis	
No information or related services	Clinical protocol should include information on HIV post-exposure prophylaxis (PEP) and referral to STI/HIV services according to the WHO Clinical Handbook.
4.4 Post-exposure prophylaxis for sexually transmitted infections	
No information or related services	Clinical protocol should include information on prophylaxis for the common STIs and the hepatitis B vaccine for survivors of sexual assault; according to national standards OSSCs should have STI/HIV rapid tests and STI drugs

Essential service: 5. Mental health assessment and care	
5.1 Mental health care for survivors of intimate partner violence	
No simplified chart in OSSCs for assessment of mental health problems	Develop and use clinical protocol with a simplified chart on assessment of the mental health problems identifiable actions.
5.2 Basic psychosocial support	
Some OSSCs do not have a psychologist , and some social workers need to improve their skills in psychosocial support	Train OSSC social workers on psychosocial support; OSSCs should also have full or part-time psychologists.
5.3 More severe mental health problems	
Weak link to professional mental health care providers; high cost of private service providers	Strengthen the link to available mental health care providers; address the costs within health insurance or other options. The procedures on mental health services should reflect medium-or-long term psychosocial support, stress management, empathy and follow up, and cognitive behavior therapy as per the WHO Clinical Handbook.
Essential service: 6. Documentation (Medico-Legal)	
6.1 Comprehensive and accurate documentation	
Quality of documentation is inadequate	Clinical protocol should include comprehensive, accurate documentation and follow up; revise current documentation forms, train OSSC staff and health service providers on proper documentation procedures.
6.2 Collection and documentation of forensic specimens	
No on-site or on-call forensic services	Ensure on-site or on-call forensic services in OSSCs for emergency cases.
6.3 Providing written evidence and court attendance	
Weak link with legal services in the health facility-based OSSCs	Strengthen the link with legal services; Clinical protocol should include guidance on how to write a good statement, how to document injuries in a complete and accurate way, and how to reliably collect samples from victims.
Two. ESSENTIAL JUSTICE AND POLICING SERVICES	
Essential service: 1. Prevention	
1.1 Promotion and support of organizations and initiatives seeking to end violence and increase women's equality	
Some MDTs not yet functional or active	Enhance collaboration among relevant stakeholders including the media and MDTs; strengthen their capacity through regular sensitization, training workshops and other initiatives.

1.2 Support awareness raising on the unacceptability of men's and boy's violence against women	
Recognition of such issues among some OSSCs is low	Improve the professional competence of OSSC staff to be recognized as resource persons on DV/GBV especially at the aimag level
1.3 Stopping violence and preventing future violence against women	
Some OSSCs have weak links with the police	Strengthen collaboration of police and OSSCs particularly in UB; refresher training for police on DV/GBV including data collection and analysis, early intervention, and quick response.
1.4 Encouraging women to report violence perpetrated against them	
Lack of information in MDTs, and the community police	Increase availability of information posters and leaflets with contact information to report DV/GBV.
Essential service: 2. Initial Contact	
2.1 Availability	
Community awareness is low	Increase access to information and community awareness, train front line workers (community police officers, social workers) particularly at the soum level.
2.2 Accessibility	
Accessibility is a challenge in rural areas	Increase access to information in rural areas; sensitize civil servants working in soums and bags on DV/GBV; budget for outreach to soums. In addition, 10 more sites for the establishment of the OSSCs will be identified through UNFPA's Combating GBV Project.
2.3 Responsiveness	
Survivors often have repeat interviews	Ensure harmonization of client assessments to minimize re-traumatization.
Essential service: 3. Investigation	
3.1 Cases of violence against women are given high investigation priority	
Generally, there are limited on-site police services at OSSCs	Ensure OSSCs implement front-line, on-site, on-call policing and justice services in line with the "one-stop" approach.
3.2 Victim /survivor medical and psycho-social needs are addressed	
Some OSSCs have weak links with police and justice systems	Enhance cooperation between OSSC and police to address survivors' medical and psychological needs.
3.3 Relevant information and evidence is collected from the survivor and witnesses	
Not all OSSCs call the police to take statements; there is no dedicated room for taking statements at police stations or OSSCs	Strengthen a "one-stop" service approach for survivors by having police take statements in the OSSC; improve the statement-taking environment to minimize re-traumatization of victims.

3.4 A thorough investigation is conducted	
The majority of OSSCs do not have legal specialists; on-site legal services are limited	Enhance cooperation of OSSCs, police and justice service providers as well as follow-up support services through MDTs.
3.5 Professional accountability is maintained throughout the investigation	
No major gap related to OSSCs	Train police and justice service providers regularly; put in place an accountability mechanism.
Three. ESSENTIAL SOCIAL SERVICES	
Essential service: 1. Crisis information	
1.1 Information content	
Content of crisis information was inadequate	Develop standard content for clear, concise and accurate crisis information.
1.2 Information provision	
Lack of crisis information	Ensure crisis information is widely available and accessible in the form of posters and leaflets and offer a wide range of contact methods including in person, by phone, and through email.
Essential service: 2. Crisis counseling	
2.1 Availability	
There is no protocol on crisis counseling	Clinical protocols should include crisis counseling; all OSSCs need to ensure 24 hour crisis counseling.
2.2 Relevance	
Lack of counseling skills especially for girls affected by sexual assault	Train counselors/social workers to ensure crisis counseling is appropriate to the various forms of violence experienced by women and girls.
2.3 Accessibility	
Limited access to crisis counseling in rural areas and for adolescents	Train social workers in schools and soums to provide front line crisis counseling.
Essential service: 3. Help lines	
3.1 Availability	
Some OSSCs do not have 24 hour help lines	Clinical protocols should include help line services; ensure all OSSCs provide telephone help lines free of charge or toll-free 24 hours a day, 7 days a week, or for a minimum of four hours per day including weekends and holidays
3.2 Accessibility	
Access is limited in rural areas	Ensure help lines are accessible via mobile phones.
Essential service: 4. Safe and secure accommodation	
4.1 Safe protection rooms and shelters	
Some OSSCs are note able to offer 24 hour safe rooms; and some aren't able to provide basic provisions such as food	Ensure all OSSCs have at least two safe, comfortable and user-friendly rooms with basic provisions, focusing on women and children's needs.

4.2 Responsiveness	
Some safe rooms do not meet the national standard	Provide spaces that ensure privacy and confidentiality for women and girls, develop an individualized support plan; ensure OSSC shelters/safe rooms meet standards.
Essential service: 5. Material and financial aid	
5.1 Availability	
OSSCs and MDTs do not have adequate budget to address the needs of clients	Ensure that OSSCs and MDTs have the budget to support access to emergency transportation, food, and safe accommodation free of charge; provide in-kind and other non-monetary aid such as basic personal and health care items; facilitate access to social protection according to social protection procedures.
5.2 Accessibility	
No specific financial aid is available for survivors	Ensure a range of means for women and girls to safely access material and financial aid.
Essential service: 6. Creation, recovery, replacement of ID documents	
6.1 Availability	
No major gap	ID document creation, recovery and replacement should be included as part of the social services procedure.
Essential service: 7. Legal and rights information and advice	
7.1 Availability	
Limited information on rights and legal information in OSSCs	Increase clients' access to clear and accurate information about their rights.
7.2 Accessibility	
Limited access for the most vulnerable women	Enhance collaboration with NGOs working with specific groups such as persons with disabilities, adolescents, and migrants; disseminate information through MDTs and NGOs.
Essential service: 8. Psycho-social support and counseling	
8.1 Individual and group counseling	
Only the NGO OSSC has peer support group counseling	Conduct regular training of social workers on individualized and group counseling; build capacity to offer peer support groups.
8.2 Accessibility	
Limited access for the most vulnerable women	Improve access to information on availability of counseling services and OSSCs.
Essential service: 10. Child-focused services for any child victims	
10.1 Availability	
Some OSSCs did not integrate children's needs into their services	Ensure that all OSSCs provide child-centered, rights-based counseling and psycho-social support and follow the Guidelines on Alternative Care for Children.

10.2 Accessibility	
There is no specific procedure, training is required	Ensure services are age appropriate, child sensitive, child-friendly and in line with international standards; train OSSCs' staff and MDTs on child-sensitive and child-friendly procedures.
Essential service: 11. Community IEC and community outreach	
11.1 Community information	
There is a lack of information on OSSC services which is reflected in low demand	Disseminate information on OSSC services through different channels including MDTs.
11.2 Community education and mobilization	
The majority of OSSCs do not have adequate capacity (human resources) for community education	Ensure community education is regular and accurate; train MDTs to enhance their work in the community; collaborate with local media and use social media.
11.3 Community outreach	
The majority of OSSCs do not have adequate capacity (human resources) for community outreach	Collaborate with NGOs, peer educators, and other social workers working with groups that are hard to reach or vulnerable, and incorporate relevant information on OSSC services and DV/GBV.
Essential service: 12. Assistance towards economic independence, recovery and autonomy	
12.1 Availability	
General lack of capacity for this type of assistance	MDTs should have capacity and resources to provide sustained support for holistic recovery for a minimum of six months including: income assistance and social protection, access to vocational training, and income generation opportunities.
12.2 Accessibility	
General lack of capacity for this type of assistance	Strengthen the capacity of MDTs to support the safe reintegration of women and girls/children back into the community, where appropriate, according to their express wishes and needs.

(b) Accessibility: The assessment found that essential services provided by OSSCs are physically and economically accessible (free) for survivors, for the most part. However, women living in rural areas may encounter challenges with accessibility as a result of geographic and transportation barriers. Despite physical and economic accessibility, data showed that the number of people seeking OSSC services was low, with the exception of the TH OSSC. On average, approximately 10-15 new clients seek services each month, however demand does not seem to match need, particularly in Ulaanbaatar. For example, the UBCPO shelter reported 10,403 calls to their domestic violence hotline

in 2016 as compared to 3,458 calls in 2014. An additional 5,115 calls were reported in the first half of 2017. Service providers attribute this increase in calls to promotion of the DV and child abuse hotlines, as well as the enforcement of the LCDV.

According to interviews, several barriers can affect OSSC accessibility, including: a lack of information; a lack of 24/7 services; a lack of food or other necessary items; and a lack of full-time staff. Furthermore, survivors who need medical care tend to visit a doctor directly and most doctors currently do not implement strategies to identify survivors of violence and link them to OSSCs. In addition, there are a limited number of OSSCs and shelters in highly populated, urban areas, including Ulaanbaatar, and a lack of community awareness on the right to live free from violence. Other barriers include long distances, costs and hesitation to disclose incidents of violence or to visit OSSCs for fear of being recognized, particularly in rural areas.

(c) Adaptability: It was observed that OSSCs provide services according to the individual needs of survivors and based on safety/situation assessments undertaken by police and/or the social worker who receives the client. According to clients interviewed, protection and psychological counseling are the most important services that they needed and obtained in the OSSC. These two essential services were also identified as priorities by the OSSCs.

(d) Appropriateness: It was observed that OSSC service providers made significant efforts to deliver services in a way that was appropriate to the individual needs of survivors, respected their dignity and confidentiality, and minimized secondary victimization. This was also confirmed through client interviews. At the same time, it was found that survivors were subject to repeated interviews from social workers and police officers.

(e) Prioritize safety: The safety of victims is paramount to OSSC and shelters' service delivery. General and specific safety requirements were established and approved by the National Standard Authority.[10] At the time of the assessment, most OSSCs and shelters had between 2 and 8 well-furnished, safe rooms for that could accommodate between 2 and 30 clients. Half of the existing OSSCs had 24 hour safe accommodation and the other half only had day time accommodation. Both were available free of charge. In addition, OSSCs had basic provisions including food, underwear, toiletries, kitchen facility, and access to TV, toys for children, and books to provide a client-friendly environment. The availability of safe, 24 hour accommodation was primarily dependent on adequate staffing and the ability to provide food.

According to the LCDV, police are responsible for monitoring OSSC clients' security. However, the NCAV shelter contracted a private security company. All OSSCs and shelters met basic safety requirements as per national standards

[10] Standard of Mongolia: MNS 6040 : 2009

including protected windows and locked doors. Clients interviewed indicated that they were happy with the protection, food, living conditions, staff attitude and services provided by the OSSCs.

Client responses
"Coming here and getting advice has given me a break. The food and place is very nice and comfortable" (Survivor, PO OSSC).
"It is very nice here. The staff's service, and the convenience of the room and food are all set out very well. Now I have much more power to manage myself" (Survivor, NGO OSSC).

(f) Informed consent and confidentiality: The assessment found that for all activities, including interviews and situation assessments, OSSCs gained informed consent and respected confidentiality. Clients interviewed were happy with the privacy and confidentiality afforded to them in the OSSCs.

(g) Data collection and information management: Interviewed staff indicated that data collection begins with the client interview and a situation assessment report that is signed and approved by the client. This document may be used as evidence if the survivor chooses to take legal action. The case file opened by social worker should be maintained by other service providers until the file is closed. However, during the assessment, data quality was found to be inadequate and referral/follow-up services were not well documented.

OSSCs were using forms that were developed and approved in 2009 along with the OSSC guidelines. While new guidelines have been put into place, data collection forms have not been updated. The assessment found that data collection forms currently used by OSSCs were not standardized and had too many questions. For example, Form 1 on Basic Client Information included 42 semi-structured questions. Form 2 for children consisted of 23 questions and other modified forms include between 20 and 31 questions.

Most OSSCs and shelters gathered basic data on clients and services. For example, the NGO OSSC, the PO OSSC and UBCPD shelters disaggregated data by service type, however, most did not. Service statistics from health facility-based OSSCs were not integrated into the health information management systems of the hospital or health centers.

Some OSSCs and shelters produced written annual reports for internal reporting purposes, but did not have a systematic annual review or dissemination of reports to external stakeholders. There was also limited evidence to indicate that data collected by OSSCs and shelters was used to inform advocacy, prevention or systematic monitoring and evaluation processes.

Overall, these findings showed that data collection and information management needs further improvement. In addition, it is recommended that OSSCs have special equipment to record the first client interview for use

by police and other relevant officials. This data collection tool will serve to accurately record the client's statement and will reduce the need for repeated interviews and potential re-traumatization.

(h) Linking with other sectors and agencies through referral and coordination:

Oversight, governance and coordination of essential services: At the time of the assessment, there was no national coordination mechanism, however multi-sectoral coordination mechanisms (multi-sectoral OSSC subcommittee and/or working group) were working effectively at the local level. MDTs focused on ensuring the involvement and coordination of local entities from different sectors with an interest in GBV prevention and service provision. Local decision makers, such as the Governors and the Chairman of the Aimag Citizen's Khural, and the Heads of the Aimag Health and Police Departments, were well informed about the OSSCs in their region and expressed commitment to helping to address the challenges they faced. Despite recent political changes and turnover, local authorities remained committed to the OSSCs.

At the community level, the MDTs have a legal obligation to coordinate and provide follow-up services for survivors in their community. According to the LCDV, the MDT is chaired by the bag or khoroo governor and members typically include: social workers, police officers, primary health care providers, and social welfare officers working at the community level. At the time of the assessment, some MDTs were well established and others were only recently formed after the enforcement of the LCDV. From focus group discussions and interviews, newly organized teams still lacked an understanding of how to coordinate follow-up services, while the more experienced MDTs were more confident and had some good experiences to share. The types of essential services commonly provided by MDTs include: arranging for the provision of shelter for up to 3 months, continued legal support, and social welfare assistance for housing, for example.

Focus group discussions revealed that MDTs faced several challenges, including: community social workers have multiple responsibilities and limited time to coordinate essential services for survivors; high turnover among community workers; lack of systematic training; lack of budget; and limited involvement from bag or khoroo governors. Despite these challenges, participants agreed that the MDT approach works.

Linking with other sectors and agencies through referral: The assessment found that OSSCs' referral services to other organizations needed improvement. When OSSCs were established in aimags, a multi-sectoral team of specialists was mandated to work with the OSSC to help coordinate and ensure access to services across sectors. However, a high turnover of specialists and a heavy workload meant that this approach did not work as planned. Currently, OSSCs struggle

to link their clients to organizations in other sectors, particularly psychological services. While some aspects of referral services are being implemented effectively, the overall mechanism should be strengthened to provide easier access to multi-sectoral services.

4. LESSONS LEARNED, RECOMMENDATIONS AND CONCLUSION

A. Lessons learned

- The OSSC model is relevant as the first point of contact for survivors, providing essential services in a single location, and making referrals to other providers as needed.
- The availability of essential services and the ability of OSSCs to provide essential services varied based on the strengths and weaknesses of the different OSSC models.
- The commitment of implementing partners, including local government, is the driving force that ensures the effective operation of the OSSCs.
- Until the recently revised LCDV was passed and later enforced, OSSCs were the primary service provider for survivors of violence. Under the LCDV, the health, police, justice and social sectors and other service providers are also legally obligated to provide services. As a result, it is important to raise awareness of the essential services defined in the UN ESP across sectors.
- The integration of OSSC services into regular staff duties can be promoted as an effective means to ensure sustainability, such as in the PO OSSC. However, whenever possible, it is recommended to have a designated officer whose time and service is fully dedicated to the OSSC.
- The community-based MDT approach was found to work well at the local level; it ensures community ownership and incorporates OSSC functions into the routine activities of community workers. This, in turn, increases the effective provision of essential services to survivors in their communities.
- Better links between OSSCs, and improved communication and referral systems would better ensure a continuum of essential services provided to survivors.
- The needs of children, women and girls affected by sexual violence as well as those of survivors with disabilities should be better integrated into existing OSSC services. Service providers would also benefit from sensitization to this effect.
- According to the LCDV, shelters should provide the same types of essential services as OSSCs. For shelters, this is an opportunity to fill a gap to address the longer-term needs of survivors as OSSCs typically provide services on a short term basis.

B. Recommendations

The assessment makes the following recommendations based on "Fundamental Elements" as structured in the UN ESP Guidelines.

Comprehensive legislation and legal framework

- Enhance awareness and knowledge of service providers and stakeholders from the health, justice/police and social sectors on international standards and recent legislative and policy frameworks for the provision of essential services for survivors;
- Develop and implement the National Standard or Guidelines on Essential Services according to the UN ESP Guidelines.

Governance oversight and accountability

- Strengthen coordination of essential services provided by OSSCs and other organizations and put appropriate mechanism for case management into place;
- Provide regular practical training and guidance for community-based MDTs and consider a performance-based incentive mechanism to promote their role in GBV prevention and service provision.

Human resources and training

- Ensure that all OSSCs have adequate human resources to deliver and coordinate quality essential services 24/7, as per the LCDV and in line with international standards;
- Institutionalize all existing OSSCs by integrating them into National Standards or organizational structures, including human resource and budget allocation, relevant job descriptions and performance indicators;
- For the PO OSSC in Zavkhan aimag, professional social workers and psychologists should be hired on a full or part-time basis to ensure the OSSC has dedicated staff (non-police);
- Provide systematic training on international standards for quality essential services to providers in the health, police/justice and social sectors as well as OSSCs;
- Conduct on-the-job competence-based training for OSSC service providers on psychological counselling, stress management, empathy and support to survivors;
- Increase the dissemination of information through local media to empower survivors to seek existing services and ensure that posters and leaflets are available in OSSCs and MDTs;
- Support community outreach through close collaboration between OSSC staff and local MDTs; support potential victims to seek services and provide follow-up services.

Resources and financing

- Ensure that all OSSCs have enough rooms for safe accommodation, private counselling and 24/7 services;
- Establish an initial interview space for survivors and procure the necessary equipment to record interviews to avoid re-traumatization;
- Address financing barriers by preparing an evidence-based budget and advocate to the local government to include it in its regular proposal to the Ministry of Finance.
- Review relevant legal regulations related to free services to ensure state funding and reimbursement (from health insurance or social welfare funds) are being utilized and ensure the inclusion of OSSC services in accordance with the LCDV;
- Conduct realistic costing exercises for the different OSSC models that can be used for evidence-based budgets and cost-benefit analyses (to justify scale-up and to demonstrate adherence to international standards);
- Review results of the stand-alone NGO OSSC model to identify best practices and advocate for resources to replicate the model in other areas;
- Leverage international programme funds for new OSSCs: in addition to GBV prevalence and high demand (population size), consider the relevance, comparative advantages and disadvantages of existing OSSC models and the commitment of local authorities to ensure national ownership and institutionalization as early as possible;

Monitoring and evaluation

- Review and revise existing data collection forms used by OSSCs according to international best practices;
- Develop supportive supervision tools to regularly monitor the implementation of the principles that underpin essential services, including: a rights-based and victim-centred approach, as well as the service standards and operational guidelines of the OSSCs;
- Improve staff knowledge and skills to ensure consistency, data quality and data utilization to advocate for funding and to improve performance;
- Explore opportunities to integrate OSSC service statistics into health and police information management systems;
- Improve the quality of annual reports and information sharing practices among multi-sectoral stakeholders, including joint annual review meetings.

C. Conclusion

The findings of the assessment confirmed a high degree of relevance of the OSSC approach for survivors of violence. The existing OSSC models have a

lot of potential to continue to provide quality essential services in an integrated way, however, multi-sectoral collaboration, coordination and accountability must be strengthened.

The principles defined in the LCDV and other legislation that underpins OSSCs services are generally aligned with the overriding principles and common characteristics of quality essential services identified in the UN ESP Guidelines. It was also observed that OSSCs are making an effort to implement these principles in the delivery of essential services.

The assessment findings also suggest that existing OSSCs have made significant progress to ensure availability and increase accessibility of essential services. Though there remain barriers to access and the quality of some services needs improvement, OSSCs are functioning effectively and efficiently with limited resources and capacity. There should be no major obstacle that would prevent the long-term sustainability of services provided by OSSCs. OSSCs' service provision should be strengthened to ensure that all necessary services are provided in an integrated way, and fully aligned with UN ESP Guidelines.

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