



# Implementation Fidelity of Gender Based Violence Screening among Health Care Providers in the Health Care Facilities of Dodoma Region, Tanzania

Hindu Ibrahim, Secilia Ng'weshemi

Department of Public Health, School of Nursing and Public Health, University of Dodoma, Dodoma, Tanzania

Email: Hindupty@gmail.com, mwatty92@yahoo.com

**How to cite this paper:** Ibrahim, H. and Ng'weshemi, S. (2021) Implementation Fidelity of Gender Based Violence Screening among Health Care Providers in the Health Care Facilities of Dodoma Region, Tanzania. *Open Access Library Journal*, 8: e7979. <https://doi.org/10.4236/oalib.1107979>

**Received:** May 12, 2021

**Accepted:** October 19, 2021

**Published:** October 22, 2021

Copyright © 2021 by author(s) and Open Access Library Inc.

This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).

<http://creativecommons.org/licenses/by/4.0/>



Open Access

## Abstract

**Background:** The Gender Based Violence (GBV) screening rate among health care providers is low despite the strategies to initiate GBV screening set by the Ministry of Health in Tanzania through implementation fidelity. This proposed study is an attempt to fill the gap by determining the GBV screening Implementation Fidelity, focusing on adherence to Protocols and Procedures in implementing GBV screening and factors affecting adherence to the implementation fidelity of GBV screening among the health care providers in the health facilities of Dodoma Region. **Method:** This was an analytical cross-sectional study; quantitative approach. A multi-stage sampling technique was applied to obtain 384 healthcare providers. The Interviewer-administered questionnaire was used to collect data from healthcare providers in health facilities of the Dodoma Region. SPSS was used for the analysis of descriptive statistics to determine the level of adherence, and logistic regression for factors affecting adherence to GBV screening. **Objective:** The objective is to assess the implementation fidelity of GBV screening among healthcare providers in the healthcare facilities of the Dodoma Region. **Results:** Doctors and nurses who were not trained on GBV screening were 305 (79.4%). There is a low level of adherence to the implementation fidelity of GBV screening among the health care providers in the Dodoma Region, where by 16.4% (63) adhered to GBV screening. Those who were not trained were less likely to adherence GBV screening practices compared to those who were trained (AOR = 0.206,  $p < 0.0001$ ). Nurses were less likely to adhere to GBV screening practices in reference to the doctors (AOR = 0.46,  $p = 0.037$ ). Those who disagreed with the statement that there were few opportunities to speak with women, were more likely to adhere to GBV screening practices (AOR = 2.8,  $p$

---

= 0.008) compared to those who agreed. **Conclusion:** The results show that most of the health care providers in the Dodoma Region do not adhere to the GBV screening; a low level of adherence indicates that most of the clients who are faced with Gender Based Violence are not identified and given appropriate management and referral. This study contributes to showing the situation analysis of how GBV screening is done in health facilities. **Recommendation:** It is recommended to address factors to improve the adherence of GBV screening including enough training to the health care providers.

### Subject Areas

Health Policy

### Keywords

Gender Based Violence Screening, Implementation Fidelity, Health Care Providers

---

## 1. Introduction

Screening of Gender Based Violence is a crucial point in identifying the survivors of GBV and provides the appropriate management for their healing, including appropriate referrals within the health facilities or outside the health facility, like to Police, Social Welfare and Legal Aids. Without screening, most survivors of GBV will not be identified and given appropriate management. It follows that screening helps to prevent avoidable diseases, such as sexually transmitted diseases, psychological problems, trauma, or even death [1]. GBV screening can be done before or during other types of services with the help of the Abuse Assessment Screening Tool from the Ministry of Health. Subsequent to the term screening is implementation fidelity, which refers to the degree to which an intervention or a program is delivered as intended [2]. Implementation fidelity marks the central theme of this study in that it entails an account of whether the service is being delivered as it was designed, including staff trained, content, frequency, duration, and coverage of the service being provided.

However, research shows that GBV has received little attention and practice worldwide. For example, health providers in the US are not screening for IPV and SV in college health centers albeit the US Government has provided a guideline and directions about the screening of women [3]. There is only 20% of screening conducted while the issues of intimate partner violence are experienced to be high in the country [4]. While this is just an account of one country in the world, high socio-economic and political development in the country, it suffices to illustrate the magnitude of intimate partner violence and a low screening tendency that goes around, particularly for developing countries. This slow response has made Hutchinson [3] suggest further research to determine the factors that influence health providers to adhere to the implementation fidel-

ity of GBV screening.

Tanzania has had practices to ensure such crimes are identified and given appropriate management and even brought to justice. The Government designed the implementation fidelity by preparing the National Management Guideline on Response and Prevention of Gender Based Violence through screening of survivors. The Government has also enacted laws that would introduce confidence to the survivors come forward and testify in private or even in the court of law [1].

The strategies to initiate GBV screening, as set by the Ministry of Health in Tanzania, include the implementation fidelity, capacitating the health care providers by in-service training on how to screen clients and manage survivors. Despite these strategies, the DHIS 2 data of 2019 show that only 40% and 11% of women and men who attended health facilities were screened for GBV respectively. The reasons for the poor implementation fidelity of GBV screening in health facilities are scant in the research available. This proposed study was an attempt to fill the gap by determining the level and factors which affect the implementation fidelity of GBV screening among the health care providers in health facilities of the Dodoma Region.

#### **Objectives of the study include**

**Broad Objective:** To assess the implementation fidelity of GBV screening among healthcare providers in healthcare facilities of the Dodoma Region.

#### **Specific Objectives**

- To determine the level of adherence to the implementation fidelity of GBV screening among the healthcare providers in the health facilities of the Dodoma Region.
- To determine factors affecting adherence to the implementation fidelity of GBV screening among the health care providers in the health facilities of Dodoma Region.

## **2. Methodology**

### **2.1. Location of the Study**

This study was conducted at the health facilities of Dodoma Region (*i.e.* Hospitals, Health Centers and Dispensaries) in four Councils of Dodoma Region among doctors and nurses by using an interviewer-administered questionnaire. The region has eight councils and a population of two million. The study was conducted from January to March 2021. The region was selected due to the high prevalence of Gender Based Violence. The TDHS's (2010) data shows that Dodoma is the second region with 71% of sexual and physical violence for women aged 15 - 49 who have ever experienced violence from their husbands/partners [5]. Moreover, the current statistics by the TDHS (2015/16) show that the region has 50% of sexual and physical violence and 48% of FGM [6].

### **2.2. Study Design and Approach**

Analytical cross-sectional study design was used with the quantitative approach

to conduct the study. Data were collected for 1 month period starting from 11 January to 3 February, 2021. Data of this study were collected through a specially designed questionnaire. This questionnaire assessed the adherence through checklist whereby the score of 1 if participants yes showed or item observed; score of 0 if participants did not show or item not observed.

A pilot study was carried out on 38 health care providers (not included in the final study). The necessary modifications according to the results obtained were done, so some statements were reworded. Also, the structure of the questionnaire sheet was reformatted to facilitate data collection.

### 2.3. Study Population

The study population was the Health Care Providers (Doctors and Nurses) who are responsible for screening clients and managing survivors at inpatient and outpatient clinics in Hospitals, Health Centers and Dispensaries of the Dodoma Region.

### 2.4. Inclusion Criteria

All Health Care Providers (Doctors and Nurses) work in Government Health facilities because Government facilities are responsible for filling PF3 after GBV survivor management.

### 2.5. Exclusion Criteria

There are healthcare providers who will refuse consenting to participate.

### 2.6. Sampling Procedure

**Multi-stage** sampling procedure was employed. This involved three stages to obtain the population to be studied.

### 2.7. Variable Measurement

#### Independent variables

**Social demographic factors:** Health Care Providers were asked about their social profile including age, sex, working experience, occupation, training related to GBV.

#### Dependent Variables

Implementation fidelity in adherence of GBV Screening was measured by nominal scale as suggested by CDC and WHO Gender Based Violence Quality Assurance tool by using twelve (12) questions: Yes (Observed) = 1 mark, No (Not Observed) = 0 mark; which was converted to (100%). Those who scored above 50% were considered to adhere GBV screening and those who scored below 50% was considered not to adhere screening.

- Health Care Providers showed the standard process (e.g. job) aligns with national guidelines which show the steps of Gender Based Violence screening
- Health Care Providers showed the standard process (e.g. algorithm, etc.)

aligns with national guidelines which showed the steps of Gender Based Violence screening.

- Observed personal documentation of filled GBV Medical forms.
- Observed personal documentation of filled Consent forms.
- Observed personal documentation of filled Patient files.
- Observed personal documentation of filled PF3.
- Observed personal documentation of filled Chain of Custody (Hand-over book for GBV forensic materials).
- Observed documentation of filled Registers, Tally sheet and Monthly summary form.
- Observed documented established and adhered system of referrals or linkages to other services within the health facility is in place and established by the Medical Practitioners.
- Observed whether there are patient's files, GBV medical forms and registers and whether sexual assault survivors offered emergency contraception (female), PEP, TT and STI prophylaxis by the provider.
- Health Care Providers attend to the current client need (Documented).

It is observed if providers had received training on how to ask about GBV Screening.

## 2.8. Ethical Consideration

All the necessary approvals for carrying out the research were obtained. The Ethics Committee of the University of Dodoma approved the research. A written consent form explaining the purpose of the research was prepared and signed by the health care providers before filling the questionnaire. In addition, the research was reviewed by the lecturers from the department of public health at the University of Dodoma, its purpose and importance of the research were discussed.

## 2.9. Statistical Analysis

Descriptive measures were utilized (count, percentage, arithmetic mean and standard deviation) as well as transformation was used to determine range of measures for the level of adherence. Also, inferential statistics (logistic regressions) were used for association of variable; significance was considered when p value less than 0.05 inferences was made using 95% confidence interval.

A pre-coded sheet was used. All questions were coded before data collection. This facilitated both data entry and verification as well as reduced the probability of errors during data entry. Data were fed to the computer directly from the questionnaire without an intermediate data transfer sheet. The SPSS Version 26 was used for data entry. A file for data entry was prepared and structured according to the variables in the questionnaire. After data were fed to the SPSS; then data cleaning was performed for categorical and numerical data. These methods included simple frequency, descriptive, as well as assessed the normality of data through exploring by checking histogram shape for normal distribu-

tion, detrended normal Q-Q plot and 5% trimmed mean through the descriptive table. Percent score was calculated for the total adherence score as well as for each domain of adherence.

### 3. Results

The presented and discussed results will base on the social demographic characteristic, level of adherence to the implementation fidelity of GBV screening, descriptive findings for factors affecting the implementation fidelity of GBV together with the Unadjusted and Adjusted odds ratio for Association of the Factors with Adherence on Implementation Fidelity of GBV Screening Practices to the health care providers in Dodoma Region.

#### 3.1. Socio-Demographic Characteristics of Participants

**Table 1** shows the social demographic characteristics of the participants. The results have shown that most of the respondents are in the age factor majority of between 25 - 44 years which amounts to 354 (92.2%). Among the health care providers, many were female 267 (69.5%). Regarding the occupation of the health care providers, many were assistant nursing officers 109 (28.4%).

The health care providers who were not trained on management and respond to GBV are 269 (70.1%). Among the health care providers who were trained 74 (19.3%) were trained in service and 41 (10.7%) were trained pre services. Also among the health care providers who were not trained for management and response to GBV, 147 (38.3%) got information of GBV from mentorship and 122 (31.8%) got information on GBV from self-study.

Clinical practice experience of health care providers showed that most of the providers are in the group of work experience of below 10 years which amounts to 335 (87.2%). The minimum age of the participants was 22 and the maximum age was 59 with a mean age of 33.80 (SD = 6.48). Thirty (30) health facilities were visited during data collection, and huge numbers of health care providers were from Health centers 207 (53.9%).

**Table 1.** Social demographic characteristics of the study sample (N = 384).

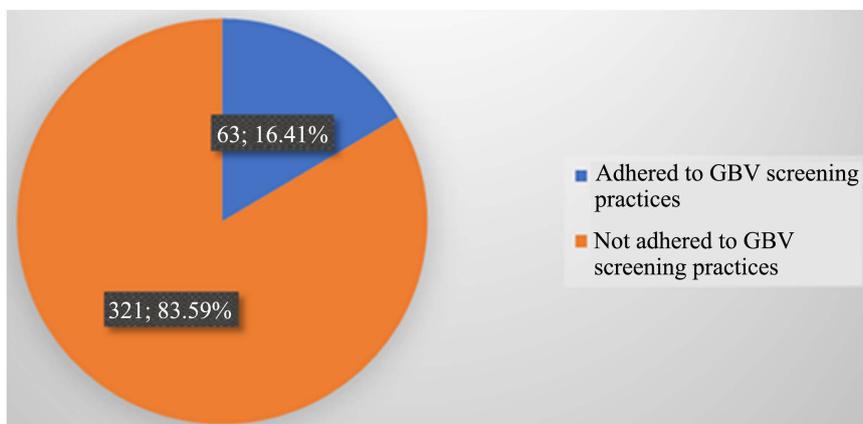
Variable	Frequency (n)	Percentage (%)
<b>Age group</b> (mean age = 33.80, SD = 6.48)		
18 - 24	3	0.8
25 - 44	354	92.2
45 - 60	27	7.0
<b>Sex</b>		
Male	117	30.5
Female	267	69.5
<b>Occupation</b>		

**Continued**

Medical Doctor	44	11.5
Assistant Medical Officer	38	9.9
Clinical Officer	69	18.0
Medical Doctor Specialist	12	3.1
Nursing Officer	18	4.7
Assistant Nursing Officer	109	28.4
Enrolled Nurse	87	22.7
Nursing Specialist	2	0.5
Others	5	1.3
<b>Years in clinical Practice</b>		
≥10	335	87.2
11 - 20	37	9.6
21 - 30	8	2.1
31 - 40	4	1.1
<b>Training for GBV</b>		
Yes	115	29.9
No	269	70.1
<b>Place of being Trained GBV (N = 115)</b>		
Pre-service	41	35.7
In-service	74	64.3
<b>Place of obtained Information on GBV (N = 269)</b>		
Self-study	122	45.4
Mentorship	147	54.6
<b>Health facilities (N = 30)</b>		
Hospitals	7	23.3
Health Centers	11	36.7
Dispensary	12	40.0

### 3.2. Level of Adherence to GBV Screening Practices on Implementation Fidelity among the Health Care Providers in Dodoma Region

**Figure 1** shows the overall level of adherence of the implementation fidelity of GBV screening practice among the health care providers in Dodoma Region, whereby among 384 health care providers majority 83.6% (321) had not adhered while only 16.4% (63) had adhered on implementation fidelity of GBV screening.



**Figure 1.** Overall level of adherence on the implementation fidelity of GBV screening practice among health care providers (N = 384).

On descriptive findings (**Table 2**) on the components of Adherence on implementation of GBV screening practices, only 20.6% of health care providers acknowledge that they have been trained on GBV screening, however, 58.9% showed personal documentation of PEP, TT, STI prophylaxis, while only 15.6% showed job aid contain SOPs. On the other aspect, almost all health care providers did not show the important filled forms for GBV screening including, filled GBV Medical Forms (96.6%), Consent Form (96.4%); moreover nearly all health care providers (99%) did not show any filled chain of custody.

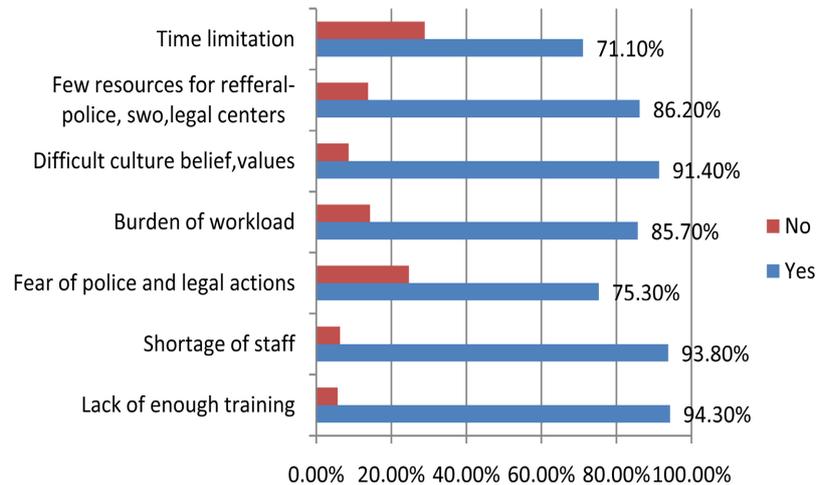
**Table 2.** Distributions of items in the adherence to the implementation fidelity of GBV screening practices among health care providers.

S/N	Adherence sub Items	Yes, n (%)	No, n (%)
1	Showed job aid contain SOPs	60 (15.6%)	324 (84.4%)
2	Showed the algorithm	142 (37.0%)	242 (63.0%)
3	Showed Personal filled GBV Medical Forms	13 (3.4%)	371 (96.6%)
4	Showed Personal filled Consent Form	14 (3.6%)	370 (96.4%)
5	Showed Personal filled patients files	99 (25.8%)	285 (74.2%)
6	Showed Personal filled PF3	92 (24.0%)	292 (76.0%)
7	Showed Personal filled chain of custody	4 (1.0%)	380 (99.0%)
8	Showed personal filled Register	94 (24.5%)	290 (75.5%)
9	Showed personal documentation of PEP, TT, STI prophylaxis	158 (41.1%)	226 (58.9%)
10	Showed the system of Referrals and linkages	168 (43.8%)	216 (56.3%)
11	Showed attended current need	50 (13%)	334 (87%)
12	Trained on GBV screening	79 (20.6%)	305 (79.4%)

### 3.3. Factors Affecting Adherence on Implementing GBV Screening Practices among Health Care Providers

**Figure 2** shows factors affecting adherence on implementing GBV screening

practices stated by the health care providers, which include lack of enough training on screening and addressing GBV 362 (94.3%), shortage of staff 360 (93.8%), fear of police proceeding and legal action 289 (75.3%), the burden of workload 329 (85.7%), difficult in cultural beliefs and values 351 (91.4%) there are few resources for referral of the survivors in the community including police, social welfare, and legal centers 331 (86.2%); due to the service provision at the health facility, health care providers stated to have limited time to perform other services including GBV 273 (71.1%).



**Figure 2.** Factors affecting adherence on implementing GBV screening practices among health care providers (N = 384).

### 3.4. Unadjusted and Adjusted Odd Ratios for Factors Associated with Adherence on Implementation Fidelity of GBV Screening Practices among Healthcare Providers in Health Facilities of Dodoma Region (N = 384)

The results of the models are presented in **Table 3**. The adjusted results in the occupation of the healthcare providers show a statistical significant relationship in that nurses were less likely to adhere to GBV screening practices in reference to the doctors (AOR = 0.46,  $p = 0.037$ ). With regard to the sex of the healthcare providers, the results show that there is a statistical significance and females were statistically less likely to adhere to the GBV screening practices in comparison to the males (AOR = 0.303,  $p = 0.001$ ). In relation to GBV training, those who were not trained were significantly less likely to adhere to GBV screening practices in reference to those who were trained (AOR = 0.206,  $p < 0.0001$ ). Moreover, those who disagreed with the statement that there were few opportunities to speak with women, were more likely to adhere to GBV screening practices (AOR = 2.8,  $p = 0.008$ ) compared to those who agreed. However, those who agreed that there are few resources for referral in the community were significantly more likely to adhere to the GBV screening practices in reference to those who disagreed (AOR = 5.8,  $p = 0.011$ ).

**Table 3.** Unadjusted and adjusted odds ratios for factors associated with adherence on implementation fidelity of GBV screening practices among healthcare providers in health facilities of Dodoma Region (N = 384).

Variable	Unadjusted		Adjusted	
	OR (95% CI)	p-value	OR (95% CI)	p-value
<b>Social demographic Factor</b>				
<b>Occupation category of healthcare providers</b>				
Doctor	Reference		Reference	
Nurse	3.601 [2.023, 6.41]	<0.0001	0.460 [0.222, 0.954]	<b>0.037</b>
<b>Training of GBV</b>				
Yes	Reference		Reference	
No	6.221 [3.485, 11.104]	<0.0001	0.206 [0.107, 0.398]	<b>&lt;0.0001</b>
<b>Sex of the healthcare provider</b>				
Male	Reference		Reference	
Female	3.104 [1.784, 5.398]	<0.0001	0.303 [0.150, 0.610]	<b>0.001</b>
<b>Social-cultural factor</b>				
<b>1) Few opportunities to speak with women</b>				
Agree	Reference		Reference	
Disagree	2.746 [1.409, 5.354]	0.003	2.874 [1.325, 6.232]	<b>0.008</b>
<b>2) There are few resources for referral in the community</b>				
Agree	0.271 [0.082, 0.898]	0.033	5.844 [1.494, 22.85]	<b>0.011</b>
Disagree	Reference		Reference	

## 4. Discussion

This current study was conducted among health care providers in Dodoma Region, Tanzania to reveal the implementation fidelity of GBV screening, focusing on the component of adherence. The study focused on the overall level of adherence to protocols and procedures on implementation of GBV screening, by observing different sub-items of adherence.

Results showed that few health care providers in the health facilities adhered to the implementation fidelity of GBV screening. Whereby only 16.4% of health care providers adhered to protocols and practices on the implementation fidelity of GBV screening. Among the sub-items of assessing the level of adherence, the criteria for assessing filled chain of custody, consent form and GBV Medical form was most poorly performed and more than 95% of health care providers did not fill these forms which do facilitate them in screening the clients and provide appropriate GBV care. This could be probably the majorities are not trained on management and respond to GBV. Therefore, they are not oriented on the specific tools to be used and how to document them even though the forms were

unavailable in most of the health facilities. A study that was conducted in Kuwait supported that lack of GBV training among healthcare providers hindered the provision of standardized services to the GBV survivors [5].

This is similar to the study which was done in the US which states that; despite the U.S government provides guidelines and direction regarding screening of women on sexual violence and intimate partner violence, providers do not adhere to the screening for IPV and SV in college health centers [3]. The physicians and nurses involved in and the study by Hutchinson above revealed that there was a low rate of IPV/SV screening by (20%).

Another study which was conducted in Kuwait to examine the attitude of healthcare staff in adherence to screening for Gender Based Violence showed that nurses do screen by (26.4%) [7].

The study of the Dadaab refugee camp of Kenya was conducted to examine the feasibility and acceptability of universal screening for GBV in refugee population who attended in health clinics and revealed that providers don't adhere to screening and, about 15% of potential participants were offered screening [8].

Walton *et al.* [9] argued that only 8% of HCP routinely do adhere to screening for IPV and Low screening rates have also been identified among physicians. In a study by Walton *et al.* [9], 406 women were interviewed about IPV screening. Of the 406 women, only 20% could remember being screened for IPV [9]

The current study identified different social-cultural factors reported by high percentages, *i.e.* more than seventy percent for each factor may probably cause the healthcare providers not to adhere and provide quality services to GBV screening practices. These results might have been so possibly because staffs are not enough in health facilities and are overloaded with service provision which limits their time to concentrate on GBV screening and see it as a burden. This observation is supported by the research that was conducted in the low-income Latina population by Alvarez which suggested that additional screenings add burdens to medical providers which make GBV screening difficult to be incorporated into the workflow [10].

The provision of GBV services requires multi-sectoral coordination of external services at the nearby facilities. The services provided include police, social welfare, and legal centers. However, these services are mostly scattered in rural areas. A few resources for referral of the GBV survivors make the GBV screening difficult. This is evidenced by the study of Bloom who claimed that providers may not screen for GBV if there are limited community resources [4].

Societies have their own cultural beliefs which can impact GBV screening, like acceptance of wife-beating, tolerate GBV incidence and don't disclose it. This is evidenced by the study done in Egypt which explained that Egyptian society has religious and conservative behavior, and could be the reasons that they don't like to be interfered and managed their conflicts which might make them get angry if they are asked about GBV incidence [11].

Healthcare providers fear police proceedings because most of them have not

been enabled to stand in the court and provide forensic evidence. Still few healthcare providers are trained on management and respond to GBV and VAC due to inadequate resources to expand the programme in the whole country. The study done in Kentucky observed that patients' lacked access to many GBV trained healthcare providers who can stand with them for medical and legal perspectives because most of them are not capacitated [4].

The findings concur with those of the study conducted in the Latina population which was done by Alvarez *et al.* revealed that additional screenings add burdens to medical providers which make IPV screening difficult to be incorporated into the workflow [10].

Also, other research conducted in primary healthcare centers of Kuwait in 2012 showed that different factors act as barriers towards screening for GBV; time constraints and a heavy workload were stated as barriers by physicians and nurses respectively [12].

Also, community culture (fear from insult, religious belief) was explained by the healthcare providers in Egypt that some of them have certain opinions and prejudices based on their own upbringing, culture, and beliefs. These biases can affect their professional behavior, including their intention to ask about abuse and create errors in clinical judgment in violence cases [11]. The study of Lokuge *et al.* reported that there was a lack of proper training for healthcare providers is the barrier to manage the survivors towards GBV screening [13]. Also, another study by Alvarez *et al.* revealed that providers felt unprepared to help women respond to their situation because they lacked official training to know what next to help the violated survivors [10]. In addition, the study conducted in Egypt supported that providers could help patients who experienced Gender Based Violence because they lack guidelines or training to do this [11]. Moreover, the study conducted in Kuwait showed that physicians and nurses existed in a shortage which made the process of GBV screening difficult. This was stated by physicians and nurses respectively [12].

Also, the healthcare providers demonstrated some fear and were not ready to participate in police proceedings and legal actions against Gender Based Violence incidents because they lacked knowledge on police and legal proceeding [12]. Furthermore, some contradictory results are observed when the current study is compared to the findings of a previous study that was conducted in Kuwait. In the study conducted in Kuwait, the healthcare providers explained to be shy and offended women when they asked those questions about abuse [12]. The current study revealed being offended when asked about issues of violence has a low contribution to be a barrier of the healthcare providers towards GBV screening; possibly healthcare providers see probing women to understand the violence they face as their professional responsibility to get a deep insight of the patient problem and not offending them. Furthermore, the study by Alvarez *et al.* confirmed that they screen every new patient once a year as part of their assessment and responsibility that they have arranged and it is not the matter of

insulting the clients [10].

Also, in the same study of Kuwait, there was a fear of revenge by healthcare providers from the husband or relatives. This happens when the husband or relatives discover the healthcare provider intervene to settle the situation of Gender-Based Violence which existed between the two sides [12]. This contradicts with the current study which revealed that fear of retaliation/revenge from the perpetrator has a low contribution, by less than fifty percent, in making the healthcare providers fail in screening clients about GBV.

This might be due to the reason that society in the current study believes that it is against the law to do GBV to others and someone might be convicted for that when trying to revenge for the healthcare providers. Also, it is the responsibility of the providers to intervene with the clients and provide holistic care including GBV care. This is also supported by the Tanzania laws include the Penal Code Cap 16, which states that it is an offence against the Administration of Lawful Authority [14].

The adjusted logistic regression was conducted on adherence and revealed that there is a statistically significant relationship and nurses were less likely to adhere to GBV screening practices compared to doctors. This might happen because nurses are not always involved in taking the history and diagnosis of the clients. This can make them lose the skills that are important in GBV screening. This is evidenced by the study done in Texas which stated that skills and experience were also significant influences for GBV screening among nurses. The type of nurse and the highest degree earned is likely predictors for GBV screening practices; *i.e.* advanced degrees may offer expanded education in the area of abuse [15]. Also, the study conducted in Kuwait stated that the lack of experience in the screening process was explained by nurses that hindered them from doing GBV screening [12]. In the sex of the healthcare provider, there is a statistical significant relationship as female providers were statistically less likely to do adherence to GBV screening practices in comparison to males. Possibly, female healthcare providers in the current study obtained a high representation of the sample compared to males. This is similar to the study done in Egypt whereby females formed a large sample compared to males. However, the results of the study conducted in Egypt showed that women had more readiness to screen for intimate partner violence out of sympathy for fellow women [11].

In relation to GBV training, those who were not trained were significantly less likely to do adherence GBV screening practices compared to those who were trained. This is because training develops the capacity of the healthcare providers on issues of Gender-Based Violence screening and survivor management. It is not easy to adhere and provide quality service if providers are not trained to provide the respective services. The implementation fidelity theory support that for effective execution of the programs, healthcare providers need to be trained to know what they are required to perform [2].

Moreover, there is a statistical significance and those who disagree with the issue of few opportunities to speak with women were more likely to do adhe-

rence GBV screening practices when compared to those who agreed. Possibly the chances to speak with women are available within the health facilities and those who get a chance to interact with the clients are the ones who do well in GBV screening. This is evidenced by the study of Alvarez *et al.* and healthcare providers who explained that they get opportunities to screen women. They screened women who come at the first visit and those who are repeated to come at the health facility [10].

However, those who agreed that there are few resources for referral in the community were significantly more likely to adhere to the GBV screening practices when compared to those who disagreed. Possibly, those who adhered to GBV screening found it easy to identify the necessary resources required for survivors; they could tell about the availability of resources. It is hypothesized in the Health Belief Model that providers may not screen for GBV if there are limited community resources. The efficient availability of resources influences the providers towards GBV screening [4]. Other studies emphasize the lack of resources and claim that, even when they could be available, the ability to connect the survivor is so difficult [10].

Methodologically, the study is limited in scope in that it draws its data from Dodoma only whose population may have a different cultural orientation from other regions. A study like this may have different findings when conducted in areas with different socio-political differences from Dodoma

For further research, it is recommended to perform this kind of study on assessing the level of adherence in other zones which have integrated GBV screening in health facilities as well perform a further study to identify factors that lead to the low level of adherence to the implementation fidelity of GBV screening among the health care providers.

## 5. Dissemination of the Results

The result will be disseminated to the University of Dodoma, Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), President Office, Regional Administration and Local Government Authority (PORALG), Regional Administrative Secretariat (RAS), District Executive Directors (DED), Regional Medical Officer (RMO), District Medical Officers (DMO), Development/Implementing partners and published to the relevant journal.

## Acknowledgements

We would like to acknowledge the University of Dodoma to give permission to conduct this study, together with all lectures and assistant lectures at the College of Health in Dodoma University to ensure this research is successful.

## Contribution of the Authors

Hindu Ibrahim as a student of Masters of Public Health at the University of

Dodoma in the Department of Public Health; has designed, collected data with the assistants, analyzed data and prepared the manuscript under the supervision of Dr. Secilia Ng'weshemi who provided input for modification in all stages.

### Ethics Approval and Consent to Participate

This research has received ethics approval from the University of Dodoma, Institutional Research Review Committee. All participants were requested to consent before enrolment into the study. All participant information is kept confidential and accessible only to the key investigative team. All published data are anonymized and can be accessed based on a written request to the Principal Investigator.

### Consent for Publication

Not applicable because this manuscript does not contain any individual person's data in any form.

### Conflicts of Interest

The authors declare that they have no competing interests with regard to this publication.

### References

- [1] Stark, L. and Landis, D. (2017) Violence against Children in Humanitarian Settings: A Literature Review of Population-Based Approaches. *Social Science and Medicine*, **152**, 125-137. <https://doi.org/10.1016/j.socscimed.2016.01.052>
- [2] Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J. and Balain, S. (2007) A Conceptual Framework for Implementation Fidelity. *Implementation Science*, **2**, 1-9. <https://doi.org/10.1186/1748-5908-2-40>
- [3] Hutchinson, M.A.T. (2019) No Title Research in Nursing & Health. *Research in Nursing and Health*, **42**, 284-295. <https://doi.org/10.1002/nur.21950>
- [4] Bloom, E. (2014) UCLA Electronic Theses and Dissertations. Just Ask: Healthcare Provider Screening for Intimate Partner Violence and Human Trafficking Victims in Southern California Permalink.
- [5] Qasem, H.D., Hamadah, F.A., Qasem, K.D., Mohamed, I., El-shazly, M.K., Qasem, H.D., Mohamed, I., *et al.* (2019). Knowledge and Attitude of Primary Health Care Staff Screening and Not Screening for Domestic Violence against Women Knowledge and Attitude of Primary Health Care Staff Screening and Not Screening for Domestic Violence against Women. *Alexandria Journal of Medicine*, **49**, 181-187. <https://doi.org/10.1016/j.ajme.2012.07.006>
- [6] TDHS (2010) No Title, Tanzania.
- [7] Programmes, M.G.V. and Workshop, P.T. (2012) GBV Assessment & Situation Analysis Tools.
- [8] Vu, A., Wirtz, L.A., Bundgaard, S., Nair, A., Luttah, G., Ngugi, S. and Glass, N. (2020) Feasibility and Acceptability of a Universal Screening and Referral Protocol for Gender-Based Violence with Women Seeking Care in Health Clinics in Dadaab Refugee Camps in Kenya. *Global Mental Health*, **4**, E21. <https://doi.org/10.1017/gmh.2017.18>

- [9] Walton, L.M., Dpt, H.B. and Dpt, T.T. (2015) Intimate Partner Violence Screening and Implications for Health Care Providers. *Online Journal of Health Ethics*, **11**, Article 5. <https://doi.org/10.18785/ojhe.1101.05>
- [10] Alvarez, C., *et al.* (2017) Responding to Intimate Partner Violence: Healthcare Providers' Current Practices and Views on Integrating a Safety Decision Aid into Primary Care Settings. *Research in Nursing & Health*, **41**, 145-155.
- [11] Ibrahim, E., Hamed, N. and Ahmed, L. (2021) Views of Primary Healthcare Providers of the Challenges to Screening for Intimate Partner Violence, Egypt. *Eastern Mediterranean Health Journal*, **27**, 233-241. <https://doi.org/10.26719/emhj.20.125>
- [12] Alotaby, I.Y., Alkandari, B.A., Alshamali, K.A., Kamel, M.I. and El-Shazly, M.K. (2013) Barriers for Domestic Violence Screening in Primary Health Care Centers. *Alexandria Journal of Medicine*, **49**, 175-180. <https://doi.org/10.1016/j.ajme.2012.07.005>
- [13] Lokuge, K., Verputten, M., Ajakali, M., Tolboom, B., Joshy, G., Thurber, K.A., Banks, E., *et al.* (2016) Health Services for Gender-Based Violence: Médecins Sans Frontières Experience Caring for Survivors in Urban Papua New Guinea. *PLoS ONE*, **11**, e0156813. <https://doi.org/10.1371/journal.pone.0156813>
- [14] Tanzania, U.R. (1981) Chapter 16. [https://www.un.org/depts/los/LEGISLATIONANDTREATIES/PDFFILES/TZA\\_pe\\_nal\\_code.pdf](https://www.un.org/depts/los/LEGISLATIONANDTREATIES/PDFFILES/TZA_pe_nal_code.pdf)
- [15] Heady, C. (2018) Factors Influencing Intimate Partner Violence Screening by Rural Texas Emergency Room Nurses-PHD Dissertation-Texas.

## Abbreviation

CDC—Center for Disease Control and Prevention  
 DHIS—District Health Information System  
 GBV—Gender Based Violence  
 IPV—Intimate Partner Violence  
 PEP—Post Exposure Prophylaxis  
 PF3—Police Form Number three  
 STI—Sexual Transmitted Infection  
 SV—Sexual Violence  
 TDHS—Tanzania Demographic and Health Survey  
 TT—Tetanus Toxoid  
 US—United States  
 WHO—World Health Organization