Needs Assessment Report: Insights from AANHPI/MENA-Serving Community Health Centers

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community health synergy

apigbv
ASIAN PACIFIC INSTITUTE ON GENDER-BASED VIOLENCE

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

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We also acknowledge the leadership provided by Community Health Synergy, Asian Pacific Institute on Gender-Based Violence (API-GBV), and the Association of Asian Pacific Community Health Centers (AAPCHO) team members to support the execution of this project.

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INTRODUCTION

In January 2024, the Asian Pacific Institute on Gender-Based Violence (API-GBV), in partnership with the Association of Asian Pacific Community Health Organizations (AAPCHO) and Community Health Synergy (CHS), undertook a critical initiative to strengthen the support offered to community health centers (CHCs) serving Asian/Asian American, Native Hawaiian, and Pacific Islander (AANHPI), and Middle Eastern and North African (MENA)[1] survivors of gender-based violence (GBV).

Through the formation of the AANHPI/MENA Collaborative to End Gender-Based Violence, the three organizations recognized the importance of elevating the unique needs, challenges, and strengths of CHCs working across a broad and diverse geographic landscape—including the continental U.S., Hawai'i, and the U.S. Affiliated Pacific Islands.

To better understand and address these needs, the Collaborative launched a national needs assessment focused on GBV prevention and response within CHCs serving AANHPI and MENA communities. This assessment employed a multi-method approach, utilizing a survey completed by 18 CHCs, a focus group with 8 CHC cohort members, and 5 key informant interviews with CHCs. The goal was to generate actionable insights into how community health centers deliver culturally responsive, survivor-centered prevention and intervention services, identify gaps in existing systems, and highlight emerging best practices.

The findings outlined in this report are intended to guide future programmatic directions for CHCs, inform national training and technical assistance strategies, shape policy and research opportunities, and facilitate stronger partnerships. By centering the voices and expertise of CHC staff and leadership, this needs assessment represents a pivotal step toward bridging service gaps and strengthening the capacity of health centers to respond to and prevent gender-based violence within AANHPI and MENA communities nationwide. Through these efforts, the Collaborative remains committed to building a more equitable, inclusive, and supportive landscape for all survivors of gender-based violence.

[1] Throughout this report, Middle Eastern and North African (MENA) communities include but are not limited to the following communities: Arab, Azerbaijani, Kurd, Turk, Egyptian, and other Middle Eastern and North African nations. Another way to refer to this region in terms of its geography is SWANA or Southwest Asian and North African. Most non-governmental agencies include Central Asian, West Asian, and some South Asian countries for their religious, cultural, or linguistic similarities. Historically, the U.S. Census has categorized MENA as White. However, the lived experiences of MENA people in the U.S. often do not align with those of non-MENA White communities.

METHODS

Sample of AANHPI/MENA-Serving Community Health Centers

This study was directed at all community health centers in AAPCHO's network across the U.S., Hawai'i, and the U.S. Affiliated Pacific Islands that serve AANHPI/MENA communities. A comprehensive list of these CHCs was compiled using AAPCHO's membership list of 31 CHCs as well as AAPCHO's Community Health Worker Workforce Collaborative which included 5 non-member CHCs and 34 culturally specific health-focused community-based organizations. CHC leaders and staff members who were responsible for gender-based violence prevention services were encouraged to participate, including roles such as Community Health Workers, Health Advocates, Social Workers, Physicians, Nurse Practitioners, Physician Assistants, Program Supervisors, Program Managers, and Program Coordinators. A total of 39 individuals representing 21 unique CHCs and 2 CBOs participated in the study. Table 1 illustrates organizations' participation in the needs assessment by data collection method.

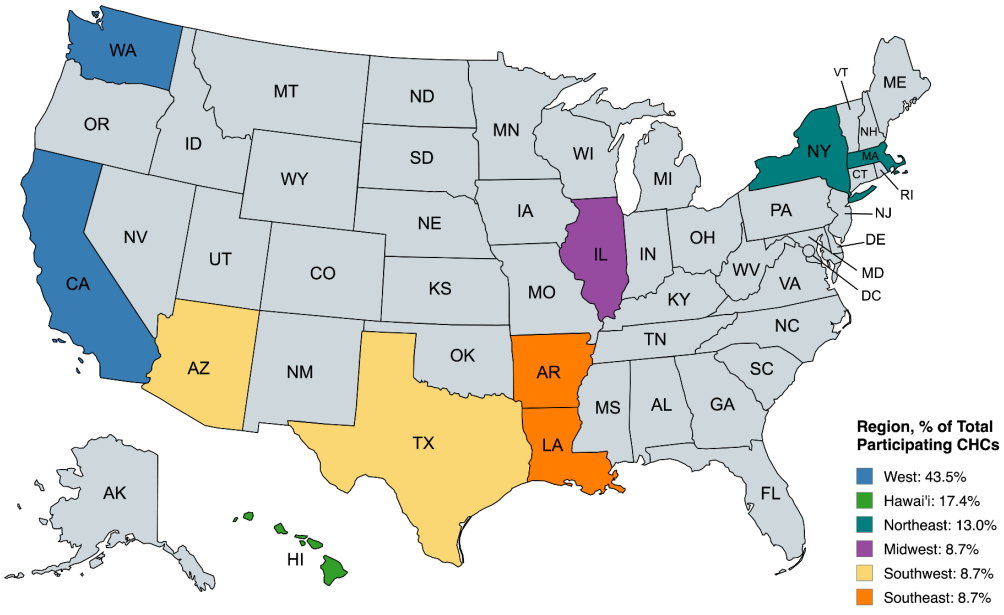
Table 1: Organizational Participation in Needs Assessment (n=number of CHC or CBOs)

State	CHC or CBO Identifier (n=23)	Survey (n=18)	Focus Group (n=8)	Key Informant Interviews (n=5)
AR	CHC#1		X	
AZ	CBO#1	X		
CA	CHC #2	X		X
CA	CHC #3	X		
CA	CHC #4	X		X
CA	CHC #5	X		X
CA	CHC #6	X		X
CA	CHC #7	X		
CA	CHC #8	X		
CA	CHC #9	X		
CA	CHC #10	X		
HI	CHC #11		X	
HI	CHC #12	X		
HI	CHC #13	X	X	
HI	CHC #14	X		
IL	CHC #15		X	

IL	CBO#2	X		
LA	CHC #16	X		
MA	CHC #17	X	X	
NY	CHC #18	X	X	
NY	CHC #19	X		X
TX	CHC #20		X	
WA	CHC #21		X	

Geographic Distribution

Of the 23 CHCs participating in the survey, focus group, and/or key informant interviews, there was a wide range of geographic focus areas. CHCs were located across 9 U.S. states, and as shown on the map below, all regions, except the Pacific Islands, were represented. The majority of responses came from the West (43.5%), followed by Hawai'i (17.4%) and the Northeast (13.0%).



Survey Development and Administration

Survey Development

The 2024 CHC Needs Assessment Survey was developed by Community Health Synergy in collaboration with project partners, API-GBV (including their advisory committee) and AAPCHO to capture quantitative and qualitative data on GBV prevention, screening, and response activities across CHCs. The survey (see here for a reference copy of the 2024 CHC Needs Assessment Survey) included 25 questions related to individual and organizational demographics, patient populations, types of GBV assessment and interventions, patient and community needs, partnership opportunities, and training and technical assistance needs. Draft survey questions were reviewed by members of the API-GBV Advisory Council to ensure clarity, inclusivity, and relevance. Council members were invited to provide feedback on the content, wording, and framing of survey items as well as suggestions for improvement. This input helped refine the survey to better capture CHC needs and inform meaningful follow-up strategies.

Survey Data Collection Procedures

The survey was administered online via SurveyMonkey from May to July 2024, allowing participants the flexibility to answer as many or as few questions as they chose. The survey link was distributed as a QR code through an AAPCHO email and newsletter campaign that began in May 2024, reaching leaders and staff from 32 member CHCs, as well as an additional 5 non-member CHCs and 34 AANHPI-serving health-focused community-based organizations. The survey included a cover page explaining the purpose and goals of the survey followed by 25 questions described above. Follow-up emails were sent to CHCs that did not complete the survey, and the survey link was reposted to AAPCHO's newsletter every month for the duration of the campaign. Data collection closed3 months after the original administration. In total, survey respondents represented 16 CHCs and 2 CBOs out of the 36 CHCs and 34CBOs invited to participate, resulting in a 25.7% response rate. This response rate is reasonable considering that CHC staff face significant demands on their time and resources, making it challenging to prioritize survey completion alongside other pressing responsibilities.

Focus Group and Key Informant Interview Guide Development and Administration

Focus Group and Key Informant Interview Guide Development

The 2024 CHC Focus Group Guide and Key Informant Interview Guide were also developed by Community Health Synergy in collaboration with project partners, API-GBV and AAPCHO. A semi-structured discussion guide was used to elicit detailed perspectives on successful strategies, cultural adaptations, barriers, resource needs, and priorities related to GBV services. In addition, cohort members shared which aspects of GBV-related training and technical assistance, whether from this Collaborative or other sources, were most impactful for their

teams. See here for a reference copy of the 2024 CHC Needs Assessment Focus Group Guide and here for the Key Informant Interview Guide.

Focus Group and Key Informant Interview Data Collection Procedures

Focus Group: Community Health Synergy facilitated a 1-hour focus group with members of the AANHPI/MENA Collaborative to End Gender-Based Violence CHC Cohort on March 20, 2025. Nine participants included staff and leaders representing 8 CHCs serving AANHPI and MENA communities. The focus group was held virtually on Zoom, audio-recorded with participant consent, and supported by a notetaker to ensure accurate capture of responses. Open-ended questions encouraged in-depth discussion, while the group format allowed for dynamic exchange of ideas, shared experiences, and the identification of common themes. The transcript was anonymized and analyzed using thematic analysis to extract key insights and illustrative quotes, which informed the overall findings and recommendations of the report.

Key informant interviews. All survey respondents were invited to participate in key informant interviews to more deeply explore the same domains explored in the focus group including current strategies, cultural adaptations, barriers, resource needs, and priorities related to GBV services. 6 staff members representing 5 CHCs accepted the invitation to participate in semi-structured key informant interviews conducted by CHS between April and August 2025. Interviewees included directors, program managers, social workers, and frontline providers with direct experience in GBV response. Interviews were conducted by Community Health Synergy and each session was audio-recorded with participant consent, transcribed, and anonymized to ensure confidentiality. The process emphasized open-ended questions and allowed for in-depth exploration of both organizational practices and personal perspectives, providing rich qualitative data to inform thematic analysis and recommendations.

Analysis Methods

Data sources

The quantitative analysis utilized a spreadsheet exported from SurveyMonkey containing item-level responses for all participants. Qualitative analyses utilized transcripts from the focus group and five key informant interviews with staff and leadership from 13 CHCs participating in this needs assessment. Prior to analysis, the transcripts were cleaned by removing non-essential data, including timestamps, filler words, and system-generated messages. Unclear or inaudible sections were identified, and the original recording of the focus group or interview was referenced to fill in gaps. The final cleaned version of the transcript was reviewed by internal staff and approved for analysis.

Analytical approach

Patterns in the survey data were synthesized to identify areas of common concern as well as unique needs, providing a foundation for interpreting organizational priorities and informing

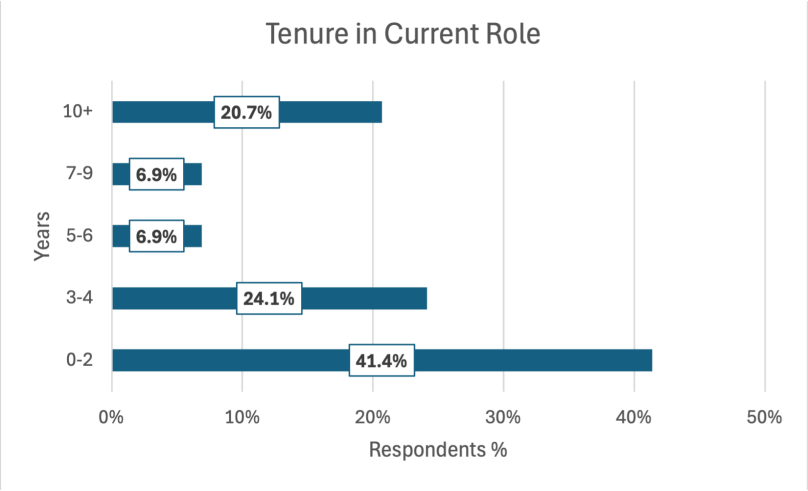
subsequent recommendations. For focus group and key informant interview data, a thematic analysis was conducted to examine strategies, challenges, and needs related to addressing GBV. Transcripts from the focus group and key informant interviews were reviewed multiple times to ensure familiarity with the content, after which meaningful excerpts were coded based on their relevance to areas such as support approaches, cultural tailoring, barriers to care, training needs, partnerships, and future priorities. Codes were systematically compared and grouped into broader themes and subthemes, allowing patterns and points of divergence across CHCs to be identified. To ground the findings in participants' perspectives, illustrative quotes were selected for each theme, and the coding framework was refined through iterative review and cross-checking to ensure consistency and accuracy.

SURVEY RESULTS

Description of the Respondents

Tenure in Current Role

Respondents varied in their length of service, with the largest proportion (41.4%) having served in their current roles for 0–2 years, indicating a relatively new workforce. Meanwhile, 20.7% had ten or more years of experience, suggesting a blend of fresh perspectives and seasoned expertise within these organizations.



Organizational Characteristics

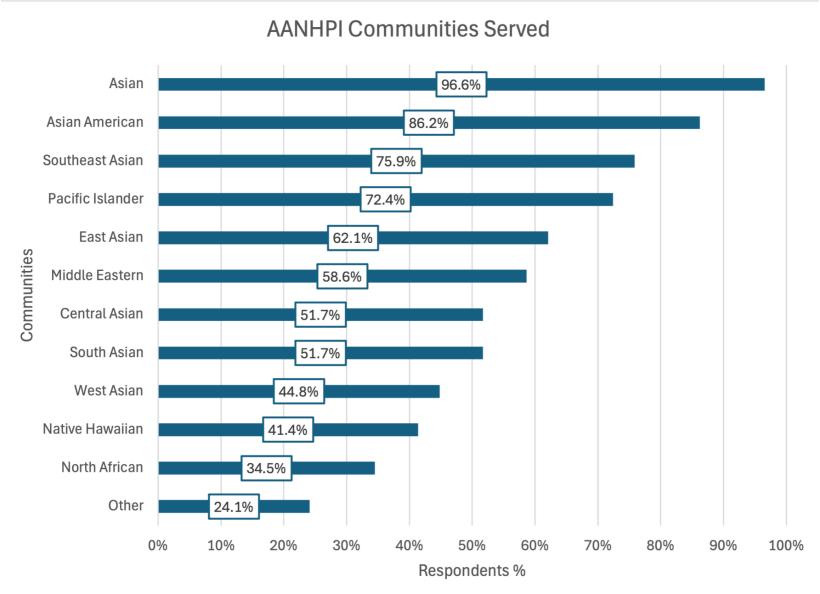
The survey asked respondents to classify their organization type by choosing from one or more classifications on the list. The results are shown below for the 18 organizational survey responses. Most participating organizations (83.3%) identified as Federally Qualified Health Centers (FQHCs), with 1-2 also functioning as a mental health facility, school-based health

center, or family planning clinic. Two organizations that did not identify as a FQHC identified as a community-based organization.

How would you describe your organization? Check all that apply. (n=18)		
Answer Options	Response Percent	Response Count
Community Health Center	38.9%	7
Federally Qualified Health Center	83.3%	15
Family Planning Clinic	5.6%	1
Mental Health Facility	11.1%	2
School-Based Health Center	5.6%	1
Other: Community-Based Organization/Community Service Non-profit organization	11.1%	2

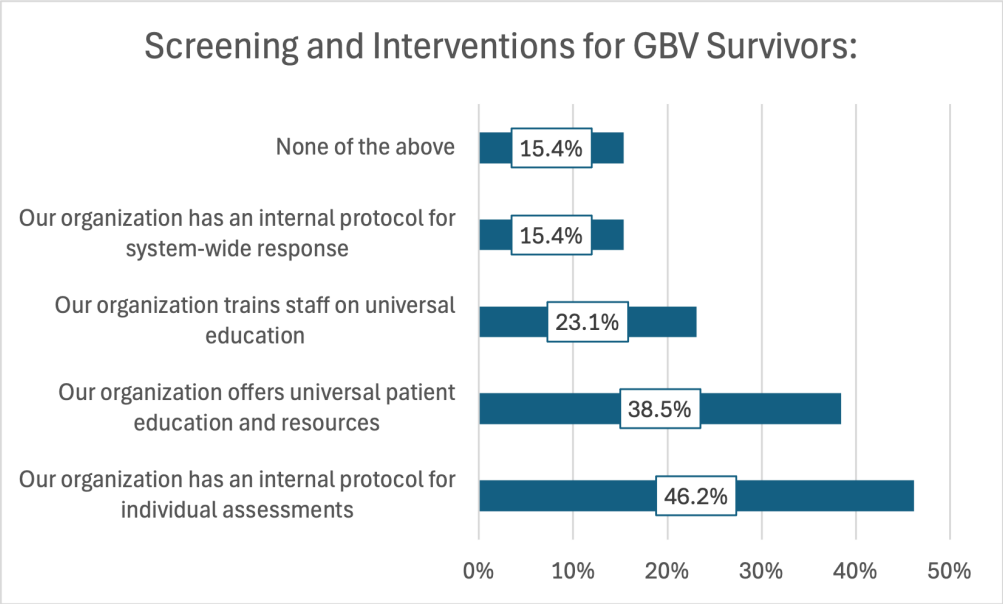
AANHPI/MENA Communities Served

The organizations surveyed serve a wide range of communities, with the majority serving Asian, Asian American, Southeast Asian, and Pacific Islander populations. Many also serve Middle Eastern, North African, and other groups, reflecting the cultural and linguistic diversity of their patient base.



Screening and Interventions for GBV Survivors

Nearly half of organizations (46.2%) reported having an internal protocol for individual assessments related to gender-based violence, making this the most commonly implemented measure. Universal patient education and resources were offered by 38.5% of organizations, while 23.1% indicated that they train staff on universal education practices. Fewer organizations (15.4%) reported having an internal protocol for system-wide response, suggesting that broader organizational strategies are less common compared to individual-focused protocols. Similarly, 15.4% of respondents stated that they have none of the listed measures in place, highlighting potential gaps in standardized approaches to addressing gender-based violence.



GBV Screening Tools Used

Several organizations reported using recognized tools to screen for gender-based violence. The Woman Abuse Screening Tool (WAST) and Partner Violence Screen (PVS) were the most commonly cited, each used by 28 respondents. The Abuse Assessment Screen (AAS) was reported by 2 respondents, while the Hurt, Insult, Threaten, and Scream (HITS) tool was the least common at 1 respondent. Some organizations shared that they did not use any of the listed tools but instead used their own screening protocols. Seven respondents were unsure which tools were used, indicating a need for greater clarity and training in this area. The seven respondents who were unsure of their organization's screening tools highlighted a critical opportunity for improvement. This gap suggests that technical assistance and training initiatives should not only promote evidence-based tools but also ensure staff members understand and can confidently identify the protocols their organizations employ.

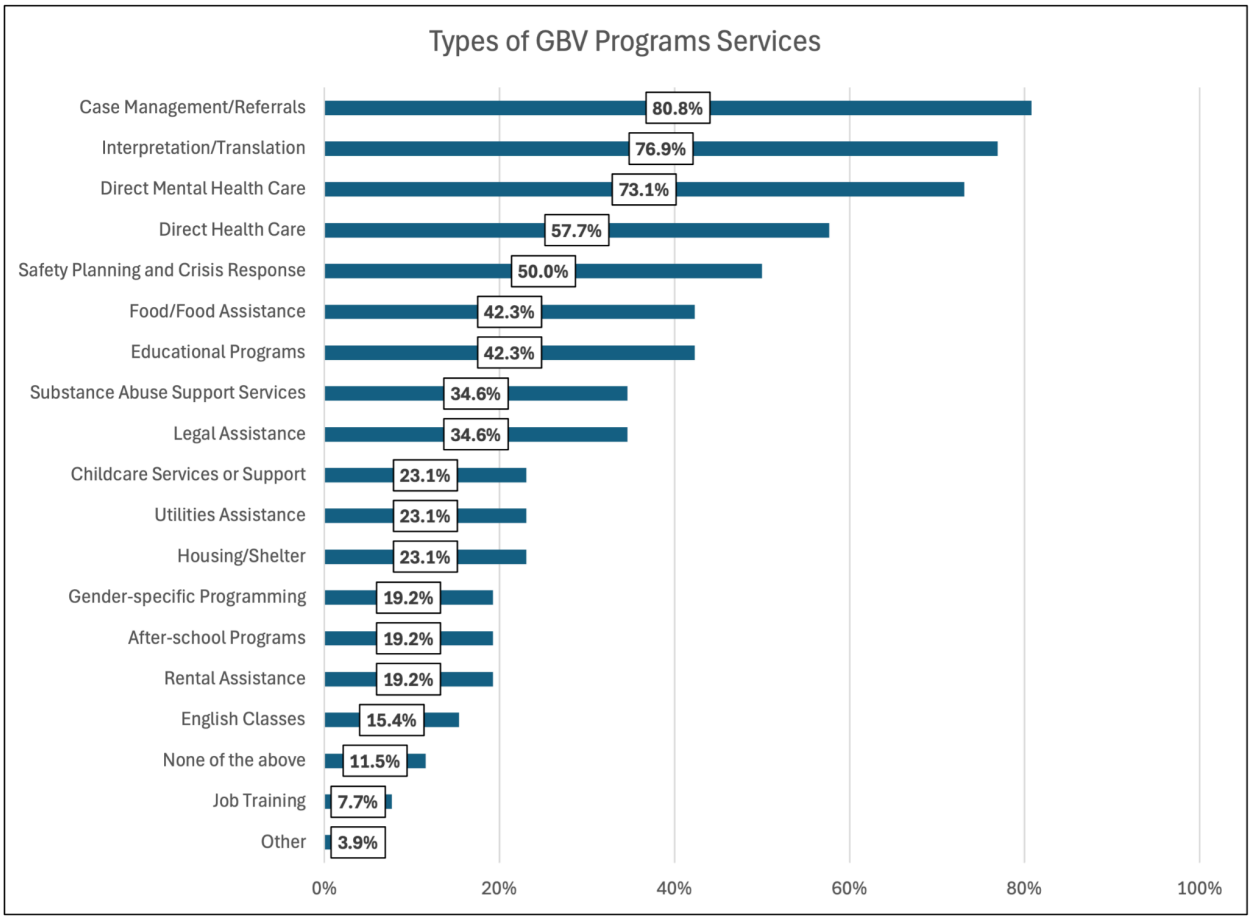
Other screening tools reported included:

- Commercial Exploitation of Children (CSEC) screening tools

- Victim Needs Screening Tool (VNST)
- Danger Assessment (DA)
- Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5)
- Adverse Childhood Experiences (ACEs) questionnaire
- Staying Healthy Assessment
- PRAPARE (a preventive health assessment tool)
- American Academy of Family Physicians (AAFP) screening resources

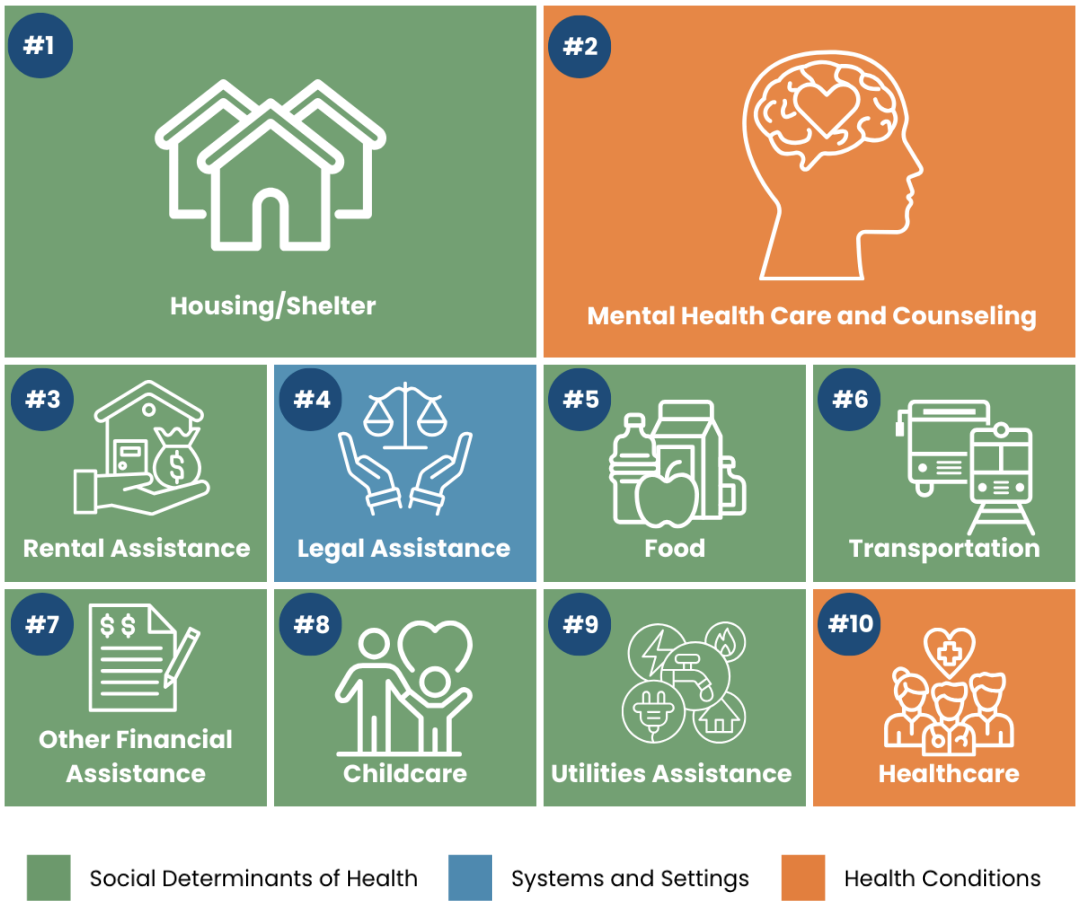
Types of GBV Programs and Services

Among the 26 survey respondents, the most commonly provided gender-based violence programs and services were case management and referrals (80.8%), interpretation and translation services (76.9%), and direct mental health care (73.1%). Other frequently offered services included direct health care (57.7%), safety planning and crisis response (50.0%), and educational programs (42.3%). Fewer organizations reported providing legal assistance (34.6%), substance abuse support services (34.6%), housing or shelter (23.1%), and childcare services (23.1%). The least common services were English classes (15.4%) and job training (7.7%). A small proportion (11.5%) indicated that they do not provide any of the listed services, and one organization (3.9%) noted offering other types of support, namely transportation, dental care, and medication-assisted treatment.

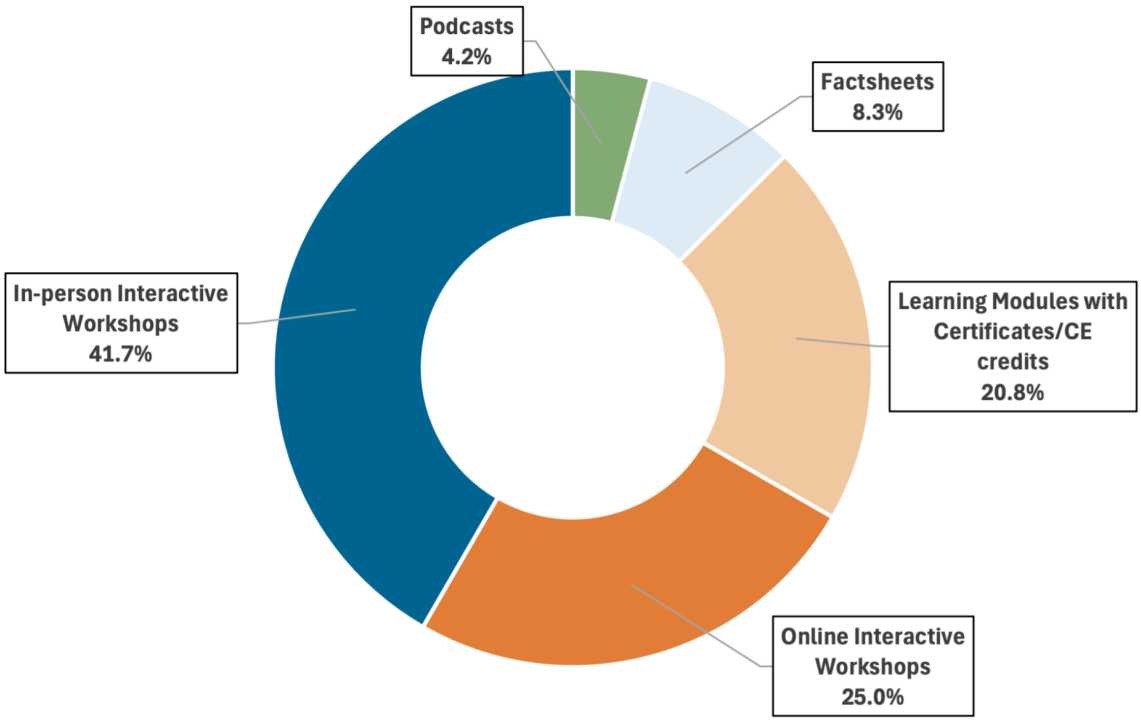


Patient Needs Related to GBV:
Respondents were asked to identify the most pressing needs in communities affected by gender-based violence. Housing and shelter ranked as the highest need (69.2%), highlighting their critical role in survivor safety. Mental health care and counseling followed closely (65.4%), emphasizing the need for trauma-informed support.

Other top needs included rental assistance and legal assistance (57.7% each), along with food (53.9%). Transportation, financial assistance, and childcare were ranked similarly at 50.0% followed by health care at 42.3%. Utilities assistance (38.5%) was identified less frequently but remains an important basic need.



Most Effective Communication & Learning Modes:
The most effective modes of communication and learning about gender-based violence were in-person interactive workshops (41.7%), followed by online interactive workshops (25.0%) and learning modules with certificates or continuing education credits (20.8%). Less commonly preferred methods included fact sheets (8.3%) and podcasts (4.2%), highlighting a strong preference for interactive and engaging formats over passive materials.



Challenges and Barriers:
Organizations face significant and multi-layered barriers in effectively screening for and responding to gender-based violence (GBV). Nearly half of the surveyed organizations, 46.2%, reported relying on internal protocols for individual assessment, yet 15.4% acknowledged having no screening or intervention protocol at all. Language and cultural differences are a pervasive challenge, with more than 96.6% of organizations serving Asian and Asian American populations and over 58.6% serving Middle Eastern communities, providers encounter wide-ranging linguistic needs and cultural stigma can discourage disclosure.

Time and resource constraints are also commonly cited, as staff often have limited capacity to engage in sensitive conversations about GBV during regular visits. Notably, only 23.1% of organizations provide universal staff training on patient education regarding GBV, while 15.4% reported having none of the listed measures in place highlighting potential gaps in standardized approaches to addressing gender-based violence. Safety and confidentiality concerns further complicate matters, particularly when patients cannot be assured of a private space during assessments.

Underlying these operational challenges are deep-rooted social norms and fears. Respondents described community reluctance driven by the fear of retaliation, possible ostracism, and the stigma attached to speaking openly about violence. This intersection of practical and cultural

barriers underscores the complexity of providing effective, survivor-centered GBV services in diverse health settings and highlights the ongoing need for clear protocols, adequate resources, and sustained cultural competency efforts.

FOCUS GROUP AND KEY INFORMANT INTERVIEW RESULTS

The results presented below are a comprehensive qualitative analysis of strategies, challenges, and emerging needs among CHCs addressing GBV in AANHPI and MENA communities. These were identified by a total of 15 individuals (9 focus group participants and 6 key informant interviewees). The results are organized by 6 identified major themes and their related subthemes (and number of participants who spoke to each subtheme, represented by *n*), along with illustrative quotes, to provide a nuanced understanding of both common practices and unique innovations across health centers spotlighting the voices and experiences of those working on the front lines of GBV response and prevention.

Theme 1: Successful Approaches to Supporting Survivors

1. **Theme 1.1: Community Partnerships and Resource Navigation (n=5).** Participants described the importance of leveraging partnerships and external resources to support survivors of GBV. It was often noted that relationships with other organizations enabled them to address a wider range of survivor needs, especially when their own resources were limited. For example:

    "What has worked for us has been the community resources or the other organizations that we're able to tap into." (Community Health Worker, Focus group participant)

    "We partner with the other four organizations in the area that provide DV services. Sometimes we might not have shelter, and we have to go and say, 'We have this. Do you have a shelter so that you can take this patient?'" (Director, Key informant interviewee)

    "Having a workforce of CHWs who have that experience of working with survivors or patients who have experienced DV, and language translation and interpretation, is really critical." (Community Health Worker, Focus group participant)

    These partnerships often included formal referral agreements, shared training opportunities, and collaborative problem-solving to address urgent needs such as shelter, legal assistance, and language access.

2. Theme 1.2 Trauma-Informed and Patient-Centered Care (n=3). A trauma-informed approach was widely recognized as foundational to an effective GBV response. Participants

emphasized the need for individualized care, flexibility in workflows, and the creation of safe environments for disclosure:

> *"Trauma-informed care, that approach is still very much important across the populations and understanding how you build your spaces and train your staff so that you are accounting for these different types of traumas." (Director, Focus group participant)*
>
> *"We serve all patients. We don't say one or the other. What we do is we have a screening that we give out—cure cards." (Director, Key informant interviewee)*
>
> *"The provider can refer through the EMR or call us, so we can come to see the patient in the exam room—a warm handoff." (Director, Key informant interviewee)*
>
> This approach was often paired with regular debriefs and support for staff, acknowledging the emotional toll of GBV work and the importance of team resilience.

3. **Theme 1.3: Workflow and Protocol Standardization (n=3).** Clear, actionable protocols were described as essential for ensuring consistent and effective responses to disclosures of violence. Regular review and revision of these protocols helped participants adapt to changing needs and integrate lessons learned:

> *"For my social services team, we do have protocol as far as workflow on how we can address this, especially for those when we're doing outreach." (Director, Key informant interviewee)*
>
> *"My goal is to revise our policy and procedures, which haven't been touched in a few years. I'm including information on staff expectations—what to do if we identify a situation.... Not just policy, but also procedure: what do you do, what are the next steps?" (Program Manager, Key informant interviewee)*

Theme 2: Cultural Tailoring and Responsiveness

1. **Theme 2.1: Linguistic and Cultural Competency (n=6).** Providing linguistically and culturally appropriate care was a recurring theme. Participants described recruiting staff who reflect the communities they serve, offering materials in multiple languages, and prioritizing cultural humility in interactions:

   > *"Almost 80% of the Health Center team speaks another language. We have annual cultural competency training. We also treat patients as if they are our own families." (Director, Key informant interviewee)*
   >
   > *"Even being able to connect a community health worker with the Khmer-speaking patient or that Spanish-speaking patient made it much easier." (Program Manager, Focus group participant)*

"We offer our forms in the respective native language of the patient. If we identify that they do not have one, we make sure the patient gets access to the written language they need." (Program Manger, Key informant interviewee)

These efforts were seen as critical for building trust, reducing stigma, and facilitating disclosure.

2. **Theme 2.2: Culturally Rooted, Survivor-Centered Frameworks (n=2).** Integrating cultural practices and employing staff with shared backgrounds was highlighted:
   "Most effective strategies for supporting victims and survivors of gender-based violence, particularly among the AANHPI and MENA communities, are grounded in culturally rooted, survivor-centered frameworks. We use peer-to-peer human spaces, intergenerational dialogue, and language-accessible advocacy that prioritizes community-defined safety. The youth programs are co-designed with our young, predominantly Southeast Asian women and girls, many of whom are survivors themselves, ensuring that the intervention is not only trauma-informed but is culturally congruent." (Program Manager, Key informant interviewee)

   "We adapt gender-based violence services by integrating cultural practices and community rituals, ceremonies, offerings, and programming in community languages, and employing staff from the Asian diaspora from similar cultural backgrounds as the youth/patients." (Program Manager, Key informant interviewee)

3. **Theme 2.3: Responsive, Needs-Based Support (n=3).** Meeting patients where they are, such as addressing basic needs and social determinants of health, and active listening were emphasized as means of building trust and respect over time:
   "We meet patients where they are. If they want housing, we help with housing. If they want food, we help with food. If they want rental assistance, we look for that. As primary care sees them regularly, we talk about the importance of getting those services, and they may open up." (Director, Key informant interviewee)

   "It's not culturally tailored services. Because we do respect the patients where they are coming from and what they are asking for by doing, listening, more of active listening." (Director, Key informant interviewee)

Theme 3: Barriers and Challenges

1. **Theme 3.1: Stigma and Cultural Norms (n=3).** Stigma and cultural expectations hinder disclosure and help-seeking:
   "*There's a lot of stigma. In the Asian community, they don't believe in going against their partner or it's wrong." (Community Health Worker, Focus group participant)*

"For certain cultures—Middle Eastern or Asian populations—it could be considered normal how couples treat each other, or family dynamics. Sometimes people don't want to report because they don't want to get their partner in trouble." (Director, Key informant interviewee)

2. **Theme 3.2: Resource and Funding Constraints (n=4).** Limited funding and resources impact service availability:
   "A lot of funding is being cut for domestic violence, and that affects the services we are providing." (Director, Key informant interviewee)

   "If every year the funding gets cut, it gets harder." (Director, Key informant interviewee)

3. **Theme 3.3: Workforce and Documentation Challenges (n=3).** Staffing shortages and technical barriers to documentation were noted:
   "Workforce is another barrier: do we have enough caseworkers to navigate the system with the victim? Once they decide to leave, that's just the start—legal, financial, school needs for children, etc." (Director, Key informant interviewee)

   "There was nothing in the medical record, in our EMR, that they could document specifically for this—what we might call a metric or diagnosis or condition." (Chief Operating Officer, Focus group participant)

Theme 4: Training and Technical Assistance

1. **Theme 4.1: Continuous Education and Skills-Building (n=5).** Ongoing, practical, and scenario-based training was valued:
   "*Twice a year, just like mandated reporter training, our DV team does a training for the whole Health Center team—from the front to the back—because we don't know where the patient is going to land." (Director, Key informant interviewee)*

   "A lot of our community health workers are trained by the Lay Counselor Academy. They have a better approach about how to get sensitive information and how to carefully provide compassion during this information gathering process." (Director, Key informant interviewee)

2. **Theme 4.2: Coaching and Ongoing Technical Assistance (n=2).** Regular check-ins and technical support were seen as highly beneficial:
   "What has been most helpful and impactful? I appreciate the slides, the webinars, the gathering, but specifically the one-on-ones with Rhodora and Deia. We've set up ongoing check-ins, and that has been the most impactful for me—the touch points.

We're going to work on setting up our protocols, a working protocol, get the committee set up. It gives us a chance to remove all the noise, focus in on the intentional questions. They are my navigators on what needs to happen, what can happen, how to sustain…That has been most impactful given the landscape and environment. That's the support our organization needs and so I'm most appreciative." (Director, Focus group participant)

"The key is what we do after training to make it useful and how we track that." (Director, Key informant interviewee)

3. **Theme 4.3: Standardization and Leadership Buy-In (n=3).** The need for leadership engagement and standardized protocols was highlighted:
   "Right now, we have standardized annual training, but it's not very practical. If you encounter a situation, how do you ask the questions? It would be helpful to have widespread, practical training for everyone at [our health center] including clinic directors and C-suite leaders." (Director, Key informant interviewee)

   "Getting buy-in from our senior leaders. As a need service organization, our HIV prevention is robust, but now as an FQHC, we're trying to figure out how community-based programming will integrate with the larger FQHC." (Director, Focus group participant)

Theme 5: Partnerships and Collaborations

1. **Theme 5.1: Interagency Cooperation and Community Networking (n=4)**. Building and maintaining relationships with other organizations was a key strategy:
   "*We've connected with the Korean Community Center of East Bay. I have colleagues from SoCal now in the Bay Area, and we've reconnected." (Program Manager, Key informant interviewee)*

   "We have several domestic violence agencies we work with, some with shelters and staff who speak our patients' languages. We also work with Womankind." (Director, Key informant interviewee)

2. **Theme 5.2: Shared Learning and Convenings (n=2).** Sharing protocols, resources, and best practices was seen as valuable:
   "Meeting with other federally qualified health centers, or the API community, or any resources that they give, everybody creating a workflow, sharing those workflow policies and procedures—it helps." (Director, Key informant interviewee)

"To strengthen partnerships, we need shared language around culturally specific gender-based violence responses and support for convening regional coalitions focused on AANHPI youth." (Program Manager, Key informant interviewee)

3. **Theme 5.3: Expanding Referral Networks (n=1)**. Broadening access to legal, mental health, and shelter services was a priority:
   "Access to legal support services, mental health professionals trained in AANHPI cultural frameworks, and funding to co-host events with grassroots partners would help bridge gaps in our referral networks." (Program Manager, Key informant interviewee)

Theme 6: Future Priorities and Support Needs

1. **Theme 6.1: Sustaining and Expanding Services (n=3).** Maintaining current services and expanding reach were top priorities:
   "*Our goal—not only for next year, but for years to come—is to provide the same services that we are providing right now without cutting anything out." (Director, Key informant interviewee)*

   "Top priorities: strengthening protocols for different departments, expanding partnerships, and increasing training opportunities." (Director, Key informant interviewee)

2. **Theme 6.2: Workforce and Funding Stability (n=2).** Ensuring adequate staffing and funding for ongoing and new initiatives was emphasized:
   "I'd be interested to learn about grant opportunities to expand our program. Also, if there is data about staffing, that would be beneficial." (Chief Operating Officer, Focus group participant)

   "Our top priority is sustaining the prevention grant for another year. We've made great progress in the first year, but what comes in the second year?" (Director, Focus group participant)

3. **Theme 6.3: Innovation and Shared Learning (n=1)**. Interest in new approaches, data management, and collective problem-solving was expressed:
   "I'd love to hear what other FQHCs are doing in regards to domestic violence documentation and things that are going to be done for informed consents. Now that a lot of organizations are also using scripts like AI scripts and all that." (Director, Key informant interviewee)

   "If, every quarter, every six months, FQHCs can get with an agenda and then meet and talk about the challenges and how they overcame those challenges. New laws are coming out all the time, and how are you keeping up with that but also providing the

services that you are supposed to provide? That would be the best learning—learning from each one of us." (Director, Key informant interviewee)

KEY RECOMMENDATIONS

Based on the comprehensive needs assessment findings of CHCs addressing GBV in AANHPI, MENA, and allied communities, the following recommendations are proposed to strengthen and sustain effective GBV response and prevention efforts:

Support future AANHPI/MENA serving CHC cohorts to receive GBV-related training and technical assistance

To enhance GBV prevention and response efforts, it is crucial to provide ongoing, culturally tailored training and technical assistance. Many CHCs have implemented regular, comprehensive training for all staff, ensuring that everyone, from front office to clinical providers, is prepared to respond to GBV disclosures. Staff have also benefited from scenario-based learning and specialized training programs that focus on sensitive information gathering and compassionate care. Technical assistance has also played a key role, helping CHCs address challenges related to confidentiality, documentation, and the use of new technologies.

Emphasize partnership building between CHCs and culturally specific community-based organizations (CBOs) focused on GBV

Strengthening partnerships between CHCs and culturally specific CBOs focused on GBV is essential for providing comprehensive support. CHCs have developed close collaborations with local domestic violence organizations, enabling timely referrals and resource sharing, especially when immediate needs such as shelter or legal assistance arise. These partnerships also facilitate shared learning and joint initiatives, broadening the network of support for survivors and enhancing service delivery for those facing multiple barriers.

Strengthen GBV prevention efforts

Prevention strategies should include the adoption of evidence-based interventions such as the CUES model (Confidentiality, Universal Education + Empowerment, Support). Some CHCs have integrated universal education and safety planning into routine care, ensuring that all patients receive information and resources related to GBV, regardless of disclosure. Approaches like warm handoffs and proactive support have made it easier for survivors to access help without needing to disclose abuse directly, increasing the reach and impact of prevention efforts.

Support funding for culturally specific activities and staff well-being

Sustained and increased funding is vital for maintaining culturally tailored activities, survivor-centered programs, and staff well-being initiatives. CHCs have experienced the negative impact of funding cuts, which can reduce services and increase staff burden. Ensuring adequate resources allows organizations to recruit and retain staff who reflect the linguistic and cultural backgrounds of their patient populations and to provide mental health and peer support to reduce burnout. Funding stability also supports the continuation and expansion of critical services for underrepresented groups, including LGBTQ+ survivors and refugees.

Develop a resource repository

There is a need for a centralized, user-friendly resource repository containing up-to-date training materials, policy templates, and culturally relevant educational content. CHCs have found value in having access to forms and resources in multiple languages as well as sharing workflows and protocols with peer organizations. A comprehensive repository, including web-based tools, online workshops, and learning modules, would accommodate diverse learning styles and ensure broad access to best practices and support materials.

Next steps for future needs assessments

Ongoing needs assessments should be conducted to ensure that GBV programs remain relevant and effective. These assessments should be inclusive, capturing the experiences of smaller or underrepresented groups within AANHPI and MENA communities. Expanding outreach to CHCs and CBOs in diverse regions will help identify unique challenges and inform the refinement of training, technical assistance, and resource development. By regularly evaluating needs and incorporating feedback, CHCs can adapt their strategies to better support survivors and advance health equity in their communities.

By implementing these recommendations, CHCs can build capacity, foster collaboration, and provide comprehensive, culturally responsive, and sustainable support for survivors of gender-based violence in AANHPI and MENA communities.