

# Investigation of Facility-Level Gender-Based Violence Data Collection and Tracking

September 2023

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## Data for Impact

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the Data for Impact (D4I) associate award 7200AA18LA00008, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Palladium International, LLC; ICF Macro, Inc.; John Snow, Inc.; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government.

SR-23-202 D4I

September 2023

## Acknowledgments

Our Data for Impact (D4I) team would like to thank the MOMENTUM implementing partners and others who supported this activity by sharing documents and participating in informational interviews. We would like to thank the following individuals: Habiba Ahmad, Director for the Ministry of Affairs in Sokoto State, Nigeria; Myra Betron, MOMENTUM Country and Global Leadership (MCGL), Jhpiego; Karen Levin, MOMENTUM Safe Surgery in Family Planning and Obstetrics (MSSFPO), EngenderHealth; Nasiru Muhammad, MSSFPO, EngenderHealth; Sylverius Mayokun Obafemi, MCGL, Jhpiego; Idara Sunday, MSSFPO, EngenderHealth; Chi Chi Undie, Population Council; and Noshaba Zafar, MOMENTUM Integrated Health Resilience (MIHR).

We also thank the United States Agency for International Development (USAID) for their financial support and USAID and CDC staff who provided contacts and feedback on this report, including Afeefa Abdur-Rahman, Sarah Huber-Krum, Liyana Ido, Joan Kraft, and Amani Selim.

Johanna Nice prepared this report with support from Bridgit Adamou, Grace Arkin, Janine Barden-O'Fallon, Taylor Reisz, Eva Silvestre, and Tory Taylor, D4I.

# Contents

Figures .....	5
Tables .....	5
Abbreviations .....	6
Executive Summary .....	7
Introduction .....	11
Methods .....	14
Findings .....	17
Barriers .....	29
Facilitators .....	31
Discussion .....	33
Limitations .....	33
Recommendations.....	34
References.....	44
Appendix 1. Literature Review Search Strategy.....	55
Appendix 2. Literature Review Results.....	57
Appendix 3. Literature Review Included Studies .....	58
Appendix 4. Interview Guide.....	63
Appendix 5. MOMENTUM implementing partner participation .....	66
Appendix 6. MOMENTUM routine screening questions .....	67
Appendix 7. MOMENTUM summary data .....	68
Appendix 8. MOMENTUM partner detailed indicator reference sheets .....	71

Figures

Figure 1. Monthly screening rate indicator (Improving the Health Sector Response to Gender Based Violence, Botts et al, 2010) ..... 26

Figure 2. Alternate monthly screening rate indicator (Improving the Health Sector Response to Gender Based Violence, Botts et al, 2010)..... 26

Figure 3. Considerations for standardizing indicators for GBV screening and response in FP settings ..... 43

Tables

Table 1. General screening information from studies included in the literature review narrative synthesis 58

Table 2. MOMENTUM implementing partners that participated in document review & informational interviews. .... 66

Table 3. Routine screening questions from USAID MOMENTUM implementing partners and other USAID projects identified via document review. .... 67

Table 4. Summary data reported by MOMENTUM partners on screening, identification, services, and referrals of GBV survivors at facilities. .... 68

## Abbreviations

AGYW	adolescent girls and young women
ANC	antenatal care
DRC	Democratic Republic of the Congo
EC	emergency contraception
FP	family planning
GBV	gender-based violence
GBVIMS	Gender-Based Violence Information Management System
ICVAC	International Classification of Violence Against Children
IPPF/WHR	International Planned Parenthood Federation, Western Hemisphere Region
IPV	intimate partner violence
LIVES	listen, inquire about needs and concerns, validate, enhance safety, and support
LGBTQI+	lesbian, gay, bisexual, transgender, queer, intersex, + other people whose identities are not heterosexual
M&E	monitoring and evaluation
MCGL	MOMENTUM Country and Global Leadership
MIHR	MOMENTUM Integrated Health Resilience
MPHD	MOMENTUM Private Healthcare Delivery
MSSFPO	MOMENTUM Safe Surgery in Family Planning and Obstetrics
NHMIS	national health management information system
NPSV	non-partner sexual violence
OPD	outpatient department
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
RC	reproductive coercion
RHIS	routine health information system
SRHS	sexual and reproductive health services
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

# Executive Summary

## Introduction

Gender-based violence (GBV), a prevalent but underreported public health problem, disproportionately affects millions of women and girls worldwide. A key objective of the *U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally* is to improve the collection, analysis and use of data and research to advance GBV prevention and response efforts. Further, integrating GBV services in family planning (FP) programming is a technical priority for the Office of Population & Reproductive Health. However, one area that needs further investigation is how to efficiently and effectively monitor routine screening for GBV, including but not limited to reproductive coercion and other forms of intimate partner violence (IPV) and non-partner sexual violence (NPSV). In response to this gap, this report focuses on data collection and reporting practices related to GBV identification and response, including routine screening and first-line support, in FP clinics and other facilities that provide sexual and reproductive health services (SRHS). Specifically, this report describes facility-level data collection processes, identifies information gaps, and explores barriers and facilitators to collecting information on GBV identification and response. The findings will contribute to a better understanding of current practices and inform steps to integrate monitoring data on GBV identification and response into routine health information systems (RHIS).

## Methods

This activity involved conducting a literature review, a review of USAID-funded project monitoring documents, and informational interviews to gather information on facilities' practices related to data collection and reporting on routine screening and first-line support for GBV among FP clients. The literature review included searching multiple databases and websites for relevant studies and policy documents. Inclusion criteria focused on studies reporting data collection tools, practices, indicators or other RHIS elements related to GBV screening and response in FP and similar clinical settings. The findings were summarized to identify best practices, identify research gaps, and draw conclusions across studies. The monitoring document review involved reviewing project documents, such as data collection forms and indicator reference sheets from clinics within the USAID-funded MOMENTUM portfolio. This review was complemented by informational interviews with MOMENTUM project staff and technical experts working on GBV integration. The interviews aimed to document current practices and gather input on integrating GBV screening indicators into RHIS. The findings from all stages of the investigation were analyzed to identify common themes and provide insights into data collection processes and challenges.

## Findings

Findings highlight the varying stages of readiness among MOMENTUM partners to implement GBV identification and response interventions. While some MOMENTUM-supported sites have fully integrated routine screening and first-line support for GBV at the facility level, others focus on GBV sensitization efforts and referral network development. The different stages of implementation and lack of standardized screening protocols, data collection approaches, and reporting indicators make assessing and comparing results across USAID partners challenging.

The main barriers to collecting information on routine screening and response for GBV include resource-related challenges, such as limited human resources and overwhelming workloads for healthcare workers.

Data quality issues, such as delayed reporting, double counting,<sup>1</sup> and lack of harmonization across data collection instruments and reporting requirements, also pose challenges. Cultural barriers and stigma around sexual violence contribute to the under-reporting of GBV cases. Providers' concerns about doing harm and the need for continuous training to ensure data quality and avoid further trauma are important considerations. Structural constraints within referral systems, such as ineffective police and legal systems, and weak infrastructure for secure data management further hinder GBV screening. However, government collaboration, continuous experiential training and mentorship, and on-site mental health services are facilitators that can improve the practice and monitoring of GBV screening and response.

## Recommendations

Based on the various stages of GBV integration, we recommend several strategies for improving the monitoring of routine GBV screening and support into FP services.

### For all organizations, regardless of the level of GBV identification & response

- **Develop a comprehensive monitoring, evaluation, and learning plan from the outset** to align with set goals, objectives, and strategies for addressing GBV based on the organizations' level of GBV integration and the capacity of their RHIS. GBV M&E results should be disseminated ethically and safely to various stakeholders to inform decisions, adjust implementations, improve collaboration, and advocate for GBV awareness. Institutionalizing M&E learnings can enable continuous program adaptation and improvement.
- **Collaborate with government ministries to integrate GBV screening and response into public services.** By participating in policy dialogues and implementation processes, they can advocate for GBV screening as a standard practice in national FP guidelines. This partnership can facilitate updates in FP service delivery protocols, advocate for secure data management, standardized violence definitions, and improved implementation processes like provider training on GBV screening techniques, awareness of referral pathways, and respect for survivors' rights.

### For organizations preparing to integrate routine screening and response for GBV into their FP programs

- **Monitor progress towards meeting WHO's minimum requirements for asking about GBV.** A Quality Assurance Tool can be used to assess whether facilities meet these standards. If minimum requirements are unmet or services are inadequate, routine enquiry should not be conducted. However, organizations should still seek to adopt a trauma-informed care approach to support GBV survivors.
- **Dedicate resources specifically to GBV screening and support interventions.** This supports a comprehensive "systems approach" to changes at every level of the organization, including infrastructure, policies, protocols, data systems, and provider training.

<sup>1</sup> Double counting refers to the inadvertent practice of counting an output, outcome, or beneficiary more than once. This can result in over-reporting, which may misrepresent the actual reach or impact of an intervention.



- **Assess providers' gender competencies using a comprehensive, standardized tool.** Training in gender awareness and GBV is vital for health organizations, and tools are available to measure the gender competency of FP providers, complemented by e-learning courses and other resources.
- **Improve data management systems to ensure secure collection and storage of sensitive GBV data.** Data systems should align with all national, sectoral, and international regulations and standards, prioritize informed consent and survivor autonomy, minimize intrusion, ensure confidentiality throughout processing, and anonymize reporting. Minimum GBV screening data collection (anonymous tallies) is recommended in emergency contexts or where data systems are inadequate.

#### **For organizations that have integrated routine GBV screening and response into their FP program**

These are the recommendations for a minimum dataset to produce standardized indicators in USAID-supported FP facilities:

- **Use globally aligned yet contextually relevant operational definitions of violence** to develop standardized, survivor-centered, acts-based screening questions for systematic data gathering and comparability. Set clear reporting requirements, including the nature of the data to be reported, timelines, formats, and accountable entities, supported by robust monitoring and evaluation mechanisms for ongoing process improvement.
- **Prioritize data collection efforts and indicators on screening for recent (past 12 months) physical, sexual, psychological/emotional IPV and NPSV.** Focusing on IPV allows for a more efficient allocation of limited resources and aligns with existing FP projects with integrated GBV programming. Partners that operate in regions with elevated rates of sexual violence or serve populations at increased risk for sexual violence victimization should also screen for NPSV. However, providers must remain vigilant and responsive to other forms of violence beyond IPV and NPSV.
- **Capture each type of IPV (physical, sexual, psychological/emotional) separately** in screening questions, registers, and reporting summaries to understand their service implications comprehensively. However, implementers should approach these recommendations cautiously, considering workload implications and ensuring adequate support and referral networks are in place.
- **Collect and report data on IPV and NPSV identified through clinical enquiry or spontaneous disclosure.** This data contributes to a better understanding of client service needs, supporting FP clinics' resource allocation and preventive strategies.
- **Track referral and service utilization rates** to ensure that the FP organization is responsive to clients' needs and has the information necessary to improve the effectiveness of services and referrals.

**For organizations that are ready and able to go beyond the minimum dataset**

- **Modify data collection systems to additionally capture information on RC screening.** This addition enables clinics to quantify efforts in identifying and supporting individuals experiencing RC, promoting reproductive autonomy and well-being. This would require the development of questions and services designed explicitly for RC.
- **Identify populations at heightened risk for violence victimization** (e.g., people with disabilities, LGBTQI+ persons) engaged by FP organizations and integrate questions tailored to their unique violence experiences to allow for an enhanced understanding of GBV among clients. Monitoring tools should allow for disaggregation by population group, tailoring data collection accordingly. Legal and social considerations are essential for determining what client characteristics are safe to collect.

Implementing these strategies will enhance the monitoring and evaluation of GBV identification and response in USAID FP settings. Standardized monitoring guidance is essential to support USAID partners in improving their data collection and reporting efforts around GBV screening and service provision.

# Introduction

The US government strengthened its commitment to comprehensively address gender-based violence (GBV) and advance equity and inclusivity in the “United States Strategy to Prevent and Respond to Gender-Based Violence Globally” (United States Agency for International Development [USAID], 2022). GBV is a highly prevalent and systematically underreported public health problem. The World Health Organisation (WHO) estimated that, globally, up to 852 million adolescent girls and women (15 years and older) had experienced physical and/or sexual violence in their lifetime as of 2018 (WHO, 2021b). This figure likely increased in recent years due to the amplified stresses and reduced support service accessibility associated with the COVID-19 pandemic (United Nations Entity for Gender Equality and the Empowerment of Women [UN Women], 2022). Further, some populations face a higher risk of experiencing GBV, including people living with HIV, adolescent girls and young women, older adults, women with disabilities, migrants, indigenous and ethnic minorities, and LGBTQI+ persons (WHO, 2021b; USAID 2022; USAID, 2023).

## Box 1: Gender-Based Violence

GBV is defined as “any harmful threat or act directed at an individual or group based on actual or perceived sex, gender, gender identity or expression, sex characteristics, sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity. Although individuals of all gender identities may experience GBV, women, girls and gender non-conforming individuals face a disproportionate risk of gender-based violence across every context due to their unequal status in society” (USAID, 2022).

GBV takes many forms and is “characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social, and other forms of control, coercion, and violence” (USAID, 2022). Intimate partner violence (IPV) is the most common form of GBV experienced globally (UN Women, 2006; WHO, 2021b) and is associated with poor sexual and reproductive health outcomes (Moore, Frohwirth, & Miller, 2010; Sarkar, 2008). IPV is especially relevant within the context of family planning (FP), as it increases the risk for reproductive coercion (RC), whereby a person's autonomous decision making regarding contraception and pregnancy is limited (USAID, 2022).

## Box 2: Reproductive Coercion

is defined as “behaviors that a partner uses to maintain power and control in a relationship that is related to reproductive health, such as explicit attempts to impregnate a partner against [their] wishes, controlling outcomes of a pregnancy, coercing a partner to have unprotected sex, and interfering with birth control methods. Control over one’s partner is at the core of intimate partner violence and reproductive coercion; [people] experiencing both acts are less likely to have the autonomy to make decisions about contraception and family planning” (Chamberlain & Levenson, 2012).

## GBV identification and response

In this report, *routine screening* refers to systematically asking clients about their experiences of GBV whether or not they have signs or symptoms (Botts et al., 2010). Routine screening may be *universal*, in which all clients are asked about their experiences of GBV, or it may focus on only certain groups of clients (e.g., new clients) (Botts et al., 2010). Survivors of GBV may also be identified through *clinical enquiry*, in which a provider asks questions based on signs or symptoms indicative of violence (WHO, 2013), and *spontaneous disclosure*, in which a client directly reports an experience of violence without waiting to be asked (Botts et al., 2013).

The primary objective of screening for GBV is to identify individuals who have experienced or are at risk of experiencing GBV to connect them with appropriate support and services. At a minimum, providers are expected to offer basic counseling in the form of *first-line support* when a client discloses violence. "LIVES"<sup>2</sup> is the WHO's global standard of care in this regard and includes immediate counseling/psychosocial support, safety planning and linkages to additional needed services (WHO, UN Women & UNFPA, 2014). The WHO provides additional clinical standards of care for GBV response, including access to comprehensive healthcare, including post-rape care (WHO, 2013). Thus, support and service provision should be an intrinsic part of the screening process, ensuring that the act of screening leads to tangible, positive outcomes for the survivors.

While there is an ongoing debate<sup>3</sup> as to the circumstances in which health providers should screen for GBV (Botts et al., 2010), routine screening accompanied by supportive services for GBV, specifically IPV, is increasingly promoted in healthcare settings. For example, in 2020, The President's Emergency Plan for AIDS Relief (PEPFAR) required routine screening for IPV as part of the implementation of HIV index case testing, pre-exposure prophylaxis (PrEP), and other HIV care and prevention interventions (PEPFAR, 2020). Further, the integration of GBV services in family planning (FP) programming is a technical priority for the Office of Population & Reproductive Health, as reflected in the work of USAID-funded projects to improve the monitoring of GBV prevention and response efforts.

### **Strengthening health information systems**

A key objective of the *U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally* is to improve the collection, analysis and use of data and research to advance GBV prevention and response efforts (USAID, 2022). However, one area in need of further investigation is how to efficiently and effectively monitor screening for GBV, including but not limited to reproductive coercion and other forms of intimate partner violence and non-partner sexual violence (NPSV). FP facilities introducing GBV identification and response interventions need to monitor progress, adjust implementation, and assess the effectiveness of their integrated programming.

Traditionally, large-scale surveys such as targeted modules within the Demographic and Health Surveys have been the primary data sources for GBV in low- and middle-income countries (WHO, 2021b), providing standardized and generalizable prevalence estimates at the population level. However, routine or administrative data—that which is collected through normal healthcare operations—can provide valuable information that is often not obtainable through surveys, such as the number of persons utilizing specific services as a result of GBV (UN Women & WHO, 2022). Indeed, routine health information systems (RHIS) at public, private, and community-level health facilities can offer a more cost-effective, continuous and accessible source of data (Silvestre, 2020). The US government, including USAID, emphasizes using routine data for informed decision making and has invested in capacity strengthening for RHIS (Silvestre, 2020).

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<sup>2</sup> LIVES stands for: **L: Listen** to the client closely, with empathy, and without judging; **I: Inquire** about their needs and concerns, including emotional, physical, social, and practical aspects; **V: Validate** the client's experience, showing understanding and belief, and assuring them that they are not to blame for the violence; **E: Enhance** safety by discussing a plan to protect from further harm if violence occurs again; and **S: Support** the client by helping them connect to information, services, and social support.

<sup>3</sup> The stance of various researchers, professional organizations and agencies is beyond the purview of this report. See Botts et al 2010 for an excellent summary of the pros and cons of introducing a routine screening policy into sexual and reproductive healthcare settings in resource-constrained settings. See WHO 2013, O'Doherty 2015 and Feltner et al., 2018 for reviews and synthesis of the evidence on efficacy.

Despite the advantages of RHIS, challenges exist in terms of coordination, training, and resource allocation (Silvestre, 2020). Routine data also has limitations for use; it cannot be used to estimate the true prevalence of violence within a community as it only represents persons who reached out for services, disclosed violence, consented to share their data, and had their data recorded and reported (WHO, 2021). Further, the quality of indicators obtained from RHIS depends on the accuracy and reliability of the data used for measurement, which can be influenced by various factors, including double (or over) counting, inadequate coverage of the targeted population or services, data precision, timeliness, and the integrity with which the data is recorded (Bloom, 2008).

While a number of resources exist to guide specialized surveys (WHO 2021b, UNDESA 2014, ICF 2019), there is limited guidance to support and improve GBV data collection in RHIS. Recently, WHO and UN Women issued guidance on advancing the collection and use of administrative data for statistical purposes, but it primarily targets intersectoral and sectoral coordinating bodies to generate data for use at the subnational or national level (UN Women & WHO, 2022). Further, most global guidance on data collection and reporting related to GBV identification and response focuses on physical, sexual, and emotional IPV and NPSV among women, as these types of violence are more prevalent and better operationalized (Kendall, 2020). Similarly, the evidence base for screening efficacy is drawn largely from studies focused on IPV among women in high-income countries (O’Doherty, 2015; Feltner et al., 2018), limiting our understanding of the role of GBV screening beyond IPV and of what works in other contexts and populations, particularly among men, adolescents, and marginalized populations.

## Needs Statement

Collecting GBV screening and response information in RHIS is expected to improve the monitoring of GBV service provision as part of FP programming. However, the extent to which FP clients are screened for GBV (including reproductive coercion, other forms of intimate partner violence and non-partner sexual violence), how they are screened, and how screening is linked to service provision is not well known. To address these gaps, this activity investigated facility-level data collection processes to identify what GBV data is being collected, gaps in data collection, and barriers and facilitators to collecting information on GBV screening. The activity also answered questions about what information is being generated, what processes and indicators are currently used for collecting data, how the information links to service provision, and what steps would be needed to integrate GBV screening data into HIS. The findings will contribute to a better understanding of current practices and inform steps to integrate monitoring data on GBV identification and response into RHIS. The goal is to outline requirements for a minimum dataset and offer additional choices for data collection based on an organization’s RHIS complexity and capacity for advanced data collection, aggregation, analysis, and reporting.

Specific research questions for this activity were:

- *How is data being collected? What is the process? Is the process integrated into the HIS?*
- *What information is being collected at health facilities on GBV screening? What indicators are used? Are the indicators standardized across projects/systems? Are the indicators strong (i.e., high-quality)? What, if any, are the information gaps?*

- *How do projects/health facilities use screening information for service delivery? Is screening information used in other ways, such as setting policies or strategies? If the information is not used, what are the challenges to doing so?*
- *What are the barriers and facilitators of generating information on GBV screening? For projects working in this area, what has been their experience incorporating GBV screening in health facility data collection processes?*

## Methods

This activity included a literature review of peer-reviewed journal articles and grey literature, a review of project documents (including data collection forms and indicator reference sheets), and informational interviews with selected project staff working in GBV prevention.

### Literature review

A literature review was conducted to determine *what is known from the existing literature about the collection, analysis, and use of data on routine screening and response for GBV in FP facilities?* The goal was to comprehensively and iteratively cover the literature on this topic to summarize findings and identify research gaps without limiting results to specific study designs (Arksey & O'Malley, 2005).

#### Search strategy

We used PubMed and the EBSCOhost Research Databases to search MEDLINE, Academic Search Complete, Africa-Wide Information, and Women's Studies International databases to identify published academic literature. Search parameters focused on studies in English published between January 2010 and August 2023. This period was selected as it best represents the period during which global policies, guidelines, and programmatic approaches related to GBV screening evolved. Focusing on more recent studies allows for examination of how these changes have been implemented and their impact on data collection and use related to GBV screening and supportive services within FP settings. Searches included medical subject heading terms, keywords and free text using search terms combined with "OR" within each string and "AND" between strings. See Appendix 1 for the detailed search strategy.

To identify relevant grey literature, we searched the websites of organizations working in FP and reproductive health for research or policy documents. For example, WHO's Institutional Repository for Information Sharing (IRIS) database was searched using the subjects 'gender-based violence' and 'intimate partner violence' to identify the most up-to-date guidance around addressing GBV at an individual and institutional level. Other organizations included UN Women (<https://www.unwomen.org/en/digital-library>), USAID development Experience Clearinghouse (<https://dec.usaid.gov/dec/content/search.aspx>), and the International Planned Parenthood Federation (<https://www.ippf.org/resources>). Additional studies were identified by reviewing reference lists of relevant studies in the database and website searches.

#### Inclusion criteria

Studies were included if they described quantitative data collection and reporting related to GBV screening and support interventions or analyzed GBV screening and support data from routine health information systems. Articles were excluded if they focused solely on the prevalence or correlates of GBV, did not include client-level quantitative data related to a routine screening program, or if screenings were focused broadly on child abuse, elder abuse, or non-GBV healthcare screenings. For research articles, the reviewers

summarized information on tools used, the type of data collected, including screening and service/referral rates, the study's purpose, context, and design, and lessons learned related to the collection use or analysis of GBV screening/support data. Similarities and differences in findings were compared to draw conclusions across studies regarding the collection and use of GBV screening and service/referral data. The reviewers also summarized data collection and reporting recommendations from policy documents, including individual-level and institutional indicators. However, while policy articles and reviews were used to inform the report generally, policy and review data was not systematically extracted into table format.

## Search results

The scoping review identified 1460 studies (1437 from databases, 23 from websites or reference lists). Of these, 85 studies were duplicates, yielding 1375 studies for screening and 174 reports that were eligible for full-text review. One hundred twenty-five studies were screened out due to not reporting any client-level quantitative data (n=67), reporting only on prevalence or correlates of IPV (n=38), or reporting on the wrong setting, population, or intervention type (n=20). A total of 29 studies (summarized in 49 articles) were included in this review for narrative synthesis and summarized under research. See Appendix 2 for the PRISMA chart and Appendix 3 for a table of included studies.

## Monitoring document review

This investigation's second stage involved reviewing project documents, such as data collection forms, indicator reference sheets and District Health Information Software 2 (DHIS2)/HIS facility reporting forms used by USAID-funded implementing partners. USAID gender advisors identified project staff from their implementing partners to approach for additional information. Project directors gathered monitoring documents and identified key contacts to participate in informational interviews. All identified organizations were funded under the USAID MOMENTUM<sup>4</sup> suite of awards:

- MOMENTUM Country and Global Leadership (MCGL)
- MOMENTUM Integrated Health Resilience (MIHR)
- MOMENTUM Private Healthcare Delivery (MPHD)
- MOMENTUM Safe Surgery in Family Planning and Obstetrics (MSSFPO)

Several former USAID projects with experience integrating GBV screening into existing health programs were also identified through the USAID Development Experience Clearinghouse (e.g., Advancing Partners & Communities [APC] Project in Guyana; The RESPOND project in Guinea; Data.FI/Palladium in Nigeria). Published program screening protocols and evaluation reports provided insight into each program's data collection tools and barriers and facilitators around collecting screening data and were subsequently incorporated into the document review.

Document review methodology was adapted from *MEASURE Evaluation's rapid assessment of the collection and reporting of GEND\_GB data*,<sup>5</sup> which, among other resources, generated a data quality review tool<sup>6</sup> and methods for assessment,<sup>7</sup> The Microsoft Excel version of the data quality review tool was modified to focus on the remote review of project documents and to determine which fields exist in data collection forms to

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<sup>4</sup> MOMENTUM is designed to strengthen the capacity of partner institutions and local organizations to deliver quality, evidence-based maternal, newborn, and child health services, voluntary FP, and reproductive health care in USAID partner countries. For more information, visit: <https://usaidmomentum.org/about/>

<sup>5</sup> [https://www.measureevaluation.org/resources/gend\\_gb-v-rapid-data-quality-review-tool.html](https://www.measureevaluation.org/resources/gend_gb-v-rapid-data-quality-review-tool.html)

<sup>6</sup> <https://www.measureevaluation.org/resources/publications/tl-19-28/index.html>

<sup>7</sup> <https://www.measureevaluation.org/resources/publications/fs-19-339.html>

track GBV screening and referrals. Data were analyzed by capturing them in the Excel analysis matrices and comparing responses across sites to identify common themes and outliers. Copies of the data collection and reporting forms were reviewed in tandem with the analysis.

## **Informational Interviews**

The third stage of this investigation involved informational interviews conducted with identified project staff working in GBV prevention programming within the MOMENTUM portfolio and external GBV experts. The informational interviews aimed to document current practices and obtain input and recommendations on the potential for integrating GBV screening indicators into HIS.

Participants from USAID implementing partners included gender-focal persons and monitoring and evaluation (M&E) or strategic information staff. A concerted effort was made to interview country-level (local) individuals who supervised the data collection and reporting of GBV indicators to USAID or other stakeholders. The number of interviews was determined by the number of projects and availability of their staff working on GBV service provision projects. Potential respondents from other USAID-funded and non-USAID-funded organizations were identified by reviewing the literature and their participation in relevant working groups and networks. In total, six interviews with seven individuals (five women and two men) were conducted in English between February and May 2023. Five interviews were conducted with staff from MOMENTUM projects, and one interview was conducted with a non-USAID respondent, a Senior Associate and Technical Director at Population Council. They are a technical expert in sexual and GBV and have been active in policy and practice integrating IPV screening into sexual and reproductive health and HIV and AIDS services throughout East, Central, and Southern Africa.

A generic semi-structured interview guide was developed and customized for each interviewee based on their organization's monitoring documents or expertise (see Appendix 4). All interviews were conducted virtually, using Zoom, and were in English. The interviews were recorded, transcribed, and analyzed using activity objectives to identify salient themes. Appendix 5 summarizes the MOMENTUM organizations participating in the document review and informational interviews.



## Findings

This section consolidates the findings from the literature review, document review, and informational interviews to answer each of the four research question topics outlined in the introduction. These findings shed light on the current practices adopted by MOMENTUM partners involved in the integration of GBV programming within FP clinics. By situating their practices within the broader body of literature, this section offers valuable insights into the prevailing approaches and initiatives implemented by USAID partners. The aim is to provide a holistic understanding of the state of GBV programming and its monitoring within the FP context.

The MOMENTUM portfolio consists of USAID partners at different stages of readiness to implement and monitor GBV screening and referral interventions, which has significant implications for the information collected at health facilities. MCGL-supported sites in Nigeria conduct routine screenings with first-line support among all male and female clients at ANC, FP, and outpatient department (OPD) facilities. These activities have been integrated into their RHIS, although the program acknowledges challenges around the quality of screenings. Similarly, MSSFPO-supported sites in Nigeria are also performing routine screenings and first-line support, with screening eligibility differing by service delivery point. Screening is conducted among all new male and female clients aged 15 and older at OPD sites, while clients at fistula clinics, FP units and ANC units are offered GBV screening at every clinic visit without age restrictions. MSSFPO-supported sites in India operate one-stop centers that provide direct services to individuals who have experienced violence, so screenings are unnecessary. MSSFPO's other global efforts focus on developing referral networks, ensuring sites possess up-to-date comprehensive GBV referral lists within the past six months. MPHD and MIHR organizations do not formally implement GBV screening within their facilities. Instead, MIHR collaborates with designated GBV focal points in each country to identify and strengthen referral pathways and incorporate GBV sensitization into FP activities. Many MIHR-supported sites may also have pre-existing screening services, but these are not necessarily coordinated by MIHR.

### 1. How is information collected at health facilities on GBV screening?

Screening for GBV involves asking a series of direct and behavior or acts-based questions to identify individuals who may have experienced or are at risk of abuse. The following section describes the screening forms and procedures, including the development and content of screening questionnaires used by MOMENTUM partners and other FP projects, with specific attention to the measurement considerations (population, time frame, and unit of observation), types of violence (physical, sexual, emotional, psychological, economic, and RC), descriptive variables (perpetrator, severity, frequency and location of violence), and respondent characteristics (age, sex, and marital status).

#### Screening data collection forms, procedures, and personnel

Multiple paper-based forms and registers are used at MOMENTUM-supported sites to monitor the GBV screening intervention with different personnel supporting various aspects of GBV screening and service provision. Typically, staff at the facility level were trained to screen clients for GBV using a questionnaire as a prompt. In identified cases of GBV, an in-depth case management form would be completed by a GBV focal person to aid in service provision. Registers were used to combine information from the screening form and case management forms for overall reporting, culminating in a monthly summary form tracking multiple indicators.

## *Development of screening tools*

MOMENTUM partners adapted existing screening tools from USAID or PEPFAR projects, refining them through stakeholder feedback to ensure providers can respond appropriately to identified cases. Simple, scripted questions and brief screening tools were found to facilitate screenings in line with the literature by framing the questions for providers and minimizing the response burden (Andreu-Pejo, 2022; Hegarty, 2021; Spangaro, 2011). Implementers also allowed flexibility to build rapport and ensure safe screening. For example, starting assessments with general health and relationship questions, rather than directly asking about physical or sexual violence, made clients more comfortable with the screening process (Falb, 2017; Gupta, 2017).

*Based on how the screening has been done, and how we monitor it over time, we noticed that when you just come in and then start asking a patient, “Have you experienced this, this, this?” then you tend to be getting a “No, no, no” response from them. So, we changed the format in the way we actually screen patients. (MSSFPO, Nigeria)*

The level of flexibility varied among MOMENTUM partners, with some acknowledging that questions need not be asked verbatim and others allowing the use of customized tools at each site. Because tools are constantly changing, many of the documents reviewed for this report have already undergone further refinement since they were first shared.

### **Screening procedures: screening approach and frequency**

MOMENTUM partners use a routine screening approach with repeated enquiry, emphasizing that screening should not be a one-time intervention. However, due to time constraints and quality concerns, interviewees noted that facilities reduced the frequency of screenings over time.

*Instead of screening everybody, we’re using some sort of criteria to reduce the number of people screened because we also realized that we needed to do quality screening to be able to begin to identify more cases because there’s been a lot of issues around the low case identification. (MCGL, Nigeria)*

Few of the studies identified in the literature review discussed the frequency of screening, but among those conducted under routine practice, screening frequency varied. It was common to screen at first visit and then annually in primary care settings (Hunter, 2014; Iverson, 2020), while higher screening frequencies were reported in HIV programs (e.g., every six months for returning clients with a history of GBV or relevant risk factors [APC Guyana]), or any time a client reported having a new partner (Hartman, 2019).

While a repeated enquiry approach enhances client disclosure (Bott et al., 2010), it also presents a risk of inflating the number of individuals screened and disclosing violence, which interviewees reported addressing in several ways. In Kenya and Nigeria, screening forms were stored in patient files, prompting providers to review them and rescreen only if the client had not previously reported any GBV experiences. In Nigeria, registers also included fields to indicate if the client had been previously screened. In Uganda, stickers were placed on the health cards of refugee clients to notify providers that they had already undergone screening, compensating for the absence of typical medical files. Rather than re-screening, clients who were identified as survivors were followed up to ensure appropriate care, including prevention of and response to new acts of violence. One interviewee suggested that the experience of disclosing GBV through screening and subsequent rapport developed with providers will encourage clients to self-disclose new cases of GBV.

## Screening and the RHIS

The availability and use of GBV data among MCGL and MSSFPO-supported facilities indicate that GBV screenings and referral activities are integrated into the RHIS among some MOMENTUM partners; however, the actual indicators and means of verification vary by MOMENTUM partner based on the specific systems and protocols in place. This is discussed in greater detail in subsequent sections.

## 2. What information is collected at health facilities on GBV screening?

### Screening questions: Population, time frame and unit of observation

When gathering data on GBV, three key measurement considerations should be considered: the target population, the time frame of violence, and the unit of observation (persons or incidents) (UNDESA, 2014). Regarding the target population for MOMENTUM partners, women and girls attending facilities were the primary beneficiaries of screening, but males were also eligible for screening. Age ranges varied by MOMENTUM implementing partner and service delivery point. Clients were the unit of observation across all MOMENTUM partners, with no data collected on the number of incidents of violence perpetrated against clients. The time frame of violence for screening questions was specific to the past year, which allows for estimating the extent and nature of current levels of violence and the number of individuals who may require assistance (UNDESA, 2014). However, the ideal screening time frame was a point of question among interviewees. Some suggested the value of recalling past experiences of GBV to provide psychosocial support, while others noted survivors who did not want to revisit older experiences or may need more time to come forward. Others advocated for specifying current experiences of violence to keep the workload manageable and focused on urgent service needs:

*Because if you ask about everything under the sun, you need to make sure that you're prepared to respond to everything under the sun. So, what is it if you're asking about "ever"? (Population Council, Kenya & Uganda)*

### Screening questions: Types of Violence

Global guidance on the use of administrative data for measuring violence against women suggests focusing data collection efforts first on sexual, physical, and psychological violence (UN Women & WHO, 2022). In contrast, statistical guidance geared towards prevalence surveys suggests that collecting data on physical, sexual, psychological, and economic violence should be considered essential, with additional data collection tailored to the local context (e.g., including questions on female genital mutilation in countries where it is relevant) (UNDESA, 2014). However, many core indicators on the prevalence of GBV prioritize indicators on experiences of sexual and physical violence,<sup>8</sup> counting psychological and economic violence separately, if at all (WHO, 2021b; UNDESA, 2014; UNAIDS, 2023).

Currently, all MOMENTUM screening tools reviewed for this activity included separate questions on physical, sexual, emotional, and psychological violence, but not economic violence or reproductive coercion. Interviewees considered data collection on physical and sexual violence essential and straightforward.

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<sup>8</sup> For example, the UNAIDS 2023 indicator registry measures the percentage of people in a key population who report having experienced physical and/or sexual violence in the last 12 months (UNAIDS, 2023). UNDESA's core indicators on violence against women include the total and age-specific rate of ever-partnered women subjected to sexual and/or physical violence by current or former intimate partner in the past 12 months vs. the total and age-specific rate of ever-partnered women subjected to psychological violence in the past 12 months by an intimate partner and the total and age-specific rate of ever-partnered women subjected to economic violence in the past 12 months by an intimate partner (UNDESA, 2014)

However, MOMENTUM implementers used screening questionnaires with separate definitions for emotional and psychological violence, despite acknowledging that there was not a clear difference between the two forms of violence, and they were often combined for reporting purposes. Further, questions on psychological/emotional violence were not limited to IPV, which is the recommended approach for statistical purposes (UNDESA, 2014). See Appendix 6 for the questions used by MOMENTUM and other USAID partners.

Data on economic violence, which includes actions that control or limit an individual's access to financial resources, was collected by only one MOMENTUM partner<sup>9</sup>. This gap among MOMENTUM partners aligns with IPV research and practice from the broader literature, which tends to overlook economic violence or conflate it with psychological abuse (Stylianou, 2018). Defining economic violence is challenging as it can vary substantially by setting, and there are no globally accepted standardized questions to capture data on it (UNDESA, 2014). Nevertheless, interviewees suggested that economic violence should be included in screening tools, as it can have significant impacts, such as limiting access to family planning services. Some stakeholders initially considered including economic violence in screening tools but later dropped the idea due to uncertainty regarding appropriate service provision, though they now believe it could be initially addressed through psychosocial counseling.

Interviewees also noted that many clients reported more than one type of violence, and providers used different strategies to capture this information, such as selecting a primary category of violence based on a hierarchy (first sexual, then physical, followed by psychological/emotional). This hierarchical strategy is also employed by PEPFAR clinics with GEND\_GBV targets<sup>10</sup> and humanitarian agencies using the Gender-Based Violence Data Management System (GBVIMS).<sup>11</sup> Another strategy employed by a MOMENTUM partner was to count individuals under each relevant type of violence but without including a category for *any* experience of violence. Both of these methods present challenges to accurately measuring the types of violence experienced by clients, as the former potentially under-counts non-prioritized types of violence, while the latter makes it difficult to identify the de-duplicated number of individuals experiencing any violence.

Despite its relevance to FP and sexual and reproductive health (Silverman, 2014), screening for RC was lacking among MOMENTUM partners, underlining a notable gap in current practices. There are also challenges in the broader literature with documenting and addressing RC, including limited conceptual and definitional clarity (Tarzia & Hegarty, 2021). While there is no validated clinical screening tool for RC, studies support the feasibility of introducing routine RC screenings with a few additional questions in FP settings

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<sup>9</sup> This partner reported summary data on the number of GBV survivors experiencing a denial of resources, which was categorized as psychological violence in the screening form. This categorization of economic coercion as psychological violence aligns with CDC's definition of "psychological aggression" (e.g., the use of verbal and nonverbal communication with the intent to a) harm another person mentally or emotionally and/or b) exert control over another person. Includes but is not limited to making threats of physical or sexual violence, involving the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm; humiliating, degrading, or intentionally embarrassing or diminishing the victim; using coercive control of what the victim can and cannot do; withholding information from the victim; isolating the victim from friends and family; controlling the victim's reproductive or sexual health; and denying the victim access to money or other basic resources (Breiding, 2015).

<sup>10</sup> GEND\_GBV is a PEPFAR MER indicator measuring the number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package of GBV services. Standardized indicator guidance requires disaggregating services by violence type; services for an individual who has experienced both sexual and physical and/or emotional violence is counted only under the sexual violence disaggregate. All forms of violence that have a component of sexual violence are counted only as sexual violence (Kanagasabai, 2023). For more details on this indicator, see PEPFAR's indicator reference guide: <https://www.state.gov/pepfar-fy-2022-mer-indicators/fy23-mer-2-6-1-indicator-reference-guide/>

<sup>11</sup> The GBVIMS can only capture one type of violence per incident. To avoid double-counting when more than one type of violence occurs in a GBV incident, the type of violence captured is prioritized in the following mutually exclusive order: rape, sexual assault, physical assault, forced marriage, denial of resources/opportunities/services, psychological/emotional, and non-GBV. See the Gender-Based Violence Classification tool at <http://gbvims.com/wp/wp-content/uploads/Annex-B-Classification-Tool.pdf>

(Cheng, 2021; Galrao, 2022; Decker, 2017; Delamou & Samandari, 2014; Samandari et al., 2016) and other healthcare settings (Wirtz, 2016; Vu, 2016; Vu, 2017; Turan, 2013). For instance, public FP clinics in Australia successfully screened for RC by adding two RC questions to the existing IPV tool (Cheng, 2021). A former USAID project, the RESPOND project in Guinea, also incorporated two RC-related questions within FP clinics' IPV training and screening tools, though RC information was not disaggregated for reporting (Delamou & Samandari, 2014; Samandari et al., 2016). A study in Niger (Silverman & Raj, 2014) and ongoing studies in Kenya, Niger, and Bangladesh (per key informant interview) have integrated RC questions into IPV screenings, with forthcoming results expected to provide more insights into the acceptability and feasibility of RC screenings and associated outcomes. See Box 3 for selected examples of RC questions from published literature. Note many studies measured *lifetime* RC; however, reference to 'ever' in the questions could be adjusted to "past 12 months" to identify recent or ongoing RC.

**Box 3. Example of RC screening questions in FP settings from peer reviewed literature**

Cheng et al. 2021, pg. 350:

- Has your partner or ex-partner ever interfered with your choice or ability to use contraception?
- Has your partner or ex-partner ever forced you to:
- Become pregnant?
- Continue a pregnancy that was unwanted/unplanned?
- Terminate a pregnancy that you wanted to continue?

Silverman & Raj, 2014, pg. 3: Six items asked about whether a woman's husband had ever:

- Tried to force or pressure her to become pregnant,
- Taken her FP method away from her,
- Kept her from going to the clinic to access FP methods,
- Said he would leave if she did not get pregnant, or
- Hurt her physically because she did not get pregnant.
- The sixth item asked if anyone including the woman's husband, in-laws, or co-wives pressured her, made her feel badly, or treated her badly in the past 12 months for not having a child.

*Screening questions: Descriptive variables*

Understanding the different dimensions of violence experienced is crucial in addressing GBV. Accordingly, screening questionnaires may include factors like the relationship to the perpetrator and details regarding the severity, frequency, and location of violence to effectively identify and support survivors (UNDESA, 2014). MOMENTUM partners collected information on the survivor's relationship to the perpetrator during the initial screening process. However, only one MOMENTUM partner used this perpetrator data to categorize their type of violence as IPV or not for reporting purposes. In contrast, studies identified in the literature review overwhelmingly focused on screening for IPV (with or without RC) (Cheng, 2021; Christofides, 2010; Colombini, 2021; Das, 2022; Decker, 2017; Galrao, 2022; Gupta, 2017; Hartmann, 2019; Hegarty, 2021; Hunter, 2017; Iskandar, 2015; Iverson, 2023; Laisser, 2011; Miller, 2016; Palitto, 2016; Samandari, 2016; Silverman, 2020; Sutherland, 2011; Thompson, 2022; Turan, 2013; Undie, 2014; Undie, 2016; Wagman, 2015; Zapata-Calvente, 2022), suggesting it is a feasible and acceptable focus for FP and other SRHS or primary care facilities. Instead of beginning by inquiring about any form of GBV and then addressing the perpetrator, these studies usually formulated questions specifically focused on intimate partners (e.g., "Has a partner or ex-partner hit, slapped, kicked, or otherwise physically hurt you?" [Hegarty, 2021] or "Are you currently in a relationship with a person who physically hurts you?" [Undie, 2014]).

Severity, frequency, and location of violence were not collected in the MOMENTUM partner initial screening process but were addressed in case management forms to guide service provision for identified cases. Monthly summary forms of MCGL and MSSFPO included counts of GBV cases treated for injuries, but tallies of persons in need of post-GBV treatment and data on perpetrator type would be required to measure indicators recommended by MEASURE Evaluation, such as the severity of physical IPV (Bloom, 2008).

#### *Screening questions: Personal characteristics of respondents*

Collecting information on the personal characteristics of respondents at the point of screening allows programs to identify and address factors associated with risk for different magnitudes and types of violence (UNDESA, 2014; WHO & UN Women, 2022). Age and sex were captured in all reviewed screening data collection tools. Sex was captured and reported as male or female, though one MOMENTUM partner had an open-ended field for sex, which may have allowed for additional gender identities. The client's age was captured by recording the age at the time of the visit or marking an age category, though categories varied by implementor. Marital status is a recommended characteristic as it is relevant to IPV (UNDESA, 2014); however, only one MOMENTUM partner's tool included marital status as an open-ended text field, and this tool is not yet in use (MIHR). Without this level of detail, indicator results cannot be limited to clients who have or have ever had an intimate partner (as would be ideal for indicators specific to IPV.)

Partners expressed interest in collecting data on clients who are at increased risk for violence victimization, including people with disabilities, adolescent girls and young women, and first-time mothers. However, the screening forms or registers did not always reflect these fields. See boxes 4–8 for considerations around gender-inclusive monitoring and monitoring populations at increased risk for violence victimization.

#### **Box 4. Screening boys and men for GBV**

While girls and women are disproportionately affected by violence, boys and men also experience GBV (Kolbe, 2020; CDC, 2020; ICRC, 2022). Perpetrators of sexual violence against men often use domination, power, and control tactics, reflecting similar gender norms found in sexual violence against women and girls (Kiss, 2020). However, male survivors receive little attention in healthcare settings or supportive interventions (Kimberg, 2008; Kiss, 2020). There is a conspicuous gap in comprehensive data on GBV against boys and men; most GBV studies and surveillance systems center on female populations. Few studies identified via the literature review included males in their screening eligibility criteria (Das, 2022; APC, Guyana; Thompson, 2022). This data gap minimizes male victimhood and hampers development of inclusive and holistic strategies to combat GBV. Monitoring and evaluation strategies should ensure sufficient samples of males and disaggregate results by gender to inform the design and delivery of gender-sensitive and, where required, gender-specific approaches (Kiss 2020). Research may be needed on appropriate screening tools for men, as some authors suggest unique tools are necessary (Wirtz, 2016; Vu, 2016), while others prefer tools that can be used by males and females in busy healthcare settings (Mutiso, 2021).

**Box 5. Screening for GBV among people with disabilities**

Globally, women with disabilities may be at higher risk of exposure to violence and specific forms of violence including RC, but little is known about the intersection of disability and violence (Cheng et al., 2021; Meyer, Stöckl, Vorfeld, Kamenov, & García-Moreno, 2022). Research focused on violence against women with disabilities has included data on perpetrators specific to women with disabilities (e.g., personal carers or staff at institutions) and disability-specific abuse (e.g., “As an adult, has anyone you know ignored or refused to help you with an important personal need such as using the bathroom, banking, dressing, eating, communicating, or going out in the community?” Or “In the last year, has anyone you know broken or kept you from using important things such as a phone, wheelchair, cane, walker, respirator, communication device, service animal, and other assistive devices?” [Curry et al., 2009]). Meyers et al (2022) contains a full list of disability-specific violence items from this body of literature.

**Box 6. Screening for GBV among AGYW**

AGYW are at high risk for violence by intimate and non-intimate partners (Mathur et al, 2018; Decker et al, 2015; Kanagasabai et al, 2023). A study on the feasibility of routine IPV screening at a public health hospital in Kenya found that AGYW had higher disclosure rates and were more likely to report sexual violence than other female clients (Undie et al, 2016), while studies at PEPFAR supported health facilities suggests AGYW screening positive for IPV have low uptake of referrals (Colombini, 2021), and low completion rates of post-exposure prophylaxis (PEP) (Kanagasabai 2023). Youth-friendly services and attitudes were important facilitators for AGYW disclosure, while on-site social workers or trained counsellors facilitated service uptake (Colombini, 2021; Vu, 2017). Accompaniment to the clinic by a caregiver can also pose a barrier to screening among AGYW, which can be addressed by allowing only client-provider clinical consultations and explaining the importance of privacy and confidentiality to family members (Vu, 2017). Custom indicators on GBV screening among AGYW in the PEPFAR DREAMS program in South Africa include a cascade focused on the number of AGYW receiving routine or clinical enquiry for violence, the number of AGYW receiving first-line support (“LIVES”) as a proxy for disclosing an experience of violence, the number of AGYW referred to a provider offering the minimum package of services for GBV, and the number of AGYW receiving a service from a provider offering the minimum package of services for GBV. The indicator data is recorded in a centralized database combining identifiable, individual-level data across various DREAMS implementing partners to track referrals and service uptake.

**Box 7. Screening for GBV among LGBTQI+ persons**

GBV against LGBTQIA+ people is rooted in socio-cultural prejudices, systemic discrimination, and heteronormative biases (Meyer, 2003) and often predicated on perceived non-conformity to gender norms and expressions (UN 2015). In addition to IPV (Brown & Herman, 2015; Bermea, 2021; Liu, 2021; Peitzmeier et al., 2020), members of the LGBTQI+ community may face unique forms of GBV, including forced outings and so-called ‘corrective rape’ (Bermea, 2021; Doan-Minh, 2019). Transgender individuals, in particular, face elevated rates of violence, including hate-motivated killings (Arayasirikul 2022; Human Rights Campaign, 2022). LGBTQIA+ individuals who experience GBV may be at an elevated risk for HIV/AIDS, sexually transmitted infections, unwanted pregnancies, and other reproductive health complications due to forced sexual encounters (Bermea, 2021; Kiss, 2020). Additionally, LGBTQI+ individuals face disparities in accessing essential sexual and reproductive health services (Brown & Herman, 2015; Khozah, 2023).

Despite an increased risk for GBV victimization, data on GBV against the LGBTQI+ community remains sparse. Stigmatization and fear of further victimization leads to underreporting, while many research and data collection efforts still operate within a binary gender framework. For example, most routine information systems only capture biological sex, typically defaulting to cisgender categorizations of male and female (UN Women & WHO, 2022). However, there is a growing push for international standards that better capture gender identity (e.g., differentiating between cisgender, transgender, and non-binary individuals) in data collection and reporting for more accurate representation and support (UN & WHO, 2022; UNECE 2021; UNODC & UN Women, 2022; Blondeel, 2016; Wirtz, 2020). USAID has also committed to ensuring meaningful participation of LGBTQI+ persons across all monitoring, evaluation, and learning efforts, so that systems support inclusive accountability and decision making (USAID, 2023).

A number of tools to identify IPV have also been developed for LGBTQI+ populations, including the Identity Abuse Measure (Woulfe, 2018), the sexual and gender minorities–specific IPV Conflicts Tactics Scale (Dyer, 2019), the IPV-Gay and Bisexual Men (GBM) scale (Stephenson, 2013) and the transgender-related IPV Tool (Peitzmeier, 2019). Further, while implementation research is scarce among this population; a recent study suggested routine IPV screening among transgender primary care patients in the U.S. was a feasible and acceptable approach for clients and providers, with post-screening referral and service utilization rates comparable to other populations (Das, 2022). Notably, the study was conducted in a trans-competent health setting, using a self-administered electronic screener, and referral services were integrated on-site, mitigating many of the barriers experienced by transgender and other LGBTQIA+ clients.



### **Box 8. Screening for violence in humanitarian settings**

GBV within conflict-affected areas is considered epidemic with as many as one in five women in humanitarian settings experiencing sexual violence (Vu, et al., 2014). Though largely unreported, boys and men, as well as LGBTQI+ persons also experience sexual violence in humanitarian emergencies (Kiss, 2020; ICRC, 2022). Multiple evaluations suggest routine GBV screening in an emergency context is feasible and acceptable to clients and providers, despite challenges with providers' workload and limited private space to conduct screenings (Vu & Wirtz, 2017; Undie, 2016; IRC, 2015). Additionally, screening tools have been developed and validated in multiple fragile contexts to aid providers in supporting disclosure and referring survivors to appropriate services, notably the Johns Hopkins 'Assessment Screen to Identify Survivors Toolkit for Gender Based Violence' (ASIST-GBV) (Wirtz et al., 2013; Wirtz et al., 2014; Vu et al., 2016; Wirtz et al., 2016). Along with increased programming, there is a recognized need for improved monitoring and evaluation of GBV services in humanitarian settings. However, variability in how programs collect, analyze, and report data, as well as the lack of secure data systems, make it difficult to obtain high quality data. As a result, the Gender-Based Violence Information Management System (GBVIMS) was developed by a consortium of UN agencies and International Rescue Committee (IRC) to improve data quality and comparability for the purpose of evidence-informed decision making in humanitarian settings. GBVIMS is a data management system for providers to safely collect, store, analyze, and share data related to reported incidents of GBV. The database software is open-source and accompanying resources, such as operational definitions of violence, incident reporting forms and case management guidelines are available online: <https://www.gbvims.com/>. Additional resources developed to improve data collection in GBV programming in humanitarian settings include the WHO's *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (WHO, 2007) and USAID's comprehensive *Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions along the Relief to Development Continuum* (Menon, 2014).

### ***Service and referral data***

For clients who disclose an experience of violence, an in-depth case management form was completed by a GBV focal person (e.g., a nurse with specialized GBV training) in MOMENTUM-supported sites. The case management form was designed to gather essential data and aid in service provision. For example, one form shared by a site in Nigeria documents client demographic details (name, age, sex, occupation, education level, first-time visit), the types of injuries sustained and location, any client vulnerabilities (e.g., disabilities), an assessment of client safety, a summary of the violence using the client's words, whether the client was counseled, a list of clinical services provided to sexually assaulted clients, and a list of other non-clinical services or referrals provided. To protect client confidentiality, de-identified data from this form was then copied to registers, typically by the GBV focal person, and used to produce monthly summaries of key service and referral data. See Appendix 7 for details on how MOMENTUM partners report supplementary summary data on screenings and service/referral data.

### ***Indicators***

The International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) provides guidance on implementing and monitoring routine GBV screening policies in FP settings (Bott et al., 2010). Typical service statistics used by IPPF/WHR partner organizations include the number and percentage of

clients screened, the number and percentage of clients answering yes to screening questions, and the number and percentage of clients referred to outside services. Ideally, organizations would measure the proportion of *eligible* clients screened over a given period, with eligibility determined by the clinic’s screening protocols (e.g., the protocol may be to screen only new clients, to screen all female clients, to screen clients who had not been recently screened; to screen at only certain kinds of visits, etc.). However, in resource-poor settings, it can be challenging to accurately measure the denominator (number of clients eligible for screening), leading to adjusted indicators where the denominator is the total number of clients attended, regardless of eligibility. Indicators adjusted in this manner may underestimate the true screening rate.

**Figure 1. Monthly screening rate indicator (Improving the Health Sector Response to Gender Based Violence, Botts et al, 2010)**

$$\frac{\text{Number of women screened per month}}{\text{Number of women attended who were eligible* for screening that month}} \times 100 = \text{The monthly screening rate}$$

IPPF/WHR notes that collecting service statistics in FP settings poses challenges due to the lack of computerized information systems in many clinics and variations in information systems within and across organizations (Bott et al., 2010). Different patient flow systems and screening protocols further complicate data collection. However, measuring the proportion of all clients attended at the clinic who report GBV can help estimate the demand for GBV-related services and track changes in screening levels over time. IPPF/WHR suggests additional service statistics when integrating GBV screening and support, such as the percentage of detected violence cases categorized as physical, sexual, or psychological; the percentage of identified survivors accepting referrals; and the number of clients receiving each type of service (as a result of direct provision or completed referral). These statistics provide further insights into the nature and outcomes of interventions related to GBV in healthcare settings.

**Figure 2. Alternate monthly screening rate indicator (Improving the Health Sector Response to Gender Based Violence, Botts et al, 2010)**

$$\frac{\text{Number of women screened per month}}{\text{Number of women attended that month (whether or not they were eligible for screening)}} \times 100 = \text{The monthly screening rate}$$

MOMENTUM partners reported few standardized reporting requirements, with informational needs differing by program. For example, MSSFPO partners are looking at how to integrate GBV screening and referrals and data collection within already siloed systems, which may be driven by higher-level ministry decisions filtered down. One interviewee noted less emphasis on GBV data in the current MOMENTUM portfolio than in previous iterations of the project. At the same time, implementers noted that reporting requirements and indicators are constantly changing through consultation with stakeholders, including USAID and local government stakeholders and can become quite extensive.

Most indicators shared by MOMENTUM partners were considered supplementary and at the country-level, such as MCGL's number of new partnerships formed to address GBV, the percentage of government health budget allocated to GBV, and the number of clients screened for GBV who are referred to clinical and non-clinical services per the WHO guidelines, by five-year age groups. MCGL also developed a facility-level dashboard of indicators focused on the number of clients screened among all clients attended at ANC, FP, and OPD sites. These output indicators follow the IPPF/WHR indicator guidance utilizing an adjusted denominator of clients attended at the clinic. This is a common and practical approach with the limitation that it may underestimate the true screening rate. At the country level, MSSFPO Nigeria reports to USAID/Nigeria on the number of GBV referrals and the number screened at fistula clinics.

The only detailed indicator reference sheets shared as part of the document review focused on outcomes related to facility readiness to screen for GBV, such as the percentage of supported facilities with an updated referral list and the percentage of facilities that meet the minimum requirements for screening for GBV per the WHO guidelines. These indicators offer a good starting point for monitoring facilities' capacity to screen. However, the indicator on the percentage of supported facilities with an updated referral list is limited by a reliance on facility self-report and the interpretation of 'active and updated referral list' may vary. While no minimum definition is provided within the PIRS for the contents of a referral services list, the implementors guide sites to include the latest contact details for clinical, psycho-social, legal, financial, shelter home/safe house, GBV hotline, and services for child GBV survivors. The lack of specific guidance within the PIRS provides context-specific flexibility but also makes it difficult to assess how well the referral list meets the comprehensive needs of clients. Beyond referrals, it would also be valuable to monitor whether facilities have a dedicated case manager/social worker at the facility who can support referrals. See Appendix 8 for the full indicator reference sheets.

### *Information gaps*

A critical information gap that MOMENTUM partners note is the quality of data despite the amount of data collected. In particular, many interviewees reported that disclosure rates are lower than expected. Potential explanations offered by interviewees were whether a person feels comfortable disclosing the first time they're asked and how well the providers conduct the screenings. Low disclosure to service providers and local authorities is well-documented in the literature (Palermo, 2014) for reasons such as shame, stigma and fear of discrimination, high tolerance, or normalization of GBV, limited knowledge about service availability, and lack of confidence in services and confidentiality, among others (Christofides, 2010; Colombini et al., 2017; Wirtz et al., 2013; Wirtz et al., 2014).

*I think we collect a lot of data, and sometimes, you know, I think the question is how much of this data is essential, especially given that the providers are feeling like, okay, this is taking up extra time, but we are trying to do the full LIVES. (MCGL, Nigeria)*

Another information gap reported by multiple interviewees was around better understanding local preferences and needs to improve referral uptake, which is especially challenging to provide and monitor. One interviewee suggested this would be too much for a routine monitoring activity but would be valuable as a side study.

*It would just be interesting to see how to innovate with referrals and figure out how to do them better. Understanding that there will always be that portion of clients who, even in a perfect world, will just not be able to make it because this is not their priority right now or*

*because they came in for one thing and they really weren't prepared to add on another service that particular day. (Population Council, Kenya & Uganda)*

Interviewees also noted multiple ongoing research projects relevant to GBV screening, the findings of which should be incorporated into any final recommendations from this report. MCGL is analyzing data from a clinical trial on the acceptability, feasibility, and impact of integrating GBV screening and first-line support into ANC and FP services in Nigeria. Another interviewee mentioned studies on incorporating RC questions into routine IPV screenings in low- and middle-income countries, including Kenya, Niger, and Bangladesh.

### **3. How do projects/health facilities use screening information?**

#### **Service delivery**

Implementers reported that screening results in customized service delivery, primarily implementer and psychosocial support services. Referral uptake to specialized services was often lower than expected. Implementers suggested this was due to the challenge of following up to see if referrals were completed without putting the client at risk.

#### **Programmatic decision making**

The resulting data is also used for decision making to improve service delivery at the facility level and higher and inform policies and strategies among stakeholders. For example, MCGL developed data dashboards for monthly facility-level data review meetings to encourage teams to use their data for decision making. MSSFPO reported the creation of a technical working group, including civil society organizations and government stakeholders, that meets quarterly at the state level in Nigeria to review data across implementers to ensure appropriate service provision and address challenges. This data feeds into the federal level, where the Ministry of Women's Affairs and other partners developed a situation room and national dashboard for GBV data collection and harmonization to support resource allocation for services to the survivors.<sup>12</sup>

*We use our data—during the validation of the data, we sit down, we validate, and we now look at the different types of gender-based violence and which type of services those survivors need and by then, we decide, we sit down, we distribute based on the need of those survivors. (Ministry of Women's Affairs, Nigeria)*

#### **Data collection advocacy**

Data is also used strategically to advocate for improving national data collection strategies. For example, MCGL considered using more sophisticated registers, such as those developed and in use by GBV centers in Nigeria, but instead adopted a national-level tool so they could use their experience to advocate for improvements.

*We opted to align with NHMIS, the National Health Management information system for Nigeria...so that at some point, we can demonstrate that, "Okay, we have used the National Register. We have used the national tool. This is what we believe are the modifications that should be made at the national level." (MCGL Nigeria)*

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<sup>12</sup> Nigeria's National Gender Based Violence Dashboard, available at: <https://reportgbv.ng/#/>

## 4. What are the barriers and facilitators of generating information on GBV screening?

### Barriers

#### *Institutional capacity and support*

Barriers to integrating GBV screenings into health services are well-documented (Colombini, 2017; Schwab-Reese, 2018; Andreu-Pejo, 2022). Less is known about the barriers and facilitators to integrating GBV screening data into health information systems, such as the documentation and reporting of screening results and service utilization (Colombini et al., 2017). However, the facilitators and barriers shared by interviewees were closely tied to the feasibility and acceptability of the GBV screening and referral intervention itself, as one respondent shared, “Sorry if this is conflating the intervention with the data collection, but to me, it's all kind of one” (MCGL, global).

Regarding the intervention, barriers and facilitators are often interlinked across clients, providers, and the health system (Andreu-Pejo, 2022; Colombini, 2017). For example, lack of institutional support and resources for GBV integration can lead to limited training opportunities, inadequate coordination, absence of standardized guidelines, provider discomfort and negative attitudes towards screenings, and reduced client participation and disclosure of violence due to negative perceptions of the health system's capacity to provide care (Andreu-Pejo, 2022). Accordingly, one interviewee's recommendation for facilitating the collection and use of GBV data is to make screening a mandated practice for all health programming, with dedicated funding and activities focused on building the data management infrastructure, training, and referral pathways necessary to safely screen for GBV. This recommendation also aligns with guidance from the IRC to allocate resources specifically to the screening intervention when implementing GBV screenings in humanitarian settings, for example, ensuring providers take ownership of the activity and responsibilities are integrated into job descriptions and project outputs (IRC, 2015).

*Specific indicators should be part of the overall program design, and to collect the data against those indicators should be part of the program, so then it is systematically embedded in the design of the program, and then we can address the GBV issues... GBV services should be part and parcel of the health system. (MIHR, global)*

#### *Human resources*

The most common barriers mentioned by interviewees were resource-related, with challenges around human resources shared across MOMENTUM projects. Healthcare workers are responsible not only for providing the screening but often for documenting details for M&E purposes. Providers are not compensated for the additional responsibilities, and many feel overwhelmed by the additional workload. Limited provider time to carry out effective screening was also a common theme in the literature (Andreu-Pejo, 2022; Alvarez, 2017).

*The challenge they usually have, unfortunately, we can't solve it, is human resources for health... You know, this is not their main work they are doing; one is supporting mothers, another malaria, so different things that they have to do, and you have one or two staff, so that's a challenge. (MCGL, Nigeria)*

#### *Data quality and reporting*

MOMENTUM partners reported that data quality varies by facility and requires significant mentoring and support to maintain. A similar experience was described by a USAID-supported HIV program in Nigeria in

which a joint data review exercise identified a low prevalence of GBV screenings in certain HIV clinics, with only five percent of HIV index testing clients being screened for GBV (Data.FI, 2021). Challenges included inadequate knowledge among healthcare workers of how and with whom to conduct GBV screening, limited availability of services in communities, and difficulties in documenting and retrieving GBV screening reports by M&E staff.

MOMENTUM partners identified a lack of harmonization across data collection instruments and reporting requirements, leading to data triangulation and workload challenges. For example, some USAID partners had multiple GBV registers within the same facilities to address different funder requirements, but healthcare workers could not keep up with the various registers, leading to inconsistencies in the data across the different sources. It was suggested that a standardized register across facilities and implementers would reduce the workload on the healthcare worker and the quality of data being reported over time. The extent of reporting requirements requested by USAID was also identified as a challenge, with implementers adjusting as needed.

### ***Cultural norms***

Cultural beliefs and norms may lead to under-reporting of GBV. For example, providers in Nigeria suggested that the GBV screening intervention conflicts with norms around masculinity. The stigma around sexual violence was another noted challenge, with providers suggesting that families prefer to handle cases privately rather than report them. Interviewees also raised considerations around how providers are often deeply embedded in their communities and have been socialized in the same cultural environments. They may be survivors of GBV themselves or experience secondary trauma.

*There are considerations around the broader mandate to do no harm. GBV screening is... nuanced and fragile. You have to be careful to ensure that people are comfortable, and providers also need support. (MSSFPO, global)*

### ***Service commodities***

Interviewees noted that services related to commodities, such as post-exposure prophylaxis (PEP), emergency contraception (EC), and even HIV testing supplies, were more difficult to monitor due to stock-outs and other situations outside of the control of providers, while LIVES counseling/psychosocial support were among the most straightforward services to track as they were provided in tandem with the screening.

### ***Structural constraints within referral systems***

Another reported challenge that may lead to under-reporting of GBV and low referral uptake involves structural constraints within referral systems. For example, the evaluation of routine IPV screening in a Guinean FP clinic revealed a high prevalence of IPV (92%) among screened women yet minimal referral uptake (<1%), leading to provider demoralization and a call for in-house counseling services (Samandari, 2016). Ineffective police and legal systems can be especially discouraging. Further, there is a need for cultural competence in the care of LGBTQI+ clients (Waryold & Kornahrens, 2020).

*We don't exactly have a mandate in terms of any support, funding, or anything to push a case to a logical conclusion. So, we are just meant to continue to advocate for a robust response system at the state level... So then they report [a case of sexual violence], and the person is sent to the state, and maybe the case is not really taken the way they want, it kind of discourages some of the service providers. (MCGL, Nigeria)*

### *Survivor-centered approach and fragile contexts*

Barriers in the MIHR portfolio revolved around ensuring a survivor-centered approach, reflecting the fragile context in which GBV sensitization and integration occur. For example, many health facilities lack a secure data management system to ensure data is safely collected and stored. However, these barriers primarily affected remote locations, while larger district-level health facilities were more likely to have the necessary infrastructure and protocols in place to implement screening and referrals safely.

In other contexts where MIHR operates, such as South Sudan, DRC, Tanzania and Burkina Faso, government mandates require that health facilities report cases of GBV. However, this requirement is challenging when there is ambiguity around whether the necessary infrastructure and training are in place and how the resulting data will be used. For example, while the DRC has many well-developed GBV identification and response services, there is no national GBV tracking system (Palermo et al., 2014; Kanagsabai, 2023).

*The system is so weak, so untrained, so inexperienced, that even if they send a directive that okay, you will have to report the GBV cases, or maybe they have some central data management system, but still at the health facility level, how secure will that data be? How will we make sure that the GBV survivors are secure? Because if the person goes back to the same family or the same home where she was beaten up by her husband or partner, what will be the next step for her? (MIHR, Tanzania)*

### **Facilitators**

#### *Written screening questions and protocols*

The availability of guidelines, protocols and policies for screening practices acts as a key facilitator by enhancing provider readiness. (Alvarez, 2016; Andreu-Pejó, 2022). Essential protocol components include how providers can respond to patients experiencing IPV, resources for their clients, and the clinic's definitions of provider responsibilities (Alvarez, 2016). The presence of efficient screening tools and simple questions also facilitates screenings (Andreu-Pejó, 2022), as does adding screening questions to routine forms (Alvarez, 2016). Further, building referral pathways into screening tools can improve their use by providers (Vu, 2016; Huner, 2017; Turan, 2013).

#### *Training and mentorship*

Training and mentorship were essential facilitators of GBV data collection and services (Andreu-Pejó, 2022). Experiential training, or hands-on learning through practical application, role-playing and real-life scenarios, is highlighted in the literature as crucial to ensuring provider self-efficacy and skills (Colombini, 2021; Samandari, 2016; Falb, 2017), as is re-training providers at regular intervals (Colarossi, 2010). Many interviewees also emphasized the need for continuous training to ensure data quality and avoid harm. Data quality reviews can guide targeted training to improve GBV service provision and monitoring capacity (Data.FI, 2021). A multi-disciplinary team-based training strategy can mitigate high staff workload and stress and streamline the process for new employees (Vu, 2013). This approach includes training all staff on health and GBV, privacy, confidentiality, screening eligibility, and referrals. It also facilitates smoother transitions during staff turnover, as new recruits can learn from previously trained colleagues. In fragile contexts, strategies that precede GBV integration in FP activities are sensitization training and ongoing discussions with healthcare providers.

*This is not any other regular screening. It can create more trauma. It can put people into emotional setbacks, and then, if it is handled carelessly or not, at an expert level, it can be a*

*really big issue. So, the training of the health facility staff is extremely important. (MIHR, global)*

### ***Mental health services and case management***

Many implementers emphasized that mental health support services are critical to a GBV response. For example, counseling and psychosocial support are more acceptable than other services to survivors in certain cultural contexts, such as when GBV is considered a private family matter. Further, these services are easier to provide directly on-site through trained GBV focal persons, often nurses who have received targeted GBV training and are capacitated for case management. MOMENTUM-supported sites also typically have a social worker available at GBV one-stop centers.

The importance of onsite mental healthcare, such as a trained counselor or social worker, was echoed in the peer-reviewed literature, especially among populations that may experience additional barriers to accessing referrals, such as AGYW (Colombini, 2021), transgender persons (Das, 2021), pregnant women (Anguzu 2022), and refugee or displaced populations (Undie, 2016; Vu, 2017). Studies also shared multiple strategies for increasing on-site mental health care utilization, including maintaining two open counseling appointments on-site so clients had the option of same-day emergency sessions (Galrao, 2022) and using “warm hand-offs” where the provider directly introduces a client to relevant service providers (Das, 2021).

### ***Government collaboration***

Government collaboration is a facilitator of GBV screening and data collection. For example, MOMENTUM partners working in Nigeria described a recent meeting held with the National Gender in Health Technical Working Group to discuss how to standardize GBV screening tools at a national level.<sup>13</sup> Interviewees also reported data sharing and referral networks among facilities and government partners.

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<sup>13</sup> Report of the two-day meeting on review of the gender-based violence health data indicators and tools with the National Gender in Health Technical Working Group, February 16–17, 2023.



## Discussion

The MOMENTUM portfolio consists of implementing partners who are at various stages of readiness to implement GBV screening and referral interventions. In cases where a complete intervention is not feasible, the emphasis is appropriately placed on GBV sensitization efforts and developing referral networks, and indicators reflect these programmatic efforts. In cases where a GBV program has been fully integrated at the facility level, summary information reflects client-level data on screening, disclosure, referrals, and services. However, screening protocols and data collection and reporting approaches are not standardized across MOMENTUM partners, making assessing and comparing results difficult. For example, MCGL and MSSFPO-supported sites in Nigeria have coordinated many of their forms, including the screening questionnaire and case management form, yet their screening protocols and reporting summaries differ. These USAID partners may benefit from standardized monitoring guidance as they seek to grow and improve their data collection and reporting efforts around GBV screening and service provision. However, it is critical to keep in mind that USAID partner monitoring systems must also reflect other stakeholder requirements, especially the government's efforts to standardize GBV data collection and reporting at a national level.

The main barriers to collecting information on GBV screening and services in FP settings include resource-related challenges, such as limited human resources and overwhelming workloads for the healthcare workers expected to conduct screenings and record relevant details. Data quality issues, such as delayed reporting, double-counting, and lack of harmonization across data collection instruments and reporting requirements, also pose challenges. Cultural barriers and stigma around sexual violence contribute to the under-reporting of GBV cases. Providers' concerns about doing harm and the need for continuous training to ensure data quality and avoid further trauma are important considerations. Structural constraints within referral systems, such as ineffective legal systems, the absence of GBV screening in FP service delivery protocols and guidelines, and weak infrastructure for secure data management, further hinder GBV screening. However, government collaboration, continuous experiential training and mentorship, on-site mental health services or case managers, and survivor-centered approaches are facilitators that can improve GBV screening.

## Limitations

The limitations of this report include a potentially limited scope of the literature review due to a focus on published and easily accessible sources, as well as search terms that did not cover every form of GBV. The majority of included articles reported data on GBV screenings implemented in an evaluation context, so findings may not reflect routine conditions. For example, the research team may have provided additional staff training, support and oversight, provided monetary incentives to staff to conduct screenings or subsidized referral service costs (Samandari, 2016; Undie, 2013). We relied on project documents from specific USAID-funded implementing partners and a small sample size for informational interviews that may not fully capture diverse perspectives and are skewed toward Nigeria. We excluded non-English perspectives and had limited involvement of external experts. Scheduling interviews with former USAID partners and non-USAID technical experts was particularly challenging. Many interview requests were not acknowledged, and interviews were canceled at the last minute due to scheduling conflicts. These limitations should be considered when interpreting the findings of the report. Nonetheless, using multiple methods, including reviewing published journal articles, grey literature, project documents, and conducting interviews provides a rich array of data. In particular, the review of project documents and informational interviews with project staff provides valuable insights into the specific practices and experiences, as well as direct perspectives, of

USAID-funded implementing partners. This firsthand information can help identify the current practical aspects and challenges of implementing GBV programming within FP and similar healthcare settings.

## Recommendations

Based on the findings of this activity, we recommend the following strategies for improving the monitoring of GBV integration, including routine screening and service provision, in FP settings:

### **Strengthen capacity to effectively monitor GBV activities in all FP clinics regardless of where they are in the process of integrating GBV activities**

#### **1. Develop a monitoring, evaluation, and learning plan inclusive of GBV.**

While many MOMENTUM partners shared data collection tools and indicators that indicated GBV screening was integrated with their HIS, it was not always clear to what extent GBV screening and referral data was formally incorporated into their organization's M&E plan (as opposed to ad hoc development of tools/reporting summaries).

FP clinics should consider which goals, objectives, and strategies they are prepared to address, and then build M&E plans into the effort to address gender-based violence from the beginning. Comprehensive guidance in this regard is available through USAID's *Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions along the Relief to Development Continuum* (Menon, 2014) and the IPPF/WHO's *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries* (Bott et al., 2010).

Further, the usefulness of GBV M&E results is reliant on their safe and ethical dissemination to a diverse group of internal and external stakeholders (e.g., enabling program managers to make informed decisions, program staff to adapt implementation, service providers to make appropriate referrals, local and international organizations to collaborate and improve national GBV prevention and response efforts, and, legal aid staff, policymakers, community leaders, and activists to use the evidence to advocate for new laws, policies, and community-based awareness on GBV.) A learning plan should articulate how these results can be utilized, enabling a systems approach (Menon, 2014).

As illustrated by MOMENTUM partners working in Nigeria, lessons learned from M&E can be institutionalized within organizations, locally, regionally, and nationally. This can be done by ensuring that learning and adaptation are part of the ongoing program cycle, with time set aside for program staff to discuss M&E findings among internal and external stakeholders, identify what adaptations are required, and ensure that funding is earmarked in anticipation of potential adaptations.

#### **2. Work with government ministries to mainstream GBV screening into FP services, including updating FP service delivery policies and standards of practice.**

The work in Nigeria by MOMENTUM partners (MSSFPO & MCGL) provides a template for how clinics can collaborate effectively with government ministries to mainstream GBV screening into FP services by actively participating in policy dialogue and implementation processes.

FP clinics are uniquely positioned to advocate for the incorporation of GBV screening as a standard practice in FP service delivery guidelines at the national level. Through technical working groups and other forums, FP

clinics can work together with government authorities to update existing FP service delivery protocols to include regular GBV screening, ensuring these guidelines emphasize a survivor-centered approach. They can also advocate for secure data management systems and standardized operational definitions of violence to facilitate comparable data at all levels of implementation. FP can also collaborate with government stakeholders to improve implementation, including training protocols for healthcare providers on GBV screening techniques, awareness of referral pathways, and maintaining confidentiality and respect for survivors' rights. In this way, FP clinics and government ministries can jointly ensure that GBV screening and data collection becomes an integral part of FP services.

**Strengthen capacity to collect GBV data safely and effectively in health facilities that are preparing to integrate GBV screening by targeting noted barriers among FP/SRHS projects**

**1. Monitor progress towards establishing if the WHO minimum standards for asking about GBV are met.**

Facilities in more resource-constrained settings or facilities just starting to develop their services can use the *Gender-Based Violence Quality Assurance Tool Minimum Version*<sup>14</sup> to assess whether the WHO's minimum standards are met (and identify remaining gaps). This tool can also be used by clinics with established screening programs to support ongoing quality improvement. In brief, the WHO recommends that facilities do not screen for GBV unless services meet all of the following requirements (WHO, 2013):

1. A protocol or standard operating procedure exists for providing post-GBV services.
2. A questionnaire exists with standard questions where providers can document responses.
3. Providers offer first-line support ("LIVES")
4. Providers have received training on how to ask about GBV.
5. Providers only ask about GBV in a private setting.
6. Confidentiality is ensured.
7. A system for referrals or linkages to other services within the facility is in place.

If any of these minimum requirements are missing or GBV services are considered inadequate, providers should not conduct routine enquiry. Enquiring about violence and then providing no or poor-quality services could re-traumatize the survivor and cause distrust towards the provider.

Facilities in resource-constrained settings that are not yet ready to integrate routine screenings should still adopt a trauma-informed approach<sup>15</sup> and ensure that providers are trained to respond appropriately to spontaneous disclosures of GBV (USAID, 2022).

Organizations can monitor and report on their progress towards screening readiness across all supported facilities with the outcome indicator developed by MCGL: *Percentage of facilities that meet the minimum*

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<sup>14</sup> The GBV Quality Assurance Tool lists 24 evidence-based standards for the provision of high quality post-GBV care in health facilities. The tool was developed by Jhpiego and the U.S. Centers for Disease Control and Prevention (CDC) with reviews of resources and input from gender/GBV partners at PEPFAR, WHO, an array of international organizations, GBV health providers and ministries of health. Facilities in more resource-constrained settings or facilities just starting to develop their services should be assessed using the minimum care version of the tool. The full version should be used to assess the quality of care in well-resourced, designated post-GBV care facilities, such as One Stop Centers where key post-GBV care is offered in one location. It can be found on [The Gender-Based Violence Quality Assurance Tool: Facilitation guide \(who.int\)](https://www.who.int/publications/m/item/the-gender-based-violence-quality-assurance-tool-facilitation-guide)

<sup>15</sup> See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: <https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>

requirements for screening for gender-based violence per WHO guidelines. See Appendix 8 for the detailed indicator reference sheet.

## **2. Allocate resources specifically to the integration of GBV activities.**

Effective integration of GBV activities into health facility services requires that organizations take ownership by incorporating related responsibilities into their job descriptions and project outputs (IRC, 2015), which in turn requires dedicated funding and activities. This aligns with the recommended “systems approach” for GBV response (Heise, Ellsberg & Gottemoeller, 1999), involving comprehensive changes at all levels of the organization, encompassing physical infrastructure, policies, protocols, patient flow, referral networks, data collection systems, and provider training to address GBV disclosure with appropriate attitudes, knowledge, and skill (Bott et al., 2010).

Resources, awareness, and cooperation are also relevant to RHIS for GBV (UN & WHO, 2022). The *United States Strategy to Prevent and Respond to GBV Globally* (2022) emphasized the need to ensure that accurate, comprehensive, and recent data are collected in a confidential and trauma-informed manner, which requires training and awareness across all levels of an organization. However, this initial investment in infrastructure and human resources for a robust RHIS can lead to long-term cost efficiencies, as the data can serve multiple statistical purposes (UN & WHO, 2022).

## **3. Assess progress towards improving provider gender competency.**

Training in gender awareness, human rights, and the link between GBV and sexual and reproductive health is an especially important component of preparing health organizations to respond to GBV (Bott et al., 2010). Providers, who may have personally encountered violence or live in communities with norms endorsing violence victimization, may require significant training and support to cultivate an understanding of gender-based violence, including how to integrate a trauma-informed approach into health services, offer immediate support and appropriate referrals after a disclosure of violence, and champion the right to a life free from violence.

To assist FP facilities in assessing the knowledge, attitudes, and skills of their providers, especially in addressing GBV, the *Provider Self-Assessment Tool to Measure Gender Competency for Family Planning Services*<sup>16</sup> was developed (Andrinopoulos et al., 2023). This quantitative tool can be used for self-assessment, group assessments (including pre/post-test training evaluations), or as part of a facility-level assessment. It is part of a broader toolkit developed by USAID’s Office of Population and Reproductive Health, designed to enhance the gender competency of FP providers, and also offers e-learning courses<sup>17</sup> for provider use following their self-assessment.

## **4. Improve data management systems to ensure highly sensitive data is safely collected and stored.**

Secure data management systems are an essential component of any GBV screening program to protect the safety of clients and providers. Recommendations to ensure the design and implementation of data systems are survivor-centered are available in the WHO’s guidelines on *Improving the collection and use of*

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<sup>16</sup> See <https://www.data4impactproject.org/publications/gender-competency-tool-module-f/>

<sup>17</sup> See <https://chemonics.com/resource/defining-and-advancing-gender-competent-family-planning-service-providers/>

*administrative data on violence against women* (WHO & UN Women, 2022). See Box 9 for a summary of key considerations in this regard.

The WHO also provides a checklist for privacy and confidentiality in documentation as part of their *guidance for strengthening health systems to respond to women subjected to intimate partner violence or sexual violence* (WHO, 2017, pg. 155), which facilities may wish to adapt.

Inadequate data management systems were a noted barrier to screening for facilities working in remote and emergency contexts. In the absence of a secure data management system, the International Rescue Committee recommends that minimal data is collected in relation to GBV screening (i.e., anonymous tallies of the number of persons offered screening, the number who accepted screening, and the number who screened positive).

**Box 9. Guidelines for designing survivor-centered administrative data systems** (UN Women & WHO, 2022)

- **Regulatory compliance:** Data collection must align with national, sectoral, and international regulations and standards (i.e., how personally identifiable information will be used and with whom and under what circumstances information will be shared).
- **Informed consent:** Individuals should be informed about and explicitly consent to the sharing of their information for care and management and be reassured that aggregate data used to enhance services and policies won't identify them.
- **Access to services & autonomy:** Data collection should never act as a barrier to services. Individuals must not be denied care if they choose not to share their data. As part of provider and M&E training, emphasize the importance of survivor autonomy to decline to answer or have information collected. Design data collection tools to accommodate survivor non-response, such as having a "declined to answer" option, differentiating it from missing data.
- **Minimal response burden.** Reduce the response burden on survivors by limiting the number of questions asked and collecting only essential data. Avoid documenting details that are unnecessary for service provision or could result in discrimination against the survivor. The legal framework and social context help inform the safety of collecting specific sociodemographic variables.
- **Confidentiality and data collection.** Establish and enforce policies and procedures to ensure data confidentiality at all stages, including collection, storage, processing, analysis, and communication. Train all relevant staff in these policies and procedures. Restrict access to individual records of survivors to essential personnel (those involved in care provision or responsible for aggregating and reporting data). Data management must follow best practices for data protection and security. If records are associated with unique identifiers, data management should be performed in a secure data environment.
- **Reporting data.** For statistical purposes, individuals should never be identifiable (as opposed to case management purposes, where personally identifiable information is shared with a limited set of duty bearers for the purposes of service provision). Anonymize any information that will be publicly available (i.e., no names or other personally identifiable information and ensure numbers reported are large enough to prevent identification of individuals based on location, residence, age, ethnicity, etc.)

**For organizations that have integrated routine GBV screening and response into their FP program, improve the comparability and quality of GBV data by defining priority data collection and reporting requirements.** The following recommendations are for a minimum dataset to produce standardized indicators in USAID-supported FP facilities.

**1. Clearly define operational definitions of violence applicable to USAID FP partners and develop a minimum set of standardized screening questions, data collection protocols and reporting requirements related to GBV screening and referrals.**

The success of health interventions relies heavily on evidence-based decision making. However, the lack of standardized and consistently utilized key indicators can result in non-comparable results, impairing informed decisions about intervention strategies. As the findings of this report demonstrate, there is significant variability in how FP clinics collect and report GBV screening data.

To ensure clarity, comparability, and effectiveness in GBV screening and referral activities within the purview of USAID FP partners, it is recommended to establish operational definitions of violence that align with global standards yet remain applicable to the contexts in which implementers operate. These definitions should encapsulate all common types of GBV, including physical, sexual, and psychological/emotional violence while considering cultural sensitivities and regional variations. Operational definitions may vary by the population or circumstances; for example, UNICEF recently developed the International Classification of Violence against Children (ICVAC), which provides operational definitions for all forms of child violence.<sup>18</sup>

Following the establishment of these definitions, USAID should promote standardized screening questions that are both comprehensive and survivor centered. Standardized questions enable programs to gather systematic data on carefully defined types of violence, facilitating the collection of comparable information, understanding client needs, estimating demand for specialized services, and raising community awareness about the extent of different types of violence (Bott et al., 2010). The questions should be simple, direct, and understandable to providers and clients alike.

It may not be possible to standardize screening protocols for GBV across all clinics, given variations in client flow, physical layout, information systems, and personnel, making it challenging to establish a one-size-fits-all standard protocol applicable to all organizations (Bott et al., 2010). However, data collection protocols can be designed to prioritize survivor confidentiality and security in compliance with ethical guidelines and best practices in GBV data management.

Clear reporting requirements should also be defined, outlining the nature of data to be reported, timelines, formats, and responsible entities. This should be complemented by developing robust mechanisms for monitoring, evaluation, and learning to continuously improve GBV screening and referral processes (see Recommendation 1).

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<sup>18</sup> The ICVAC covers both interpersonal and collective violence, applicable during peacetime and armed conflicts. The classification provides countries with a tool to gauge their efforts in defining and collecting data on violence against international standards and assists in generating data that is comparable. The guidance is available here: [https://data.unicef.org/resources/international-classification-of-violence-against-children/?utm\\_id=ICVAC-launch](https://data.unicef.org/resources/international-classification-of-violence-against-children/?utm_id=ICVAC-launch)

## **2. Prioritize GBV screening data collection efforts and indicators on recent (past 12 months) physical, sexual and psychological/emotional IPV and NPSV.**

For the purpose of identifying a minimum dataset across partners, the most globally prevalent forms of violence are physical, psychological, and sexual IPV and NPSV. These specific forms also have the most well-established knowledge and practices, including legislative and policy frameworks and standards for measurement and data collection, and are promoted by the UN for the purposes of a minimum administrative dataset (Kendall, 2020).

MOMENTUM partners currently screen for *any* violence, which leads to an extensive workload. Consequently, personnel become overstretched, compromising the quality of the screening intervention and related data collection and yielding low disclosure levels. Focusing on IPV would enable FP clinics to allocate their limited resources more effectively and align data collection efforts with PEPFAR and other projects that have integrated GBV programming into FP or sexual reproductive health facilities in low- and middle-income settings (Christofides, 2010; Iskandar, 2015; Samandari, 2016; Silverman, 2020; Undie, 2014; Undie, 2016). Further, screening related to experiences of psychological violence should be limited to those perpetrated by current and former intimate partners, per global statistical guidance (UNSD, 2014).

In addition, MOMENTUM implementers working in regions with elevated rates of sexual violence or with populations who may be at higher risk for non-partner sexual violence, such as AGYW (Colombini, 2021) and populations in humanitarian/emergency settings (Undie, 2016; Vu, 2013; Wirtz, 2016; Vu, 2017) should consider implementing routine screening for non-partner sexual violence, assuming a survivor-centered approach can be maintained, and appropriate services are available.

Currently, all MOMENTUM partners ask about violence in the past 12 months. Maintaining this focus on recent experiences of violence helps identify clients at immediate risk, maintains a more manageable response workload and enables effective monitoring of progress. Additionally, a time frame focused on recent experiences helps avoid including the same individuals' past incidents in the current reporting period.

See Figure 3 for a more detailed rationale behind this indicator guidance.

## **3. Disaggregate violence by type: physical, sexual, and psychological/emotional.**

At a minimum, screening questions, registers and reporting summaries should separately capture each of these three types of violence to allow for a comprehensive understanding of the occurrence and impact of each type of violence among clinic attendees and inform targeted interventions and support services. To obtain a de-duplicated count of clients disclosing IPV/NPSV,<sup>19</sup> it's also essential to capture the total number of clients experiencing *any* of these forms of violence.

MOMENTUM partners should not collect data or report on psychological and emotional violence separately, as these forms of violence are closely intertwined and often overlap in practice. Rather, a single question or

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<sup>19</sup> Another method to reduce double-counting is to adopt a case- or incident-based approach rather than a person-based approach. This means that each reported incident of violence should be treated as a unique case, even if it involves the same individual. Using unique incident identifiers or codes makes it possible to differentiate between multiple incidents involving the same person over time, ensuring accurate data representation and preventing duplication. As multiple types of violence may occur during one incident, the case-based approach requires prioritizing the type of violence captured according to a pre-defined hierarchy. However, case-based monitoring is resource-intensive and may be impractical in the context where MOMENTUM partners and other FP projects operate.

set of questions can cover both areas to streamline the assessment process, making it more efficient for providers and clients.

For the time being, the recommendation to disaggregate violence types does not include economic violence, though this does not preclude partners from monitoring this form of violence if it is deemed a priority for their program. MOMENTUM partners and technical experts expressed a particular interest in economic violence, and research underscores its negative impact on women's autonomy (Stylianou, 2018). However, research on economic violence is still developing, with limited studies investigating its impact on reproductive health outcomes and controlling for other forms of IPV (Johnson et al., 2022). Additionally, findings from this activity indicate that MOMENTUM partners are already struggling to keep up with routine screenings and referrals/services for clients who disclose violence. Adding an additional question on economic violence will increase their workload at the point of screening and potentially increase the number of survivors identified and in need of services. Implementers will also need to ensure they can provide support at the time of disclosure and that their referral networks include resources and programming for financial literacy and economic empowerment. The findings from the Nigerian GBV screening impact evaluation mentioned by MCGL, which includes data on economic violence, can provide valuable insights into the role and significance of this type of IPV in the context of FP and the capacity of partners to address it and may help refine these recommendations.

Ultimately, the types of violence that implementers screen for and collect data on should be informed by the types of violence prevalent in the community (based on available population-based surveys) and among clinic attendees (based on stakeholder engagement), what the clinic is able to address given the resources and services available in the community, and by what is feasible within the legal system of the country.

#### **4. Collect and report data on GBV reported through spontaneous disclosure or selective screening.**

It is important to note that while screening for recent IPV and NPSV is suggested, FP clinics should also remain vigilant and responsive to other forms of interpersonal violence. Accordingly, MOMENTUM partner data collection systems should be able to monitor and report on GBV reported due to spontaneous or self-disclosure by a client, selective or clinical screening, or referral. Reporting systems should be able to disaggregate this data at the same level as data obtained via routine screening (e.g., by type of violence [physical, sexual, psychological/emotional], perpetrator [intimate partner or not], age and sex).

Collecting data on GBV outside of routine screening contributes to a better understanding of the number of clients experiencing this type of violence to inform implementer's resource allocation and preventive strategies.

#### **5. Track referral and service utilization rates.**

Tracking referral and service utilization rates in a family planning setting following routine screening is essential for ensuring access to support, assessing program effectiveness, optimizing resource allocation, and facilitating continuous improvement. To collect this data, providers should consistently document referrals made to GBV support services and client responses, including whether clients accept or decline referrals and whether services are accessed within a specified timeframe (e.g., within three months of a positive screen). Disaggregating data by sex, age and other socio-demographic characteristics can help identify disparities in access. Regular reporting with demographic breakdowns helps inform program adjustments, ensuring that services are responsive to client needs and fostering a culture of improvement



and client-centered care. This additional data also enables FP clinics to collaborate with other agencies and organizations that provide supportive services.

Suggested categories for monitoring referral and service utilization include: (1) counseling and psychological support, (2) safety planning, (3) healthcare services (treatment of acute injuries and post-rape care) and (4) specialized services (longer-term psychosocial support/counseling, legal services/counsel, law enforcement/police, child protection services, shelter, and economic empowerment activities).

In addition, for facilities that directly provide post-rape clinical care services, data collection and reporting requirements should align with PEPFAR's indicator on GBV clinical care (GEND\_GBV). This includes reporting on whether a client was eligible for and received the following services: rapid HIV testing, PEP (if reached within 72 hours), STI screening/treatment, and EC (if reached within 120 hours). Detailed resources for reporting on this indicator are also available via MEASURE evaluation's GEND\_GBV data quality toolkit: [https://www.measureevaluation.org/resources/gend\\_gbv-rapid-data-quality-review-tool.html](https://www.measureevaluation.org/resources/gend_gbv-rapid-data-quality-review-tool.html).

Note that facilities providing clinical care should also report stock-outs relevant to GBV service provision, such as using a checkbox on monthly reporting forms indicating any stockouts of drugs or commodities (e.g., PEP, EC, STI screening/treatment, and STI drugs), as these are likely to negatively impact service metrics.

**The following recommendations are for organizations that are ready and able to go beyond the minimum dataset.**

### **1. Modify data collection systems to separately capture information on RC screening.**

Integrating a standardized screening process for RC into existing GBV screening practices allows FP clinics to quantify efforts to identify and support individuals experiencing this specific form of abuse. RC screening promotes reproductive autonomy, access to contraception, and overall well-being for clients seeking FP services. By capturing information on RC screening separately, clinics can also track RC disclosure, monitor outcomes, and evaluate the effectiveness of their interventions.

As this would be a novel addition to current data collection activities, several steps would need to be taken, including:

- Develop screening protocols and tools specifically designed to identify RC. These tools can be adapted from existing RC questionnaires and should be integrated into the routine GBV screening process.
- Implement regular reviews and evaluations of the data and engage clinic staff in discussions to identify challenges, share best practices, and make necessary adjustments to improve the screening process for RC.
- As the measurement of RC is an emerging topic, new guidance and standardized instruments may become available over time; relevant updates should be incorporated into existing clinic practices.

This recommendation is conditional on implementers' capacity to not only identify but appropriately address RC. For example, clients who disclose that a partner interfered with their contraceptive choice should be offered the opportunity to discuss contraceptive options and safety concerns with a trained provider and receive additional referrals as necessary (Cheng, 2021). An important facilitator of RC screening among providers was ongoing RC education, training, and support alongside resources such as a decision-support tool for appropriately managing RC (Cheng, 2023). Regardless of whether a client is screened for RC,

studies have demonstrated the value of universal RC education and counseling interventions for FP clients (Miller, 2016; Decker, 2017).<sup>20</sup>

## **2. Identify any populations at heightened risk of violence victimization that organizations engage with and integrate questions tailored to their unique experiences with violence.**

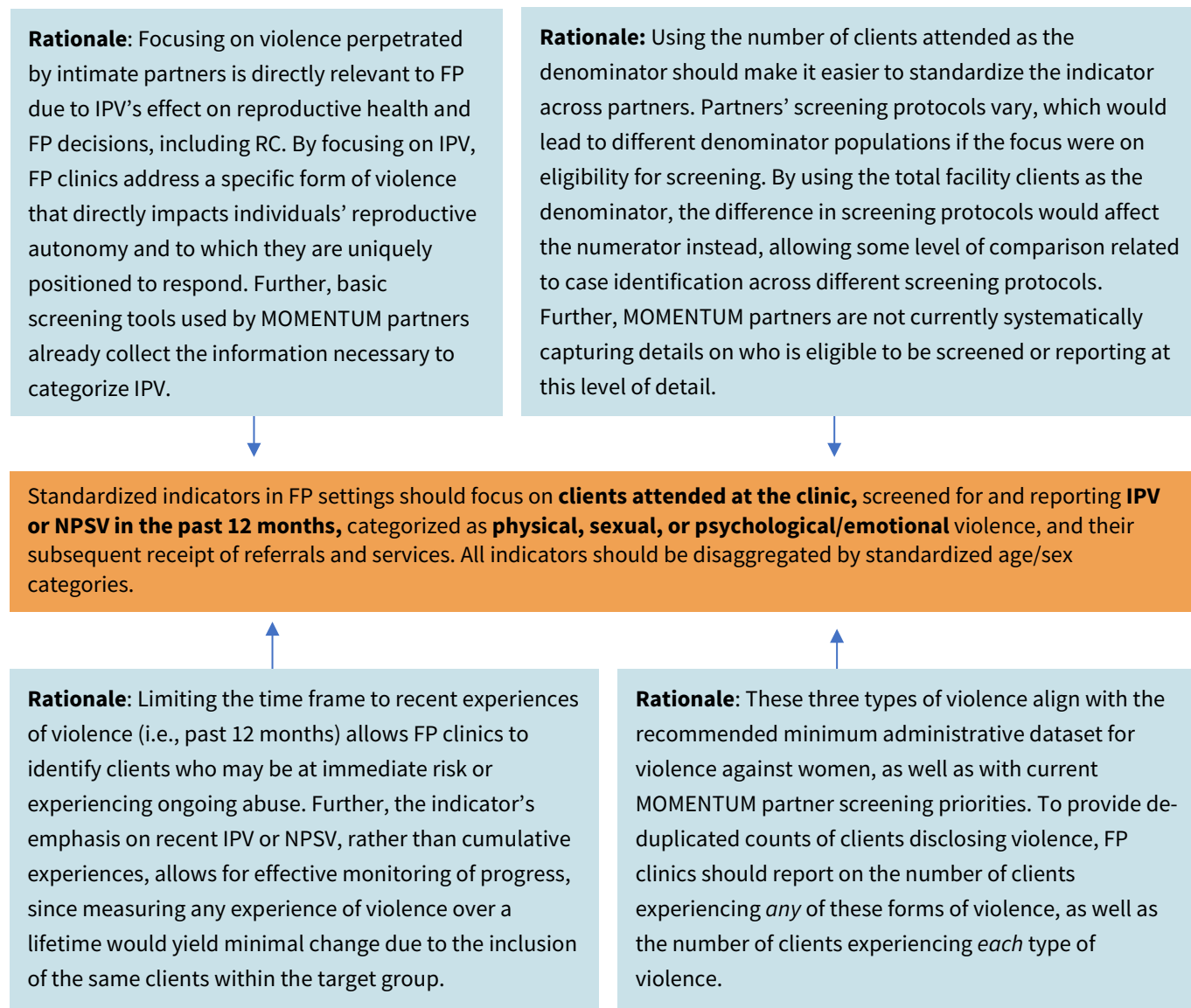
For organizations that engage with people who may be at heightened risk of violence victimization, consider collecting additional administrative data on sociodemographic characteristics that are relevant to care provision and safe to collect (WHO & UN Women, 2022). Most implementers already record data using age and sex disaggregations, but data on violence indicators may be further disaggregated by disability status, pregnancy status, marital status, sexual orientation, gender identity, ethnicity (including Indigenous status), citizenship/migration status and geographic location to generate information that can better target prevention and response interventions (WHO & UN Women, 2022). Marital status may be especially useful as this data can be used to limit IPV denominators to current or ever-partnered individuals (UNDESA, 2014).

However, the value of disaggregation should be carefully balanced against the resource demands of collecting additional client details; generally, specialized surveys offer a more comprehensive and flexible method for collecting highly disaggregated data. Further, this recommendation is conditional on implementers' programming targets and capacity to safeguard the privacy and confidentiality of individuals. Client protection should be prioritized when collecting data on key populations and other marginalized groups, as they may face stigmatization, discrimination, or legal repercussions based on their identities or activities.

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<sup>20</sup> The 'Addressing Reproductive Coercion in Health Settings (ARCHES)' model provides a useful example of how a brief family planning clinic-based IPV and RC intervention (provider-initiated universal education and counseling intervention for female clients) can be introduced to routine practice to improve client knowledge of available resources and self-efficacy to enact harm reduction behaviors (Tancredi, 2015; Miller, 2016).

**Figure 3. Considerations for standardizing indicators for GBV screening and response in FP settings**



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## Appendix 1. Literature Review Search Strategy

### Pub Med Search Strategy

Search number	Query	Results
12	11 AND (("2010/01/01"[Date - Completion]: "2023/08/24"[Date - Completion]))	180
11	9 AND 10	344
10	((("family planning services"[MeSH Terms]) OR ("sexual and reproductive healthcare services"[All Fields])) OR ("outpatient clinics, hospital"[MeSH Terms]) OR ("primary health care"[MeSH Terms]))	233,727
9	(1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7) AND 8	6,552
8	((("mass screening"[MeSH Terms]) OR ("screening"[All Fields])) OR ("risk assessment"[MeSH Terms]) OR (((("gender based violence"[MeSH Terms]) OR ("gender based violence"[All Fields]) OR ("intimate partner violence"[MeSH Terms]) OR (domestic violence[MeSH Terms]) OR ((reproductive coercion) OR ("sterilization, involuntary"[MeSH Terms]) OR (forced sterilization))) OR (((("sexual violence"[All Fields]) OR ("sexual abuse"[All Fields]) OR ("rape"[All Fields]) OR ("sexual assault"[All Fields]) OR ("sexual harassment"[All Fields])) OR (((((((("forced marriage"[All Fields]) OR ("early marriage"[All Fields]) OR ("child marriage"[All Fields]) OR ("female genital mutilation"[All Fields]) OR ("female circumcision"[All Fields]) OR ("femicide"[All Fields]) OR ("infanticide"[MeSH Terms]) OR ("honor killing"[All Fields]) OR ("acid attack"[All Fields])) OR (((((((("physical abuse"[MeSH Terms]) OR ("physical violence"[All Fields]) OR ("economic violence"[All Fields]) OR ("psychological aggression"[All Fields]) OR ("emotional abuse"[MeSH Terms])) OR ("stalking"[MeSH Terms]))	1,076,146
7	Terms])) OR (((((((("physical abuse"[MeSH Terms]) OR ("physical violence"[All Fields]) OR ("economic violence"[All Fields]) OR ("psychological aggression"[All Fields]) OR ("emotional abuse"[MeSH Terms])) OR ("stalking"[MeSH Terms])	90,386
6	((((((((("forced marriage"[All Fields]) OR ("early marriage"[All Fields]) OR ("child marriage"[All Fields]) OR ("female genital mutilation"[All Fields]) OR ("female circumcision"[All Fields]) OR ("femicide"[All Fields]) OR ("infanticide"[MeSH Terms])	5,040
5	OR ("honor killing"[All Fields]) OR ("acid attack"[All Fields])	5,382
4	((("sexual violence"[All Fields]) OR ("sexual abuse"[All Fields]) OR ("rape"[All Fields]) OR ("sexual assault"[All Fields]) OR ("sexual harassment"[All Fields])	37,747
2	((reproductive coercion) OR ("sterilization, involuntary"[MeSH Terms]) OR (forced sterilization)	2,406
1	((("gender-based violence"[MeSH Terms]) OR ("gender based violence"[All Fields]) OR ("intimate partner violence"[MeSH Terms]) OR (domestic violence [MeSH Terms]))	56,767

**EBSCOhost Research Databases Search Strategy:**

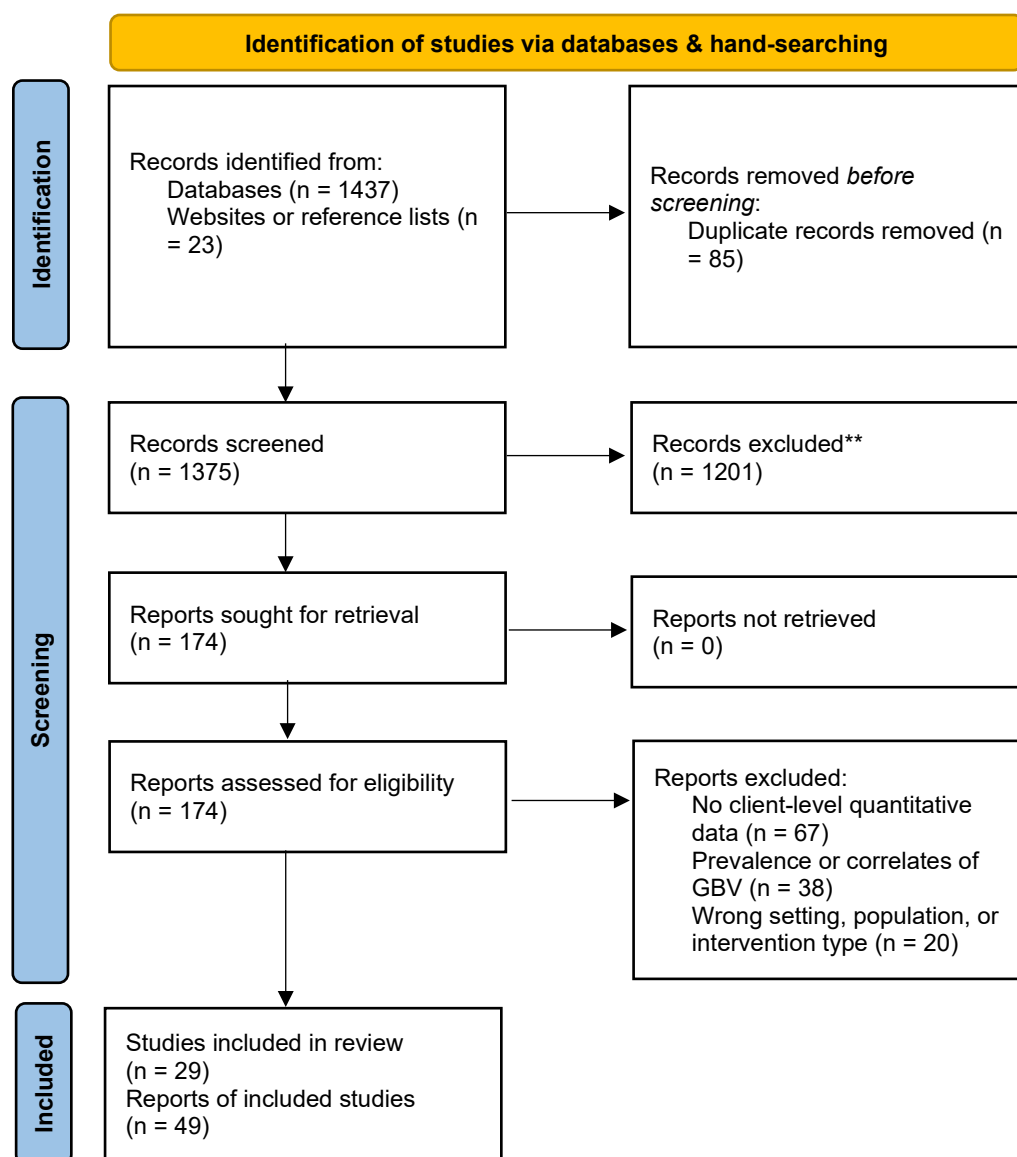
Limiters - Abstract Available; Published Date: 20100101-20230831; Databases: Academic Search Complete; Africa-Wide Information; MEDLINE; Women's Studies International

Search number	Query	Results
14	S12 AND S13	1,257
	routine data OR medical record OR health record OR monitoring and evaluation OR	
13	administrative data OR information system OR survey OR questionnaire	1,766,059
12	S10 AND S11	2,454
	family planning OR reproductive healthcare OR sexual and reproductive health	
11	services OR primary healthcare OR public healthcare	320,757
10	S8 AND S9	16,460
9	Screening OR screen OR risk assessment	1,701,997
8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8	189,101
7	psychological abuse OR emotional abuse OR psychological aggression OR stalking	43,330
6	economic violence OR financial control or economic coercion	31,827
5	sexual violence OR sexual abuse OR rape OR sexual assault OR sexual harassment	64,348
4	physical violence OR physical abuse	53,183
	forced marriage OR early marriage OR female genital mutilation OR female	
3	circumcision OR femicide OR acid attack OR honor killing	14,232
2	reproductive coercion	542
1	gender based violence OR violence against women OR intimate partner violence	38,540



## Appendix 2. Literature Review Results

PRISMA Flow Diagram



## Appendix 3. Literature Review: Included Studies

**Table 1. General screening information from studies included in the literature review narrative synthesis.**

First Author & Year	Country	Data source	Population eligible for screening	Screening tool & administration
<b>Family planning/sexual reproductive health clinics</b>				
Cheng, 2021 (PR)	Australia	Secondary analysis of routine data (electronic medical records)	Adolescent girls and women, age 16+	*2-item tool designed to measure lifetime RC *Questions adapted from two other tools/scales (Chamberlain et al., 2012 and McCauley et al., 2017) *Provider administered via electronic screening tool embedded in the clinical data systems *Clients who answered "yes" to either question classified as disclosing RC
Hunter, 2017 (PR)	Australia	Secondary analysis of routine data (electronic medical records)	Adolescent girls and women, age 16+, unaccompanied	*2-item tool focused on past year IPV *Questions developed based on NSW health policy directive *Provider administered via electronic screening tool embedded in the clinical data systems
Galrao, 2022 (PR)	Australia	Routine data (service statistics) collected as part of a screening pilot study.	Female-identifying persons, age 16+	*5-item investigator-developed tool to identify lifetime exposure to IPV and/or RC *Screening positive to IPV and/or RC was defined as answering "yes" to any of the screening questions.
Samandari, 2016 (PR); Delamou, 2014 (GL)	Guinea	Routine data (service statistics) collected as part of a screening pilot study under the USAID RESPOND project	Adolescent girls and women, age 15+,	*9-item IPV questionnaire focused on current and past IPV based on GATHER model for FP counselling *administered by trained providers and other clinic staff during routine FP counselling sessions.
Silverman, 2020 (PR)	Niger	Survey data collected as part of an cRCT of the Reaching Married Adolescents (RMA) Study	Adolescent girls, ages 13–19 years, married	* 2-item IPV tool on physical and sexual violence adapted from the Demographic and Health Survey (DHS) domestic violence module. (Positive response = Physical or Sexual IPV) * 6-item measure of RC previously validated in the U.S. and adapted to the Niger context based on formative data and stakeholder input (Positive response to any item = RC)
Decker, 2017 (PR)	USA	Survey data collected as part of pre/post study assessing ARCHES intervention in routine ("real world") conditions	Women, ages 18–35	See Tancredi 2015

First Author & Year	Country	Data source	Population eligible for screening	Screening tool & administration
Tancredi, 2015 (PR; Miller, 2016 (PR); Miller, 2017 (PR);	USA	Survey data collected as part of an cRCT of the Addressing Reproductive Coercion in Health Settings (ARCHES) project	Adolescent girls and women, ages 16–29	*10-item investigator developed measure of RC (past 3 months) and 3 items on IPV from the Conflict Tactics Scale-2 and Sexual Experiences Survey *Note IPV tool not used for case-identification; study is on universal education and brief counselling
Sutherland, 2011 (PR)	USA	Survey data collected as part of pre/post study assessing a Brief Nursing Intervention (BNI)	Women, ages 18+, already screened positive for IPV	*Abuse Assessment Screen (AAS) used to identify survivors *46-item Severity of Violence against Women Scales (SVAWS) used to measure violence severity (mild, moderate, serious), types of abuse (physical vs. sexual and frequency of abuse
HIV clinics, PrEP clinics or HIV Testing Service sites				
APC Guyana, 2017 (GL)	Guyana	Routine data (service statistics) collected as part of screening feasibility study under the USAID-funded Advancing Partners & Communities (APC) project	Clients attending HIV testing services (HTS); no age or sex restrictions provided	*4-item investigator-generated tool based on literature review and existing resources *administered by providers (social workers and community-based professionals) trained on administering the screening during HIV Support Services
Hartmann, 2019 (PR) FHI360, 2020 (GL)	South Africa	Survey data collected as part of CHARISMA (Community Health Clinic Model for Agency in Relationships and Safer Microbicide Adherence) intervention development	Women, ages 18–45, using PrEP for HIV prevention	*42-item (HEART) Healthy Relationship Assessment Tool (agree/disagree) developed from various validated scales (e.g., Partner Violence Screen, The Composite Abuse Scale, The Psychological Abuse Scale) *Administered by lay counsellors on a tablet at intake and follow up; score guides recommendations for counselling modules
Colombini, 2021 (PR)	South Africa & Tanzania	Routine data (service statistics) collected as part of GBV integration feasibility study in PrEP demonstration project (EMPOWER)	Adolescent girls and women, ages 16–24, receiving HTS at PrEP clinic	*5 items adapted from World Health Organization (WHO) guidelines on ever experienced (past and current) IPV
Wagman, 2016 (PR) Wagman, 2015 (PR)	Uganda	Survey data collected for a cRCT evaluation of the Safe Homes and Respect for Everyone (SHARE) Project	Adolescent girls and women, ages 15–49, seeking HTS	4-item adapted Conflict Tactics Scale to measure emotional, physical, and sexual IPV and intimate partner forced sex.
Humanitarian Settings				

First Author & Year	Country	Data source	Population eligible for screening	Screening tool & administration
Wirtz, 2016 (PR); Vu, 2016 (PR)	Ethiopia, Columbia	Validation and feasibility study of ASSIST-GBV Screening tool	Adolescent girls and women, age 15+, attending clinical, reproductive, or antenatal care and/or their children's health visits in humanitarian setting	*7-item ASIST-GBV screening Tool *Administered by designated service providers *Affirmative answers to any item results in a positive result.
Vu, 2017 (PR) & IRC (GL)	Kenya	Routine data (service statistics) collected as part of screening feasibility study.	Adolescent girls and women (15+), unaccompanied, living in the Dadaab refugee camps and attending participating IRC clinics	ASIST-GBV screening Tool (translated into Somali language)
Undie, 2016 (GL)	Uganda	Routine data (service statistics) collected as part of screening pilot study.	Adolescent girls and women, age 15+	* 5-item Screening Tool for Sexual and Gender-Based Violence (SGBV): *developed by Kenyatta National Hospital (KNH) in collaboration with the Population Council). *Kiswahili language version, pre-tested
Primary healthcare settings				
Hegarty, 2013 (PR); Hegarty, 2010 (PR)	Australia	Survey data collected for a cRCT evaluation of the WEAVE project	Women, ages 16–50, who screened positive for fear of a partner in the past 12 months	*The Composite Abuse Scale (CAS) was used to measure past and present relationship dynamics, types of IPV, and IPV severity and frequency
Iskandar, 2015 (PR)	Indonesia	Validation of Indonesian Woman Abuse Screening Tool (WAST)	Women ages 18+, unaccompanied to clinic, and married or involved with male partner attending PHC	*8-item Women Abuse Screening Tool (WAST)*scored 1 (never or none) to 3 (a lot or often). Total scores range from 8 to 24, and the tool developer recommended a cutoff of 13 to indicate presence of abuse.* Domestic Violence Initiative Screening (DVIS): DVIS: Interview Guide for licensed psychologist (with at least 3+ years' experience working with victims of IPV and training on DVIS). *Participants were categorized as experiencing IPV who reported being physically, emotionally, or sexually abused by their partners.
Undie, 2014 (PR); Undie, 2013 (GL)	Kenya	Routine data (service statistics) collected as part of a screening pilot study.	Women, ages 18+, attending services in the ANC, HIV comprehensive care center, or Youth Centre	*3-item investigator developed measure *Administered by providers trained to screen for IPV using this tool

First Author & Year	Country	Data source	Population eligible for screening	Screening tool & administration
Falb, 2017 (PR); Gupta, 2017 (PR)	Mexico	Survey data collected as part of an cRCT of a comprehensive healthcare provider delivered screening intervention	Women, ages 18–44, currently in a heterosexual relationship with a male partner with a positive IPV screening	10-item screening tool adapted from an abuse assessment screen used by International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR)
Laisser, 2011 (PR)	Tanzania	Routine data (service statistics) collected as part of a screening pilot study.	Women, ages 18+, receiving outpatient services	*McFarlane Abuse Assessment Screen tool modified to address emotional, physical, and sexual violence in general population with five questions *Administered by healthcare workers (clinical, nursing, medical officers, nursing officers) with previous IPV training and screening tool specific training
Das, 2022 (PR)	USA	Routine data (service statistics) collected as part of a screening pilot study.	All primary care patients, though study focused on transgender clients	*4-item questionnaire adapted from the abuse assessment screen (AAS) *self-administered on a tablet
Iverson, 2023 (PR); Iverson, 2020 (PR); Iverson, 2019 (PR)	USA	Routine data (Electronic medical record data) collected as part of an CRCT evaluating the effectiveness of integrating IPV Screening programs in Veterans Health Administration (VHA) primary care	Women, attending VHA clinics; no age limits provided	*5-item E-HITS screening tool *administered by physicians or nurses via electronic prompt *endorsement of any item indicates a positive screen (i.e., IPV disclosure)
Dichter, 2023 (PR)	USA	Secondary analysis of routine data (electronic medical records)	Women, ages 18+, who screened positive for past-year IPV during routine screening at Veterans Health Administration (VHA) clinics	*5-item Extended-Hurt, Insult, Threaten, Scream (E-HITS) tool assesses experiences of hurt, insult, threat, and scream *total scores range from 5 ("never" to all items) to 25 ("frequently" to all items), a score of $\geq 7$ or indicates an IPV+ screen.
Miller, 2023 (PR)	USA	Secondary analysis of routine data (electronic medical records)	Women, ages 18+, attending VHA primary care clinics	*5-item e-HITS screening tool *administered by physicians or nurses via electronic prompt *e-HITS scores range from 5-25 points, with a cutoff of 7 indicating a positive screen

First Author & Year	Country	Data source	Population eligible for screening	Screening tool & administration
Thompson, 2022 (PR)	USA	Routine data (service statistics) collected as part of the Technology Enhanced Screening and Supportive Assistance (TESSA) feasibility and process evaluation.	Male and female adult clients of primary healthcare/family medicine clinics	*Multi-measure instrument addressing past and current IPV, sexual assault history, potential stalking, and childhood abuse and neglect *Tool included the Hurt, Insult, Threaten & Scream (HITS) and abbreviated versions of the Danger Assessment *Self-administered via tablet
<b>Antenatal care</b>				
Hegarty et al., 2021 (PR)	Australia	Validation study of (ACTS) IPV screening tool developed for ANC settings against the CAS screener.	Pregnant women, ages 16+, unaccompanied	*4-item Afraid, Controlled, Threatened, and Slapped (ACTS) tool for measuring IPV compared to the Composite Abuse Scale (reference standard) *Binary response options (Yes/No) compared to 5-point ordinal frequency ("never" to "very frequently") response options
Turan, 2013 (PR)	Kenya	Routine data (service statistics) collected as part of IPV integration pilot	Pregnant women: no age limit provided	*6-item investigator-developed tool based on literature review and existing resources *Administered by male and female clinical officers and nurses *Clients answering "Yes" to any of these questions were considered to be at risk of or experiencing GBV
Pallitto, 2016 (PR) Garcia-Moreno, 2017 (GL) Zapata-Calvente, 2022 (PR)	South Africa	Survey data protocol for RCT of "Safe and Sound" intervention	Pregnant women, ages 18+	*12-item modified version of the WHO Multi-Country Study Instrument *self-reported tool that has been validated in multiple country settings
	Spain	Comparison of 2 IPV screening tools against the World Health Organization (WHO) IPV questionnaire.	Pregnant women: no age limit provided	* Women Abuse Screening Tool-Short (WAST-Short): The first 2/8 items of WAST. Assesses partner tension and difficulty in resolving arguments. * Abuse Assessment Screen (AAS): four questions on emotional, physical, and sexual abuse at any time during a woman's life, within the previous year, and during pregnancy. It also asks about the relationship with the aggressor, the frequency of violence, fear of the perpetrator, and the severity of physical violence.

\*PR = Peer Reviewed Article; GL = Grey literature (e.g., project report, brief, guidelines, etc.)

## Appendix 4. Interview Guide

D4I-PRH-017

Informational Interview

Date, Time

Respondent Name, Title

Organization

Email

### Background:

- Summary of respondent/organization background
- Summary of their GBV data collection tools (based on document review)

### Introduction

*Hello! My name is [Name]. I work with Data4Impact (D4I) and am based at Tulane University. I would like to learn more about your organization's gender-based violence (GBV) data collection and reporting experiences for the United States Agency for International Development. The information I gather will be used to identify feasible GBV indicators for ongoing data collection efforts.*

*Your response to all questions is voluntary. If it is ok with you, I will record this interview to assist with notes and analysis.*

### Questions

#### Respondent Information

*I want to start with some background on your role at [organization]*

- 1. What is your title/position?**
- 2. Please briefly describe your role, if any, in designing, conducting or supervising GBV data collection and reporting procedures.**

#### Data Collection forms

*You shared [#] data collection tools with us, which I will display on the screen while we talk so that we can go through them together.*

- 3. Are all these tools currently in use? If so, how widely used are they?**
  - Prompt, as needed:
    - How many sites? Urban/rural?
    - Are tools and procedures standardized across all sites?
    - Any challenges to implementing these tools? Any facilitators to implement these tools?
- 4. Let's look specifically at the [GBV screening tool]. Can you walk me through how this tool is used on-site?**
  - Prompt, as needed:
    - How did you select, adapt, or develop the screening tool?

- Who conducts the screening? Have they received training on how to conduct and document the screening?
- How often should screening occur?
- Does the screener ask specifically about each type of violence, or do they select the type of violence based on the client's description of their experience?
- Do they ask about any other types of violence not in the form (i.e., reproductive coercion)?
- What does the screener do if a client has experienced more than one type of violence, or reports more than one perpetrator in the past year?
- How is the detailed information on the perpetrator used?
- Where are the answers to the screening questions recorded? Who has access to this information? i.e., Are the answers to previously asked screening questions accessible to health workers at later visits?
- How do you ensure the screening is safe for clients?
- Are there any legal reporting requirements?
- Are there any challenges to completing the screening? Facilitators?

**5. Now, let's look at the [GBV register]. How are these registers used?**

- Prompt, as needed:
  - Where is the screening data stored? Who captures the screening data in the register?
    - Are there any additional fields you would like to capture in the screening register? What about vulnerable or target populations, such as pregnant females or people with disabilities?
  - Are registers filled out completely and correctly with no blanks (even if the answer is N/A or ND)
  - Are there any challenges to completing these registers? Facilitators?

**6. Now, let's look at the [reporting summary] and [indicators]. Can you walk me through your data aggregation and reporting process?**

- Prompt, as needed:
  - Please explain the process of how data is aggregated to obtain [indicator].
  - From which forms or registers do you get the data required to report on [indicator]?
  - Who is responsible for aggregating data needed to report [indicator]?
  - How do you decide if a client should be counted under [indicator]?
  - Review all disaggregate areas for the indicator: [sex, age, type of violence, service needs assessment, service provision/referral, follow-up]
  - How often does your site report indicator data, and to whom?
  - Does your site have targets for these indicators?

**Barriers and Facilitators**

*I now have a few last questions to learn your perspective on challenges and potential improvements related to GBV monitoring and reporting.*

**7. From your experience, what, if any, are the gaps in information on GBV?**

- Prompt, as needed.
  - What indicators would you drop, change, or add if you could?
  - How does your organization use GBV screening information for service delivery?
  - Is this information used in other ways, such as setting policies or strategies?
  - If not used, what are the challenges to doing so?



- 8. What are the main challenges in the monitoring and reporting process for GBV screening and referral data collection? Facilitators?**
- 9. Is there anything else you would like to tell me?**

### **Closing**

*Thank you for your time and your responses. Your participation in this interview has increased my understanding of your site's GBV data collection and reporting processes. We look forward to sharing our findings with your organization. Thank you.*

## Appendix 5. MOMENTUM implementing partner participation

Table 2. MOMENTUM implementing partners that participated in document review & informational interviews.

Organization	Data Collection Status	Document Review	Informational Interviews
MCGL	GBV screening, data collection and reporting are integrated into FP, ANC & OPD facilities in Nigeria.	Seven documents shared: <ul style="list-style-type: none"> <li>• GBV screening questions &amp; register (Nigeria)</li> <li>• Outpatient register for NHMIS (Nigeria)</li> <li>• GBV case management form (Nigeria)</li> <li>• GBV monthly summary form (Nigeria)</li> <li>• GBV dashboard indicators (Nigeria)</li> <li>• GBV facilities indicator (Global)</li> <li>• GBV quality assurance tool (global)</li> </ul>	Two interviews were conducted: <ul style="list-style-type: none"> <li>• Jhpiego GBV Monitoring, Evaluation, Research, and Learning (MERL) Advisor, Violence against Women and Girls project, Nigeria</li> <li>• Jhpiego Technical Director for Gender</li> </ul>
MIHR	No formal GBV screening or data collection. The current focus is on increasing capacity for future programming around screening.	Two documents shared: <ul style="list-style-type: none"> <li>• Draft universal screening of GBV tools &amp; guidelines (multiple countries)</li> <li>• Certification form on medical evidence of gender-based violence (DRC)</li> </ul>	One interview conducted: <ul style="list-style-type: none"> <li>• Corus International Senior Technical Advisor-SGBV</li> </ul>
MPHD	No GBV data collection.	n/a	n/a
MSSFPO	GBV screening, data collection and reporting are integrated into facilities in Nigeria. One-stop centers in India collect data on reported cases of GBV.	Eight documents shared: <ul style="list-style-type: none"> <li>• GBV Screening form (Nigeria)</li> <li>• GBV screening register (Nigeria)</li> <li>• GBV Case management form (Nigeria)</li> <li>• GBV Service Delivery Register (Nigeria)</li> <li>• GBV Monthly Summary Form (Nigeria)</li> <li>• Community to Health Facility Referral Register (Nigeria)</li> <li>• 2-Way Referral System Client Form (Nigeria)</li> <li>• Quarterly OSC MIS format for data collection (India)</li> </ul>	Two interviews conducted with three participants: <ul style="list-style-type: none"> <li>• EngenderHealth Monitoring, Evaluation, Research, and Learning (MERL) Director</li> <li>• EngenderHealth, MERL Coordinators for Ebonyi and Sokoto states, Nigeria</li> </ul>

## Appendix 6. MOMENTUM routine screening questions

**Table 3. Routine screening questions from USAID MOMENTUM implementing partners and other USAID projects identified via document review.**

Source	General	Physical	Psychological/Emotional	Sexual
<b>MCGL &amp; MSSFPO (Nigeria)</b>	Have you experienced any form of violence in the last one year? If yes, what type?	Physical (e.g., have you been slapped, punched, beaten or caused any other type of physical harm?)	Emotional (e.g., Have you been threatened or yelled at? Do you feel that you are not cared for?)  Psychological (e.g., have you been made to feel inadequate? Is there anyone exhibiting controlling behavior over you, e.g., your partner did not give you money for food? Deprived of sex?)	Sexual (e.g., sexual harassment and rape) If yes, when did this happened? 72 hours or more than 72 hours?
<b>MIHR (Draft—not in use)<sup>21</sup></b>		In the past year, has anyone punched, slapped, kicked, bitten you, or caused you any type of physical harm? ('Anyone' can include your partner, a family member, friend, neighbor, a client, stranger, supervisor, colleague, police officer, or other persons.)	Emotional: In the past year, has anyone insulted you, ignored you, yelled at you, or made you feel ashamed or bad about yourself?  Psychological: In the past year, has anyone made you feel afraid, unsafe or in danger?	In the past year, has anyone forced you to have sex or perform any sexual act, or touched you sexually in any way that you did not want?
<b>RESPOND Project – Engender Health (Guinea)</b>	What happens when you and your partner argue about something? Can you think of a time when you have ever been fearful of your partner's behavior or actions? How does your partner respond when you express your opinions, concerns, or desires?	Can you describe a time when your partner has threatened to harm you physically (scratch, slap, hit, bit or pushed)? Can you describe a time when your partner has hurt your physically (scratch, slap, hit, bit or pushed)?	Can you think of a time when your partner has ever said something to you that has made you feel badly about yourself? How long did the bad feeling last?	Has your partner ever forced you to participate in or do things you don't want to do sexually?
<b>PEPFAR PrEP Screening Questions<sup>22</sup> (Global)</b>		Has your partner ever hit, kicked, slapped, or otherwise physically hurt you?	Has your partner ever made you feel afraid, bullied, or insulted you, threatened to hurt you, or tried to control you (for example, not letting you go out of the house)?	Has your partner ever forced you into sex or forced you to have any sexual contact you did not want?

<sup>21</sup> Questionnaire is from Advancing Partners & Communities (APC) Project: [https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/guyana-gbv-screening\\_tool\\_508.pdf](https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/guyana-gbv-screening_tool_508.pdf)

<sup>22</sup> These questions are from the Standard Operating Procedure for Addressing Partner Relationships and Intimate Partner Violence in Pre-Exposure Prophylaxis (PrEP) Services October 2020, available at: [\\*PA00XB1P.pdf \(usaid.gov\)](#). They were originally adapted from the "Partner Information Form," referenced in the PEPFAR 2020 Country Operational Plan Guidance for all PEPFAR Countries, which includes an illustrative set of IPV screening questions. Available at: [Index and Partner Notification Testing Toolkit — PEPFAR Solutions Platform](#)

## Appendix 7. MOMENTUM summary data

**Table 4. Summary data reported by MOMENTUM partners on screening, identification, services, and referrals of GBV survivors at facilities.**

Organisation	MCGL (Nigeria)	MIHR (Multiple)	MSSFPO (Nigeria)	MSSFPO (India)	NHMIS (Nigeria) <sup>23</sup>
Document name	Post gender-based violence health facility care monthly summary form	Quarterly Report for GBV Screening Process	GBV Facility Monthly Summary form	Monthwise OSC MIS	National Health Management Information System – Health Facility Monthly Summary Form (Version 2018)
Document details	Facility-level reporting form in use	Draft report format contained in screening guidelines	Facility-level reporting form in use	Facility-level reporting form in use	National facility-level reporting form in use
Reporting Frequency	Monthly	Quarterly	Monthly	Monthly	Monthly
<b>Reporting Disaggregation</b>					
Sex	Male or Female	Male or Female	Male or Female	-	Male or Female
Age	Age categories (years): 0–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+	Age categories (years): <18 and Total	Age categories (days, months & years): 0–28 days; 29 days–11 months; 12–59 months; 5–9 years; 10–19 years; ≥20 years	-	Age categories (years): <20 and ≥20
Violence type	Physical, sexual, emotional, psychological	Physical, sexual, emotional, psychological, all types	Sexual assault-rape; sexual assault-other; physical assault; forced marriage; denial of resources; female genital mutilation; psychological or emotional abuse	Domestic violence, rape, sexual offense/sexual harassment, acid attack, trafficking of women, child sexual abuse, child marriage, missing/kidnapping/abduction, cyber-crime, dowry harassment/death, any other crime	<i>*No disaggregation currently, but national TWG proposed to add sexual assault-rape, physical assault, female genital mutilation.</i>
Perpetrator type	Intimate/non-intimate	-	-	-	-
Site/unit type	OPD, ANC, FP, Other	-	-	-	-

<sup>23</sup> Reporting requirements for the Nigerian National Health Management Information System (NHMIS) are included since MCGL and MSSFPO sites also report this data.

Disclosure/reporting type	Self, third party	-	-	Direct, referred	-
Service types	<p><u>All violence:</u> Basic psychosocial counseling (LIVES); treatment for acute injuries</p> <p><u>Sexual violence:</u> PEP; Emergency contraception; HTS; STI testing</p>	-	<p><u>Non-sexual violence:</u> psychosocial counseling, psychosocial support (e.g., support groups), treatment of injuries</p> <p><u>Sexual violence:</u> PEP, EC, STI testing, STI treatment, psychosocial counseling, psychosocial support (e.g., support groups)</p>	<p>Medical assistance, psycho-social support/implementer, registration of complaint – NC/FIR/DIR; Legal aid/implementer; short stay shelter; emergency services; Others, specify)</p>	<p><i>*TWG proposed to add service type disaggregation used by MSSFPO Nigeria</i></p>
Referral service or unit	<p><u>Clinical referrals:</u> by reason: lacerations, broken bones, others</p> <p><u>Non-clinical referrals:</u> legal counsel, child protection services, economic empowerment, law enforcement, temporary shelter</p>	-	<p><u>Sexual violence:</u> forensic assessment/specimen collection</p> <p><u>All types of violence:</u> Protection (law enforcement, police report, restraining orders), Access to justice (legal aid), Shelter (temporary lodging or long-term housing assistance), Economic empowerment (skill-building or training program, access to loan), Fistula repair, Psychosocial support (mental health services, support group)</p>	<p>Health facility, police, FLW, Helpline, NGO, friends/volunteers, relatives, Protection Officers DV Act</p>	<p><i>*TWG proposed to add referral type disaggregation used by MSSFPO Nigeria</i></p>
<b>GBV identification</b>					
Number of persons screened for GBV	By site/unit, sex & age	By sex & age	-	-	-
Number of persons identified ( <i>i.e., through screening</i> )	By perpetrator type, violence type, sex & age	By violence type, sex & age	-	-	-

Number of persons who reported GBV (i.e., not through screening)	By disclosure type, sex & age	-	-	By violence type & disclosure type	-
	By violence type (limited to physical or sexual), sex & age				
Number of GBV cases seen (i.e., identified via screening or reported)	-	-	By violence type, sex & age	-	By sex & age <i>*may update to disaggregate further by violence type</i>
Number of GBV cases referred to facility (incoming referrals)	-	-	-	By disclosure type & referral unit	-
<b>GBV Services</b>					
Number of safety plans developed	-	By sex & age	-	-	-
Number of persons receiving care	By sex & age By perpetrator, violence type, sex & age By service, sex & age	-	By service type and violence type (limited to sexual assault vs. non-sexual assault)	By service type	By sex & age <i>*may update to disaggregate further by service type</i>
<b>GBV Referrals</b>					
Number of persons referred	By referral service, sex & age	By sex & age	By violence type (limited to sexual assault vs. all types), referral service, sex & age		By sex & age <i>*may update to disaggregate further by violence type &amp; referral service</i>
Number of persons accepting referrals	-	By sex & age	-	-	-

## Appendix 8. MOMENTUM partner detailed indicator reference sheets

<b>Indicator</b>	GBV_Service_Outcome1: Percentage of facilities that meet the minimum requirements for screening for gender-based violence per WHO guidelines
<b>Definition</b>	<p>The percent of health facilities in the geographic region of study (e.g., country, region, community) that fulfill the minimum requirements for screening for gender-based violence, which are:</p> <ol style="list-style-type: none"> <li>1. A protocol/SOP for asking about GBV is in place.</li> <li>2. Providers are trained on how to ask about IPV or sexual violence.</li> <li>3. Providers offer first-line support (LIVES)</li> <li>4. Providers follow a standard set of questions with an area to document responses.</li> <li>5. Providers only ask about IPV or sexual violence in a private setting.</li> <li>6. Confidentiality is ensured.</li> <li>7. A system for offering referrals or linkages to other services is in place.</li> </ol> <p>Only the health facilities fulfilling all the criteria should be considered eligible for screening for GBV</p>
<b>Numerator</b>	Number of health facilities fulfilling all seven minimum requirements for screening for GBV per WHO guidelines
<b>Denominator</b>	Total number of health facilities assessed
<b>Disaggregator(s)</b>	<b>Level of Health Facility:</b> primary, secondary, or tertiary
<b>Method of Measurement</b>	<p>This indicator is assessed as part of a facility assessment or supervisory visit. The 7 components of this indicator are measured as followed:</p> <p>Item 1: Facility has a standard process to ask about GBV (e.g., job aid, algorithm, etc.) which aligns with national guidelines, or if no national guidelines are available, aligns with WHO guidelines. Facility staff should be able to state where they can access the documentation for this process when they need to refer to it (e.g., it is posted somewhere, or kept in a place readily accessible to staff).</p> <p>Items 2 and 3: Facility managers will be asked how many staff members have been trained on GBV first-line response, including how to ask about IPV or sexual violence. A minimum of one staff member must have been trained in the last year for this criterion to be met.</p> <p>Item 4: Facility managers will be asked to produce a copy of the IPV/GBV screening questionnaire. The screening questionnaire must be available to show the assessor for this criterion to be met.</p> <p>Item 5: Facility managers will be asked where and under what conditions providers would ask about IPV/GBV. This criterion is met only if the manager indicates a space</p>

	<p>with auditory and visual privacy, and indicates that a provider would only ask if a client is alone.</p> <p>Item 6: Facility managers will be asked what procedures are in place to respect client confidentiality. This criterion is met if the manager can describe a policy on sharing client information only on an as-needed basis, as well as show a locked location where client records are kept and explain how and by whom those records can be accessed.</p> <p>Item 7: Facility managers will be asked to produce a copy of the referral form, and referral protocol. These documents must be available to show the assessor for the criterion to be met.</p> <p>Scoring for each item:</p> <p>2 Yes</p> <p>1 No</p> <p>0 Don't know</p> <p>This indicator is calculated as:</p> <p>(Number of health facilities fulfilling all 7 minimum requirements for screening for GBV per WHO guidelines /Total number of health facilities surveyed) X 100</p>
<b>Purpose</b>	<p>Health service delivery programs are critical to the prevention and response to GBV. Every clinic visit made by a GBV survivor presents an opportunity to address and ameliorate the effects of violence as well as help prevent future incidents. In order to take advantage of these opportunities, health facilities and providers need to be prepared to deliver appropriate services, including identification of survivors, necessary health services, counseling, and referrals to community-based resources such as legal aid, safe shelter, and social services. This indicator allows program managers to measure program facilities' capacity to support GBV survivor needs, and identify gap areas to prioritize as part of program interventions.</p>
<b>Data Source</b>	Facility assessments and/or observational visits.
<b>Frequency of data submission</b>	Quarterly
<b>Reference</b>	<p>USAID/PEPFAR. Measure Evaluation Family Planning and Reproductive Health Indicators Database.</p> <p><a href="https://www.measureevaluation.org/prh/rh_indicators/indicator-summary">https://www.measureevaluation.org/prh/rh_indicators/indicator-summary</a></p> <p><a href="#">Gender-Based Violence Quality Assurance Tool—Minimum Care Version</a></p> <p>ADB 2013. Tool Kit on Gender Equality Results and Indicators</p>



**PERFORMANCE INDICATOR REFERENCE SHEET INDICATOR 1.7**
**Indicator 1.6 Percentage of supported facilities with an active and recently updated GBV referral list**

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of supported facilities with an active and recently updated GBV referral list</p> <p><b>Denominator:</b> Number of supported facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>“Active and recently updated” refers to the list having been updated/confirmed within the last 6 months</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p><a href="#">Prior research under the Fistula Care Plus project observed an increased risk of gender-based violence among women experiencing fistula symptoms</a>, moreover <a href="#">multiple reports have observed increases in violence against women and children during the COVID-19 pandemic</a>. country projects with either fistula prevention and treatment, and/or gender-based violence remits should be tracking linkages to GBV services as a matter of provision of quality services, under intermediate result 1.1: improved service readiness to provide quality MNCH/FP/RH interventions in public and private sectors, including emergency care.</p>
<b>Data Disaggregation</b>	SDP type, urban/rural
<b>Data Source(s) &amp; Data Collection Instruments</b>	Facility assessment / program records
<b>Method of data collection and construction</b>	Extraction from facility assessment / program records
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Baseline timeframe</b>	First quarter of support to facility
<b>Data Quality Considerations</b>	May be difficult to assess extent to which lists are “active and recently updated” given reliance on facility self-report and reporting frequency
<b>Data Use</b>	Data will be used to monitor GBV services and referral at supported facilities and identify where to focus programmatic support

This sheet was last updated on: 04/06/2022

**Data for Impact**

University of North Carolina at Chapel Hill

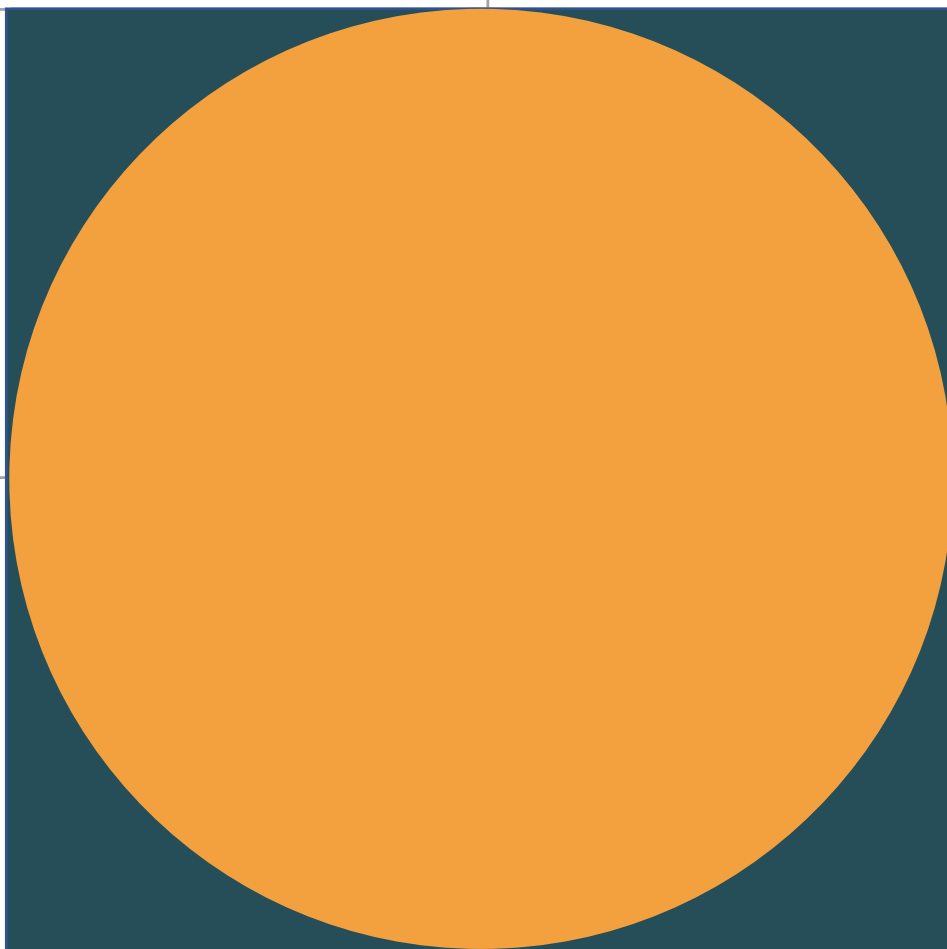
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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the Data for Impact (D4I) associate award 7200AA18LA00008, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Palladium International, LLC; ICF Macro, Inc.; John Snow, Inc.; and Tulane University. The views expressed in this publication do not necessarily reflect the views of USAID or the United States government.

SR-23-202 D4I