

## **Annex – methodology of assessment of OCMCs**

The One-Stop Centre [OSC] model is an interprofessional, usually health-system based, response to violence against women that aims to provide survivor-centered medical health services alongside a combination of psychological, social, legal, police, and/or shelter services in a single location and to minimize revictimization. The Government of Nepal has committed to providing integrated services to survivors of GBV by establishing hospital-based One-stop Crisis Management Centres (OCMCs). There are currently 92 OCMCs across Nepal.

Given the evidence gaps on the effectiveness and cost-effectiveness of OSCs, and the many barriers to implementation of the OSC model, the Special Programme of Research, Development and Research Training in Human Reproduction [HRP] and Department of Sexual and Reproductive Health and Research [SRH] within the World Health Organization held expert meetings in 2018 and 2019 to share and review experience on OSCs globally, discuss the current evidence on OSC models, develop a theory of change and develop a research protocol for a multi-country study of OSCs. The research protocol proposes a mixed methods study to assess implementation processes, quality of services and cost-effectiveness of OSC models in different geographical areas. Some specific aspects of the protocol must be adapted to the Nepal context, which will be done through an Adaptation Workshop involving key stakeholders and resulting

The main objectives of the assessment in Nepal are:

- To understand the components and types of services being delivered by OCMCs and for whom as per the OCMC Operational Guideline 2077 B.S.;
- To understand women’s perceptions of the quality of the OCMC services provided and explore their acceptability of and experiences with OCMC services
- To assess how the OCMC model is being implemented and the quality of and mechanisms for provision of coordinated services;
- To determine the value for money of the OCMC model by comparing results (benefits), such as # of service seekers reached, with the costs of implementing the model (economic evaluation);
- To explore how context affects implementation and outcomes of OCMC model.

## **Study design**

The implementation evaluation study will employ a mixed-methods study design, using qualitative and quantitative methods for data collection and analysis to address the main objectives. Qualitative methods will include semi-structured interviews with health providers and managers and women accessing OCMCs, focus groups discussions (FGDs) with key informants, and desk-based documents and OCMC-records reviews. Quantitative methods will include structured facility observations, a review of OCMC clinical records data and a survey with HCP. Further description of each method is included below. Table 1 summarises the study processes, methods for each theme and the outcomes.

The bidder should include a clear outline of ethical procedures and ethics and safety protocols, including processes for informed consent, measures to ensure confidentiality and safe and secure data management (both of primary data and any clinical data collected from hospitals), addressing risk and adverse events, and measures for ensuring safety of participants and enumerators while participating in the study.

In addition, the bidder should provide information regarding training for enumerators, including length of training, content and approach.

The exact sampling approach – for selecting individual participants in qualitative data collection, and for selecting the OCMCs to be included in quantitative data collection – will be determined at the Adaptation Workshop. However, the bidder should develop a proposal and budget that could cover selection of up to half of the OCMCs across Nepal, with consideration for selecting a sample of OCMCs that is broadly nationally representative.

**Table 1: Study objectives, research questions and related methods, indicators and outcomes**

Objectives	Research questions	Methods
<b>1. To understand the components and types of services being delivered by OCMCs and for whom;</b>	<ul style="list-style-type: none"> <li>• How is the OCMC model being implemented?               <ul style="list-style-type: none"> <li>○ Who delivers the OCMC services?</li> <li>○ Where (separate room?)</li> <li>○ What services? And which ones are offered the most?</li> <li>○ How (pathway)</li> <li>○ What were the presenting complaints?</li> <li>○ What are the types of violence and survivors that the OCMCs provide services for? (reach and equity)</li> </ul> </li> <li>• To what extent are the selected OCMC services adhering to their intended model? (fidelity)               <ul style="list-style-type: none"> <li>○ What parts were not delivered and why?</li> </ul> </li> <li>• How was the OCMC model adapted to consider the local context-specificity? (adaptation)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of OCMC policies and other documents (e.g. guidelines)</li> <li>• Facility observations of selected OCMC settings</li> <li>• Review of OCMC cases and related documents (i.e. periodic reports, OCMC documentation and referral forms)</li> <li>• Semi-structured interviews with OSC managers, OCMC providers and other on-site providers linked to OCMCs (e.g. SW, police, OBGYN, psychiatrist)</li> </ul>
<b>2. To understand women's perceptions of the quality of the OCMC services provided and explore service users' acceptability of and experiences with OCMC services</b>	<ul style="list-style-type: none"> <li>• To what extent are the selected OSCs delivering quality services to women (and meeting their quality criteria: safe, timely, confidential, women's centred and coordinated)?</li> <li>• To what extent are services accessible to women? (accessibility: cultural, language, cost, disability-friendly etc)</li> <li>• To what extent are OSCs delivering services to women in an acceptable manner? (acceptability – treated well (with respect and dignity) and received care they needed)</li> <li>• Whether and how OSC model of care decrease revictimization of women (e.g. avoid or minimise the need to retell the violent incident)?</li> </ul>	<ul style="list-style-type: none"> <li>• In-depth interviews with women who received care at OSCs</li> <li>• Review of data from hospital records/OSC registry (to look at reoccurrence and repeated visits and presenting complaints; type of referrals offered)</li> <li>• Semi-structured interviews with key informants</li> <li>• Facility observations of selected OSC settings (infrastructure, confidentiality mechanisms, equipment and supplies)</li> </ul>
<b>3. To determine the value for money of the OCMC model by comparing results (benefits), such as # of service seekers reached, with the</b>	<p>Economy:</p> <ul style="list-style-type: none"> <li>• What are the total costs of implementing the OSC model?</li> <li>• What are the costs of inputs (commodities, human resources, infrastructure and equipment, other running cost, etc)?</li> <li>• What is the cost of training a OSC staff?</li> </ul>	<ul style="list-style-type: none"> <li>• Review of accounting and budgetary data from OSC</li> <li>• Data from clinical records from hospital records/OSC registry</li> <li>• Information collected through structured facility observations of OSCs and interviews</li> <li>• Data from questionnaire</li> </ul>

<p><b>costs of implementing the model (economic evaluation);</b></p>	<p>Efficiency and Effectiveness:</p> <ul style="list-style-type: none"> <li>• What is the cost of treating a patient?</li> <li>• What is the cost of treating a patient who felt satisfied by the service provided? (or what is the level of patient's satisfaction?)</li> </ul>	
<p><b>4. To explore how context affects implementation and outcomes of OSC model</b></p>	<ul style="list-style-type: none"> <li>• How do legal, political, social, economic factors, governance structure and organizational environment affect OSC implementation and outcomes? Issues to explore include: governance structure, stakeholder and inter-agency relationships, coordination and referral networks; and broader questions about political will, support from MoH (financial and other) or other government entity and demand for OSC services. For example:             <ul style="list-style-type: none"> <li>○ How do governance structure and organisational environment affect OSC implementation and coordination of services?</li> <li>○ How does community-level context affect OSC service provision? Issues to explore: level of community interaction/awareness raising on VAW and OSCs, information about availability of OSC services, etc.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews with key informants (including health and other policy-makers from different sectors involved in OSCs)</li> <li>• Document policy analysis</li> <li>• FGDs with community representatives/leaders and existing VAW/community-based support services</li> </ul>

### **Sampling of OCMCs sites**

There are 92 OCMCs in Nepal, and the assessment will include up to half of them. The final list of OCMCs to be included in the assessment will be determined in the Sampling of OSC settings will be determined by the study country contexts. In countries with less than 50 OSC sites, we will sample all of them. In countries with more than 50, sites will be selected randomly and then a stratified analysis will be conducted to reflect numbers of years' functioning, geographical areas (rural/urban), and level of care (specialised/tertiary versus district/basic hospital).

### **Qualitative data component:**

The qualitative component will be used to gather the relevant background and contextual information (objectives 1 and 4); to gather information on perceptions of OSC quality and acceptability of services (objective 2) and on Covid-19 impact on service provision (objective 5).

The following qualitative methods will be employed:

- Semi-structured interviews with health providers, OCMC managers and other OCMC staff, key informants including health and other policy makers involved in planning, implementation and delivery of OCMC model (up to 45, final sample size to be determined in Adaptation Workshop)
- In-depth interviews with women survivors (up to 15, final sample size to be determined in Adaptation Workshop)
- Focus Group Discussions (FGDs) with NGOs, existing support groups for survivors and community members (up to 4 FGDs, final sample size to be determined in Adaptation Workshop)
- Desk-based document reviews of OSC reports (including guidelines and surveillance reports), policies and any other relevant OSC material

The bidder will adapt existing interview guides and determine appropriate methods for sampling and data collection, in discussion with WHO, UNFPA and key stakeholders at the Adaptation Workshop. Interview guides will be pilot-tested and finalised prior to commencement of qualitative data collection.

### *Suggested sampling and recruitment*

The existing protocol suggest that purposive sampling be used to select OCMC health providers and managers and other support staff. Doctors, nurses, health managers and other support staff should be selected based on their experience with and involvement in the provision of OCMC services. Key informants should also be purposely selected based on their involvement with the planning, implementation and delivery of the OCMC model. The sampling approach to be employed to identify women survivors will also be finalised at the Adaptation Workshop, however, snowball sampling could be used to identify the women survivors. FGD participants can be recruited from a convenience sample of community leaders and NGO representatives with links to the geographical area where OSCs are located. Please note that all sample sizes and sampling approaches will be confirmed at the Adaptation Workshop, after which the selected bidder will be able to revise and finalise the budget proposal.

The bidder should include consideration of qualitative data collection procedures in their application, including tape-recording and transcription of transcripts in local language and then translations into English. In addition, data analysis procedures, including development of a codebook and coding of transcripts using qualitative coding software will be required. Key themes from the document review data (see below for additional information) will be integrated with interviews and FGDs data, as needed. Themes to be explored include: availability and types of services, acceptability of and experiences with OSC services, feasibility of and challenges affecting provision of OSC services.

### **Desk-based document review**

The bidder should include methodology for a desk-based, document review of policy documents, guidelines and reports around OCMCs, to understand the intended aims of the OCMC model, the type of services and the regulatory framework in which OCMCs should operate. Policy documents related to OCMCs' development and implementation (including guidelines, standard operating procedures etc.) and OCMC reports should be retrieved from governmental online platforms and from OCMC sites.

### **Quantitative data component**

Quantitative data collection will include:

- Survey questionnaire with OSC providers
- Non-participant direct observations of OSC centres (referred to as 'structured facility observations')

- Direct observation of frontline workers at OSC centres (e.g. time) (cost data analysis)
- Review and collection of financial and administrative data (for cost data analysis)
- Review of clinical records of OSC cases in the past 6 months and of hospital statistics on the number of OSC visits in a year

The bidder will implement a knowledge, attitudes and practices questionnaire (survey instrument to be provided by WHO) with health-care providers at selected OCMCs. We will The instrument should be piloted and refined for the country-context, translated into local language, and piloted with a sample of 20 health care providers, to assess comprehensibility, feasibility, and clarity of questions. The results from the pilot test should be utilized to reframe some questions, remove some items that do not perform well, and reword items for contextual relevance. The survey should be conducted with all eligible health-care workers at the selected OCMCs (up to half of the 92 OCMCs across Nepal). WHO Headquarters will provide support for facilitate digital data collection (i.e. programming the survey), however, the bidder should include costs for infrastructure to implement digital data collection.

The bidder will also implement structured, facility observations will be conducted to complement information that may be difficult to capture via a survey and qualitative interviews, using an instrument developed by WHO. The tool will collect information about staff numbers, type of services provided, infrastructure and set up of the OCMC facilities, whether there are any education/support materials being developed or used, or any protocols or guidelines and care pathways.

A review of routine clinical data from OCMC hospital records and epidemiological/surveillance of OSC cases in the past 6 months will also be conducted, collecting the following data:

- number of VAW cases attended at OCMC in the past 6 months
- number of referrals (internal and external) offered to women
- presenting issues and type of services offered
- sociodemographic and clinical characteristics of identified women
- reoccurrence and repeated visits

### **Value for Money (cost-benefits analysis)**

The model proposed in this framework is based on the analysis of three main elements known as the 3Es: economy, efficiency, effectiveness. Value for Money is high when there is an optimum balance between all three elements: costs are relatively low (economy), productivity is high (efficiency) and successful outcomes have been achieved (effectiveness).

Analysis of Economy focuses on input costs and what drives them. As an example, a measure of economy would look at the costs of individual inputs or activities, such as the level of personnel and running costs for an OSC or the cost of training an OSC staff.

Efficiency assesses “how much you get out in relation to what you put in”. It measures the efficiency of delivering the expected outputs. Outputs need to be clearly identified, quantified and comparable. Output unit costs are most commonly collected in the form of cost per beneficiary. Using OSC as an example, a metric of efficiency would be the cost of treating a patient.

Effectiveness, the most important element of Value for Money, refers to the optimal use of resources to achieve intended outcomes. In this case, a measure of effectiveness could be the cost of who felt satisfied by the service received. This measure facilitates undertaking cost effectiveness and cost benefits analyses, as well as comparisons between the effectiveness of different OSC in achieving the same outcome.

Ideally, For each level of the theory of change developed in the adaptation workshop, the bidder will develop, in consultation with WHO and UNFPA, results (benefits) indicators to compare with the costs of delivering the services and achieving each level of result. If the relevant outcomes are available, we will also estimate the cost-benefits of the model against its health and socio-economic impact. As part of this economic evaluation, the bidder will collect costs data from reviews of financial and administrative data and direct observation at OCMC centres.

#### *Data analysis for the quantitative component*

Data from the questionnaire will be collected digitally and uploaded to WHO data storage platforms. The bidder will develop a quantitative data analysis plan, with exploratory, descriptive and multivariate analyses, and once approved by WHO and UNFPA, will conduct these analyses using quantitative data analysis software.

Information collected through structured facility observations of OSCs will be analysed descriptively using Open Clinica (in order to minimize errors and lack of standardization across site) and inform the analysis regarding infrastructure, supplies and service delivery themes.

Cost Analysis data on time allocation collected via direct observation of providers and semi-structured interviews will be transcribed verbatim, the transcripts password protected and the information inserted into an excel costing tool for initial processing. Data on time allocation collected via direct observation will be directly entered in a purposely designed excel data collection tool. Cost data from financial records will be collected using excel spreadsheets. The bidder should conduct analysis of total economic costs of service delivery, and unit costs for relevant components of the service delivery process. If the relevant outcomes are available, the bidder should also estimate the cost-benefits of the model against its health and socio-economic impact.

Data from clinical records of OSC cases (and hospital administration data) will be provided as electronic tables of the data requested (e.g. number of identifications, referrals, sociodemographic of women).