

A systematic review on the One stop centre (OSC) model for delivering services to survivors

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Overview

- Background
- Aim & Methods
- Key review findings
- Key issues and recommendations



WHAT IS ALREADY KNOWN?

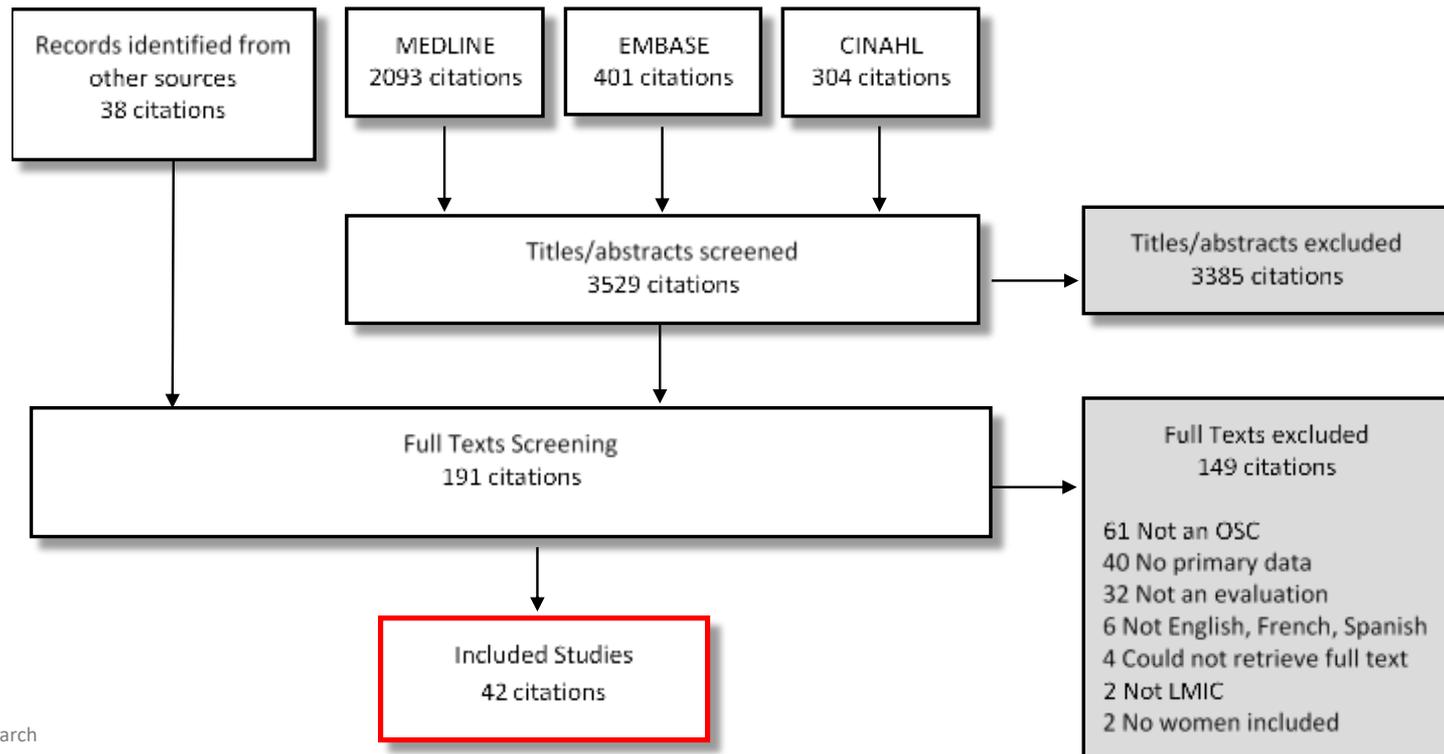
- Several process evaluations, though none evaluated effectiveness of the OSC model in meeting survivor needs (only 1 outcome evaluation)
- Increasing global implementation, scaling-up, and donor investment in OSCs
- No previous systematic review or evidence-based synthesis on the OSC model has been performed prior to the present study



Aim and methods

- mixed-method systematic review

What are the facilitators and barriers to the implementation of the OSC model as designed for survivors of IPV and/or SV in LMICs?



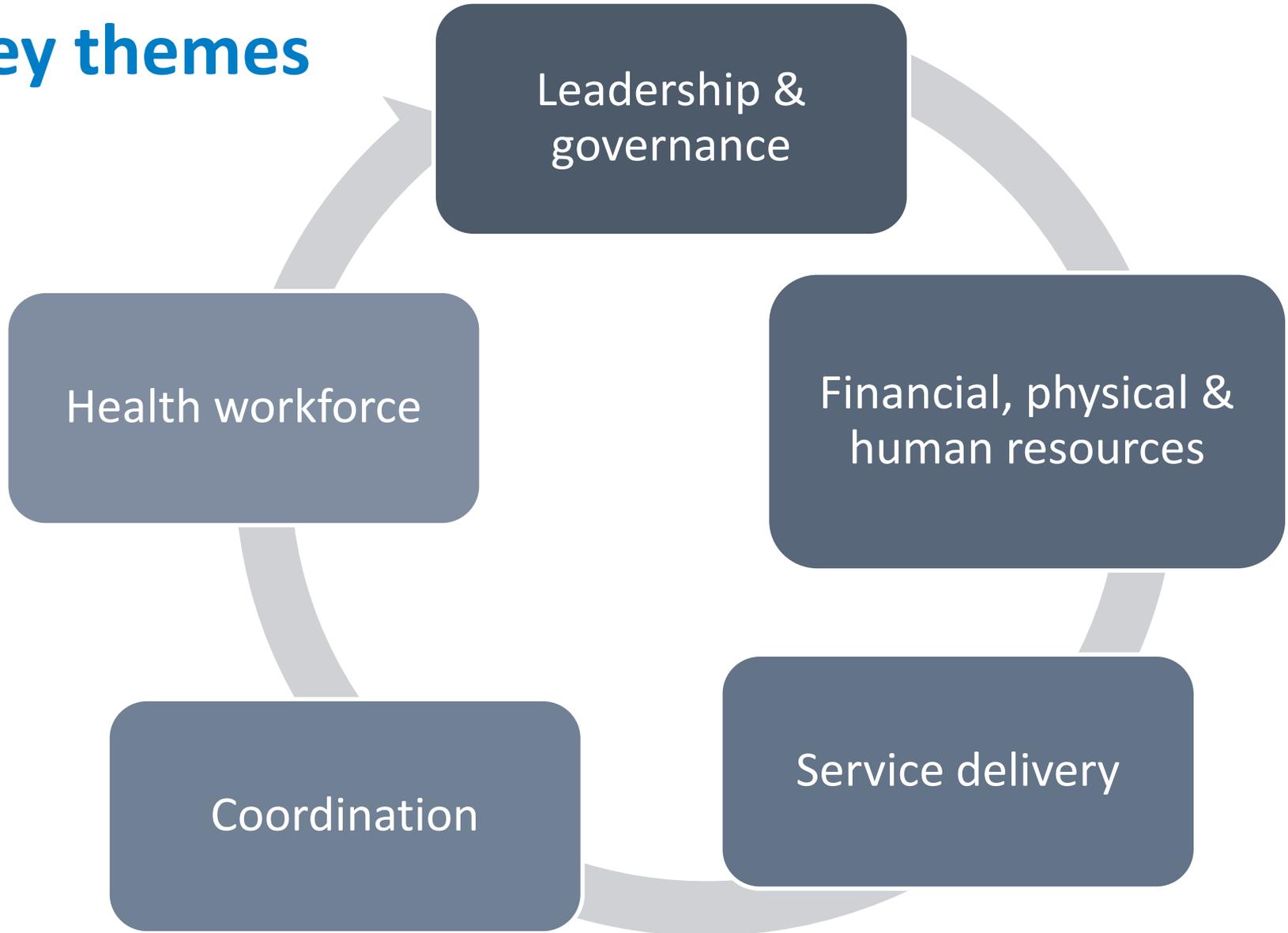
KEY REVIEW FINDINGS

Study characteristics:

- 42 studies: 18 qualitative studies; 8 quantitative, and 16 mixed methods
- From 24 LMICs: in Asia (15) and Africa (9)
- Range of hospital-based and stand-alone; majority hospital-based OSCs (government or joint NGO run)



Key themes



Governance and leadership

Barriers

- ❑ Lack of political will
- ❑ Lack of standardised SOPs affected provision of quality care
- ❑ lack of content, contextualisation of SOPs
- ❑ Lack of high-level oversight led to uncoordinated and delayed services

Facilitators

- ❑ SOPs enhanced clarity of staff roles, patients flow, and referral pathways
- ❑ Regular interagency meetings helped identify challenges (in well-established OSCs)
- ❑ Supportive laws and policies (political will)

Resources (human, financial, supplies)

Barriers

- ❑ Lack of basic supplies (SV centres)
- ❑ High running costs (in 17 countries)
- ❑ Lack of budget and planning transparency (governance)
- ❑ Staff shortage and high staff turnover (Stand-alone – volunteers)

Facilitators

- ❑ Available, on-site psychosocial services and support

Service delivery

Barriers

- ❑ Many could not provide adequate psychosocial support
- ❑ Limited opening hours at nights and weekends
- ❑ Provision of follow-up support services
- ❑ Lack of private rooms
- ❑ Re-traumatisation (multiple survivors interviews)
- ❑ Accessibility (transportation and user fees)

Facilitators

Hospital-based v. stand-alone

- ❑ Hospital-based more equipped for comprehensive care and more accessible to larger population
- ❑ NGO-run provide high quality psychosocial support

Coordination

- ❑ Most common barrier was multi-sectoral collaboration – disagreements around OSC priorities and roles, weak partnership with police and legal services and limited sharing of lessons learned
- ❑ Fragmentation – not truly one stop
- ❑ Weak referral networks and poor referral options (esp. in PHC centres)
- ❑ For a few, interprofessional staff relationship was a facilitator

Health workforce

Barriers

- ❑ Low knowledge among staff on GBV (hospital-based) and on available services
- ❑ Staff victim-blaming attitudes (also police)
- ❑ No or low training on how to offer GBV care (esp. HB)
- ❑ Little instructions on OSC policies
- ❑ Staff time constraints (HB – other job requirements)

Facilitators

- ❑ Survivors felt that sensitive staff offered better care and improved access
- ❑ Dedicated champions –support and sustainability

Key issues and recommendations

- ❑ Substantial systems-level barriers for implementation of OSCs, particularly around resourcing, service delivery and workforce
- ❑ Need to identify ways forward: how to build on what is working well (facilitators) and how these enablers can be supported in contexts with substantial challenges?
- ❑ Need for better understanding of how OSCs are implemented – rigorous evaluations to unpack challenges

Thank you