

Help-Seeking Pathways and Barriers for Survivors of Gender-based Violence in Tanzania

Results from a Study in Dar es Salaam, Mbeya, and Iringa Regions

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***Help-Seeking Pathways and Barriers for Survivors of
Gender-Based Violence in Tanzania: Results from a Study
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List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
CBO	Community-based organization
CCM	Chama Cha Mapinduzi (Tanzanian political party)
CDO	Community Development Officer
CHAMPION	Channeling Men's Positive Involvement in the National HIV/AIDS Response
CHW	Community health worker
CSO	Civil society organization
DDH	District designated hospital
DHS	Demographic and Health Survey
DMO	District Medical Officer
FBO	Faith-based organization
FP	Family planning
GBV	Gender-based violence
GoT	Government of Tanzania
HIV	Human immunodeficiency virus
ICRW	International Center for Research on Women
KII	Key informant interview
LGA	Local government authority
MCHN	Maternal and Child Health and Nutrition
MCDGC	Ministry of Community Development, Gender, and Children
MoHSW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health and Allied Sciences
NBS	National Bureau of Statistics Tanzania
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFG	Participatory focus group discussion
PF3	Police Form 3
SOSPA	Sexual Offenses Special Provisions Act
SPA	Service provision assessment
STI	Sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
UDSM	University of Dar es Salaam
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VEO	Village Executive Officer
WEO	Ward Executive Officer
WHO	World Health Organization
WLAC	Women's Legal Aid Center
WRC	Ward Reconciliation Council

Executive Summary

During the last few decades, gender-based violence (GBV) has gained international recognition as a grave social and human rights concern. In Tanzania, GBV is widespread; the most recent Tanzania and Demographic Health Survey (TDHS) found that 44% of ever-married women have experienced physical and/or sexual violence from an intimate partner in their lifetime.¹ In response to the high prevalence of violence and inadequate support services for survivors of GBV, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has launched a multi-sectoral intervention in three regions of the country: Dar es Salaam, Iringa, and Mbeya. The five objectives of the intervention are to:

- Increase the availability, quality, and utilization of GBV services;
- Reduce societal acceptance of GBV and strengthen protective factors;
- Improve the enabling/policy environment for the GBV response;
- Improve coordination of the national GBV response; and
- Improve the GBV evidence base.

To inform the design of PEPFAR's initiative by its implementing partners, the International Center for Research on Women (ICRW) and the Department of Sociology and Anthropology within the University of Dar es Salaam (UDSM) conducted a qualitative study in the three targeted regions. The study aimed to document community perceptions and attitudes about GBV, identify the range of informal and formal services currently available to GBV survivors, highlight gaps in service provision, and provide recommendations for improving existing services.

For this study, GBV was defined as violence perpetrated against women and was limited to physical or sexual violence by an intimate partner, and sexual violence perpetrated by anyone, including strangers, acquaintances, neighbors, and family members.

The research team conducted 104 key informant interviews (KIIs) with a wide array of stakeholders, service providers, and duty bearers at the national, district, and ward levels as well as participatory focus group discussions (PFGs) with 96 male and female community members.

Key Findings

Many acts of violence are considered socially acceptable.

Overall, respondents had a relatively high awareness of what constitutes GBV, and were able to list a range of violent behaviors. However, participants identified many types of GBV that were perceived to be acceptable within their communities' social and cultural norms. Respondents across sex and age groups also described a common set of violent acts regarded as "unacceptable" or "extreme" that merit a response such as reporting the incident to the police or other help-seeking channels. The unacceptable forms of GBV

¹ National Bureau of Statistics (NBS) & ICF Macro. (2011). *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS and ICF Macro.

included rape by a stranger, the threat or use of a weapon, forced anal sex, and severe physical abuse by a husband or partner.

Help-seeking from any source is very low.

One of the most important findings is that violence is infrequently reported to anyone, including medical personnel or the police. This is consistent with national statistics that indicate the low prevalence of help-seeking among survivors of GBV. The results powerfully highlight the normative influences and structural barriers that prevent most women from seeking any help after experiencing violence and from receiving appropriate care if they do seek help.

Survivors are expected to rely on the family for help.

Findings from “Pathways of Help-Seeking” maps drawn by PFG participants and ensuing discussions revealed that even when a survivor does seek help, her pathway frequently begins and ends with the family. For example, a married woman who experiences partner violence is expected to first speak with her husband’s family members. While some mechanisms exist for family meetings to address such marital issues, the ultimate goal of any actions taken is to reconcile the marriage, and not necessarily to address the woman’s needs or concerns. It is only when a problem cannot be solved within the survivor’s family or immediate social network that a survivor might consider seeking help from external or more formal sources of support.

Formal support services for survivors are limited outside Dar es Salaam, particularly in rural areas.

More comprehensive services for GBV survivors are increasingly available in Dar es Salaam, including Gender and Children’s Desks in police stations and several promising civil society interventions, such as the Women’s Legal Aid Centre (WLAC). However, women’s awareness of and access to care and support services – local government, healthcare, police, and legal assistance – were all limited in study sites outside Dar es Salaam particularly in the rural districts examined.

Help-seeking frequently follows a circuitous pathway.

Formal referral networks that integrate services across sectors are also virtually non-existent, making it extremely difficult for those survivors who do seek care to navigate the system. The pathways maps, discussions, and KIIs also revealed that referrals are required at every step, creating bottlenecks and lengthy delays in getting care and exposing survivors to potential re-traumatization as they are required to narrate their experience on repeated occasions. The result is in an exceedingly slow, cumbersome process that neither prioritizes a survivor’s needs nor responds to violence as an emergency situation.

Help-seeking patterns depend on age, marital status, and the type of violence.

Overall, older women were more reliant on traditional and informal sources (e.g., elders and religious leaders) whose support was frequently characterized by an emphasis on maintaining silence and “enduring.” In contrast, younger women reported experiencing more support and encouragement from their friends to seek help from formal sources. For unmarried girls, the available options were more restricted given that their relationships are

not formally recognized. However, even in the case of rape, because of shame and stigma, the help-seeking pathway may still end at the level of family or social networks.

Receiving adequate care, support, and justice is impeded by socio-cultural and structural barriers.

A host of socio-cultural and structural barriers prevent survivors of GBV from seeking help and from obtaining appropriate services if they decide to enter help-seeking channels. Socio-cultural barriers include women's lack of awareness of their fundamental right to live free of violence and to seek justice in cases of violence, the community's acceptance of violence as "normal," and women's fear of being blamed for reporting rape. Women also fear the social and economic consequences that may result from reporting their husbands to local authorities, including the escalation of violence or being left without financial support in the case of divorce.

Structural barriers include direct and indirect costs, distance to formal providers (particularly for women in rural areas), and corruption. Corruption, for example, can prevent a woman from accessing justice if the perpetrator has the means to "pay off" the police or local government official, or if extra payments/bribes are demanded beyond the required cost of a particular service. Lack of quality care and support due to delays in service provision, lack of proper protocols, and inadequate training of service providers in GBV are further structural barriers. Finally, there is a notable gap in psychosocial services for survivors across all provider types and sources of support.

Conclusions and Recommendations

The study revealed a number of critical gaps in providing appropriate support to women who have experienced GBV. These gaps were found across geographic sites, but barriers to help-seeking and access to care were especially prevalent in rural sites and those outside of Dar es Salaam. Based on participants' input and analysis of the data collected, the current research has developed a comprehensive set of recommendations to improve the response to GBV across all sectors and levels of government. While the present study did not focus explicitly on prevention, several of the recommendations for responding to the needs of GBV survivors—if implemented effectively—will further strengthen Tanzania's efforts to prevent and eliminate GBV. Below is a summary of the key recommendations, which are discussed in greater detail at the end of this paper.

Address socio-cultural barriers to help-seeking by survivors of GBV.

The study recommends the strategic inclusion of a series of targeted awareness raising and community mobilization initiatives to overcome the most prominent socio-cultural barriers that constrain women from seeking and receiving help. Based on the study evidence, campaign messaging will need to emphasize: violence as a misuse of power, even within relationships; the need to support rather than stigmatize survivors; the role that community members can play in preventing and responding to GBV; and how and where survivors can access support services.

Address structural barriers to help-seeking by survivors of GBV.

Strategies are required for removing key structural barriers, including direct service costs, distance to providers, and the circuitous nature of the system that responds to GBV.

Eliminating the official corruption and bribery described by study participants will require a concerted and coordinated effort by each of the sectors involved (healthcare, police, local government), and the commitment of the legal sector to enforce penalties for providers or duty bearers who request bribes to facilitate services for survivors of GBV.

Improve quality of care for survivors of GBV.

To improve the quality of care received by survivors from all key sectors, the Government of Tanzania (GoT) and PEPFAR implementing partners will need to focus on improving the training provided, integrating GBV screening and comprehensive care into existing structures, and strengthening coordination among service providers and referral systems.

Increase access to justice for survivors of GBV.

These recommendations focus on eliminating two key barriers to help-seeking and receiving appropriate support through scaling up advocacy efforts to have coerced sex by partners (including marital rape) as an offense in the penal code, and expanding the range of providers who can complete a Police Form 3 (PF3), the primary legal document for reporting GBV. In tandem with legal reform, training will need to be widely instituted to raise awareness among government authorities, civil society, healthcare professionals, and the general public about the laws that protect women's rights and punish perpetrators of violence.

Part I: Background

A. Context of GBV in Tanzania

During the last few decades, gender-based violence (GBV) has gained international recognition as a grave social and human rights concern. In Tanzania, GBV is widespread. In the 2010 TDHS, over 20% of Tanzanian women aged 15-49 years reported having experienced sexual violence in their lifetime and nearly 40% reported having experienced physical violence.² The same survey showed that 44% of ever-married women had experienced physical and/or sexual violence from an intimate partner in their lifetime. Disaggregated data for GBV among women in the regions examined in the current study are shown in Table 1. A nationally representative survey of violence against children also found that nearly 75% of girls and boys had experienced physical violence (either by an adult or intimate partner) by the age of 18 years, and that nearly 3 in 10 girls had experienced sexual violence before reaching adulthood.³

Region	Ever experienced physical violence	Ever experienced sexual violence
All Tanzania	38.7%	20.3%
Dar es Salaam	31.8%	24.1%
Iringa	42.3%	26.5%
Mbeya	48.8%	30.8%

Source: NBS et al. (2011).

Despite this high prevalence of violence, formal support services for survivors are inadequate. Although there is a growing awareness of GBV and increased efforts at a policy level to address the issue, survivors' access to health, psychosocial, and legal services remains limited. For example, there are few known shelters for survivors in Tanzania and these are predominantly located in Dar es Salaam.⁴ Moreover, an overall shortage of trained medical professionals in the country has implications for the availability of GBV-specific care.

To increase the availability and quality of services available to survivors of GBV in Dar es Salaam, Iringa, and Mbeya, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has launched a multi-sectoral intervention based on five key pillars: 1) services; 2) prevention and community protection; 3) advocacy; 4) coordination; and 5) research and evaluation.

² NBS et al. (2011).

³ United Nations Children's Fund (UNICEF), Centers for Disease Control and Prevention (CDC), & Muhimbili University of Health and Allied Services (MUHAS). (2011). *Violence against children in Tanzania: Findings from a National Survey 2009*. Dar es Salaam: UNICEF, CDC, & MUHAS. August 2011.

⁴ Betron, M. (2008). *Gender-based violence in Tanzania: An assessment of policies, programs, and promising interventions*. Washington, D.C.: USAID Health Policy Initiative.

The Channeling Men's Positive Involvement in the National HIV/AIDS Response (CHAMPION) Project is one of the key implementing agencies of this PEPFAR intervention. The overall CHAMPION Project works to promote and implement research, programs, and policies that engage men to address pressing public health problems in Tanzania, including GBV. In concert with other PEPFAR implementing partners in Tanzania, CHAMPION is working to scale up the response to GBV in the three PEPFAR priority regions of the country: Dar es Salaam, Iringa, and Mbeya through direct interventions or technical assistance to partners. As indicated in Table 1 (above), the prevalence of physical and sexual violence in these three regions is largely on par or higher than the national average.

B. Study Objectives

In order to increase the availability, quality, and utilization of GBV services, CHAMPION and other partners will need to understand the strengths and gaps in existing support services as well as community needs and potential barriers to care. This study was designed to inform the overall design of PEPFAR's initiative to scale up the response to GBV in Tanzania. This research was motivated by three key objectives:

- 1) To understand community perceptions of GBV and related patterns of and barriers to Help-Seeking;
- 2) To profile the range of services that currently exist for survivors of GBV in select districts of Dar es Salaam, Iringa, and Mbeya; and
- 3) To identify current gaps and opportunities in the provision of services to survivors of GBV in the target regions.

It is important to note that while the first component aimed to understand community-level perceptions and needs, the research was not intended to capture the lived experiences of actual survivors. Rather, the study focused on capturing perceptions, patterns, and barriers from the perspectives of male and female community members, irrespective of their experiences of violence. It is also important to note that for the purposes of this research and in alignment with the focus of PEPFAR programming priorities, (i.e., GBV related to sexual and HIV-related risks), the definition of gender-based violence used by this study was:

Violence perpetrated against women, limited to physical or sexual violence perpetrated by an intimate partner and sexual violence perpetrated by anyone, including strangers, acquaintances, neighbors, and family members.

The present research did not include questions about childhood sexual abuse or child rape to ensure the study retained a tight focus and because recent qualitative research has already been conducted in Tanzania on those topics.⁵

⁵ See UNICEF et al. (2011)

C. The Legal and Policy Framework for GBV in Tanzania

The development and passage of the following two key policies in 2011 represent important milestones and clearly indicate that the GoT is increasing its attention on GBV:

- 1) The *National Policy Guidelines for the Health Sector Prevention of and Response to Gender-based Violence*, which outline the roles and responsibilities of the MoHSW and other stakeholders in the planning and implementation of comprehensive GBV services; and
- 2) The *National Management Guidelines for the Health Sector Response to and Prevention of Gender-based Violence (GBV)*, which provide a framework for standardized medical management of GBV cases and aim to strengthen referral linkages between the community and providers.

In addition, a national clinical training curriculum is under development, which will include GBV screening protocols. While the MoHSW has taken the lead on these policy initiatives, the Ministry of Community Development, Gender, and Children (MCDGC) has also demonstrated its commitment to addressing GBV, most notably by establishing a national multi-sectoral committee on violence against women and children, and developing a community sensitization strategy.⁶

However, while the principle of gender equality is enshrined in the Tanzanian constitution (1977) and more recent legislation upholds this commitment (e.g., the Land Act and Village Land Act, 1999), legal protections against GBV are limited. The recent Sexual Offenses Special Provisions Act, 1998 (SOSPA) criminalizes various forms of GBV, including rape, sexual assault and harassment, female genital cutting (for girls aged 18 years and younger), and sex trafficking. However, marital rape is not recognized as an illegal act. The Law of Marriage Act (revised 2002) prohibits “corporal punishment” against a wife. However, this Act also fails to recognize marital rape and does not provide legal protection for unmarried women against bodily harm. Moreover, by not providing a definition of “corporal punishment,” the law is open to interpretation and excludes non-physical forms of violence (e.g., psychological violence). While some aspects of economic violence are addressed under this law—for example, fathers have the responsibility to provide child support—the law is not specific on the penalty for non-compliance, and other forms of economic violence are excluded altogether. The Law of Marriage Act further allows for child marriage (at 15 years of age with parental consent), which is another common form of gender-based violence perpetrated against women in Tanzania.⁷

Since launching its GBV initiative in 2010, PEPFAR has been collaborating closely with the Government of Tanzania to address GBV. By the end of the three-year project, Tanzania will

⁶ Fleischman, J. (2012). *Gender-based violence and HIV: Emerging lessons from the PEPFAR initiative in Tanzania*. Washington D.C.: Center for Strategic and International Studies, July 2012.

⁷ Human Development Trust. (2011). *Gaps in policies and laws that perpetuate gender based violence in Tanzania: An analysis and synthesis by Human Development Trust (HDT), Final report*. Dar es Salaam, June 2011.

have received \$21 million, with the aim of providing comprehensive services to survivors of GBV via PEPFAR HIV platforms and strengthening community-based responses and referral networks, for example, through the CHAMPION project.

Part II: Research Methodology

This study was designed and carried out over a 12-month period by a research team from the International Center for Research on Women (ICRW) and the University of Dar es Salaam (UDSM), Department of Sociology and Anthropology. ICRW developed the research protocol and instruments, and provided training to the Research Assistants in close coordination with the UDSM Principal Investigators. The full research team pilot tested and refined these instruments before the field work was carried out by the UDSM team. To ensure that findings would reflect diverse perspectives and that the research process actively engaged stakeholders in dialogue and reflection, the study utilized a participatory research approach to collect and triangulate the data of interest. The details of the methodology employed are described below.

A. Data Collection Methods

The study was carried out in selected districts of Dar es Salaam, Iringa, and Mbeya regions to document community perceptions and attitudes about gender-based violence, identify the range of services available for survivors of physical and sexual GBV, highlight gaps in service provision, and make recommendations for improving existing services. The full set of research questions for the study can be found in **Annex 1**.

The research questions were addressed through qualitative research methods, including key informant interviews (KIIs) and participatory focus groups discussions (PFGs) developed by ICRW. The field work was carried out by a team of trained researchers and research assistants from the UDSM Department of Sociology and Anthropology.

Each KII entailed approximately one hour of conversation structured around an interview guide developed for the study. A wide array of stakeholders, service providers, and duty bearers at the national, district, and ward levels were recruited for the research, as detailed in Section B below. The target groups included national health officials, healthcare providers, the police, social workers, duty bearers (magistrates, members of local councils, etc.), local government authorities, representatives from government health facilities, non-governmental organizations (NGOs), community-based organizations (CBOs), civil society organizations (CSOs), faith-based organizations (FBOs), as well as community leaders or informal groups that typically support survivors of violence.

Participatory focus groups were conducted with male and female community members at each site. This format is based on the traditional focus group discussion of approximately eight participants. Each group had a facilitator and a note taker. However, ICRW strategically incorporated participatory techniques such as community mapping, incomplete stories, and interactive ranking exercises to make these sessions more accessible and

enjoyable for participants. Such PFGs provide study participants with a forum to reflect upon the risks and realities that are present in their communities. They have been used by various disciplines to harness the voices of marginalized and disenfranchised sub-populations. The ICRW team had previously applied these participatory research methods to explore sensitive topics including sexual violence and reproductive health risks in Tanzania.⁸ These techniques are increasingly recognized as effective strategies to actively engage participants (including marginalized/stigmatized groups and individuals with varying educational levels), and generally allow for a greater sense of ownership and collaboration in the research. In addition, by validating experiences, ideas, and opinions, the participatory discussions can be an empowering process for participants.

For this study, PFGs were conducted with same sex and age groups (women 18-24 years, women 25 years+, men 18-24 years, men 25 years+) of 8-15 individuals in each of the three study sites. The sessions lasted an average of two hours per session. GBV survivors were not actively recruited for these discussions; however, given the prevalence of violence in the country, it is likely that individual survivors as well as friends and family members of survivors participated in the groups.

Throughout the research process, the ICRW and UDSM teams strictly adhered to the *WHO Safety and Ethical Guidelines for Researching Violence Against Women*. All safeguards were taken to ensure the protection of research participants, as laid out in the research protocol approved by the ICRW's Institutional Review Board and UDSM's Directorate of Research and Publications. Additionally, the protocol was reviewed by representatives of the Ministry of Health and Social Welfare (MoHSW), the EngenderHealth Monitoring and Evaluation team, and several PEPFAR implementing partners in Tanzania. Confidentiality, anonymity, and the avoidance of re-traumatization related to experiences of violence were emphasized in the protocol development, training of the research team, and throughout data collection and analysis.

Please see **Annexes 2 and 3** for the Key Informant Interview Guides and **Annex 4** for the Participatory Focus Group Guide.⁹

B. Sample Description

As set forth in the approved research protocol and in line with the programmatic priorities of the PEPFAR partners in Tanzania, the data collection was carried out in one urban and one rural district in each of the three targeted regions: Dar es Salaam, Iringa, and Mbeya. A stakeholders' meeting was held prior to finalization of the district selection to solicit input from the key government agencies associated with GBV programming: MoHSW, MCDGC, and TACAIDS. Hence, the selection of the districts was made in consultation with GoT national representatives, regional Community Development Officers, and with reference to a

⁸ See for example: McCleary-Sills, J., Douglas, Z., Rwehumbiza, A., Hamisi, A., & Mabala, R. (2011). *Vijana Tunaweza Newala: Findings from a Participatory Research and Action Project in Tanzania*. Washington, D.C.: International Center for Research on Women.

⁹ These tools are included for illustrative purposes only. Training on the use of these methods developed by ICRW is strongly advised.

directory of service providers compiled by MUHAS.¹⁰ The following criteria were applied in selecting the districts:

- Relatively high concentration of services

The team decided that the rural district selected should have a sufficiently high concentration of services to ensure that the targeted number of service providers was available for inclusion in the study.

- Geographic considerations

The rural district selected should be sufficiently far from the urban district to ensure that the rural community was not accessing services located in the urban center.

While the selection of districts according to these criteria is straightforward for Iringa and Mbeya regions, Dar es Salaam region comprises three urban districts. As such, the team made the decision to include the Districts of Ilala and Temeke in field work and Kinondoni for pilot testing. However, those organizations identified as providing services or leadership on gender-based violence at the national level were included in the sample irrespective of their location in Dar es Salaam. The rural district selected for Mbeya was Rungwe, and, for Iringa, the rural Mufindi district was included.

The process of identification of duty bearers, stakeholders, and service providers for the KIIs began with directories of civil society organizations and health providers given to the research team by CHAMPION and the Regional Community Development Officer (CDO) from Dar es Salaam, Mbeya, and Iringa. From this starting point, the team carried out a structured snowball sample to expand the number and range of informants in the final sample. In each region, the District Medical Officer (DMO) assisted in selecting and contacting the healthcare providers in the sample. Similarly, the Regional and District Administrative Secretaries granted permission for the research team to talk with Ward Executive Officers (WEOs) and Ward Reconciliation Councils (WRCs) in each area.

During each interview, respondents were asked to provide the names of other potential key informants and relevant agencies/organizations with whom the research team could speak to next. As a result of this phased snowball sampling strategy, the final sample included 104 key informants as follows:¹¹

- 15 public and private healthcare providers (7 Iringa, 3 Mbeya, 5 Dar);
- 8 WRC members (2 Iringa, 3 Mbeya, 3 Dar);
- 7 Police Gender and Children's Desk Officers (2 Iringa, 3 Mbeya, 2 Dar);
- 39 NGO/CBO/FBO representatives (12 Iringa, 16 Mbeya, 11 Dar);
- 12 ward/local leaders (3 Iringa, 5 Mbeya, 4 Dar); and
- 23 representatives from the MoHSW, MCDGC, and Ministry of Education and Vocational Training (MoEVT).

¹⁰ MUHAS, Department of Psychiatry and Mental Health. *Mapping of child protection services in Tanzania*. 15 December 2010-8 July 2011.

¹¹ In accordance with the informed consent process and approved research protocol, participants' details are not provided to protect their confidentiality.

In addition to this large sample of KIIs, a total of 96 individuals (48 men and 48 women) participated in 12 PFGs (four groups per region). Recruitment of these participants was conducted by the team of trained researchers from UDSM in close consultation with local leaders once the selection of research sites was complete. Potential participants were invited by the field research team to participate in a discussion about violence in their communities. For both KIIs and PFGs, informed consent was obtained by the research team prior to beginning each discussion, and the voluntary nature of participation was emphasized throughout the interview/focus group. In accordance with the informed consent process and approved research protocol, the KIIs and PFGs were audio recorded. Recordings were transcribed into Kiswahili, and then all of the PFGs and a selection of KII recordings were translated into English.

Notes were also taken by Research Assistants during the KIIs and PFGs using a standardized data summary form to ensure consistency. The research team reviewed the summary forms at the end of each day to assess the extent to which key themes had been addressed. If thematic gaps were identified, these themes were prioritized for subsequent interviews. Once all the data had been collected, the research team carried out analysis workshops to identify patterns and points of disagreement related to the key findings. This layered analysis allowed for iterative validation of the data within and across the sessions as well as the three target regions, and provided the foundation for the recommendations presented in Part IV of the report.

It is important to note that the selection of study sites was guided by PEPFAR prioritization of Dar es Salaam, Mbeya, and Iringa. As such, the resulting sample was not intended to be representative of all of Tanzania, but was a purposive sampling of the highest priority areas for intervention for CHAMPION and other PEPFAR partners. Only one ward per each priority district was included in this sample, and these were intentionally those wards with evidence of higher reporting of GBV and/or a higher concentration of existing services for survivors of GBV.¹² As a result of the study's selection criteria, sampling strategy, and time/budgetary limitations, the sample does not provide an exhaustive list of the services available for GBV survivors in each of the study sites. This is particularly true with respect to healthcare providers; the study captured only an illustrative cross-section of public and private providers at each level (health center, hospital, etc.). In the rural areas the sample more closely approximates the full range of providers available as there are fewer providers of health or social services. Across sites, however, the sample does capture the range of services available and the typical pathways for seeking help in each of the sites, as well as the most common socio-cultural and structural barriers to help-seeking.

¹² This determination was made in consultation with the District Community Development Officers and the District Social Welfare Officers.

Part III: Results

A. Community Perceptions of Violence

Societal acceptance of GBV is widespread in Tanzania; a recent assessment of GBV policies and services in Tanzania found that several forms of GBV, including intimate partner physical and sexual violence and rape, are “seen as normal” and “met with acceptance” by both men and women.¹³ Similarly, the 2010 TDHS found that more than half (53.5%) of women and more than a third (38.1%) of men agree with at least one justification for wife beating.¹⁴

The present study aimed to further explore these perceptions and document the norms that influence GBV reporting, help-seeking, and responses. This part of the paper presents results from the PFG exercises, which explored three key questions:

- What acts or behaviors constitute GBV in the community?
- Which of these acts are considered within the range of socially and culturally accepted norms?
- What forms of GBV are not tolerated by women and their communities?

Sub-section 1 presents findings on the types of violent acts identified by participants as GBV and perceptions on their acceptability within community norms. Sub-sections 2 and 3 then provide further detail on the types of violence generally perceived to be acceptable and those deemed to be unacceptable.

The study also aimed to assess the extent to which perceptions on the acceptability of different types of GBV were consistent between men and women, urban and rural residents, and older and younger participants. Where notable differences were found, these are highlighted in sub-section 4 below.

1. Community Definitions of GBV

Overall, respondents had a relatively high awareness of what constitutes GBV and identified a range of violent behaviors during the free-listing exercise. Throughout the discussions, however, participants described many types of GBV that are acceptable within the social and cultural norms of their communities. While this does not imply that *individuals* condone these acts, the normative environment suggests that violent behaviors are common and largely accepted as a part of relationships, marriage, or the social roles occupied by men and women. It is also important to note that there was no clear consensus within or across gender lines about which types of GBV to include under which category of acceptability.

¹³ Betron. (2008).

¹⁴ The five justifications for wife beating included in the TDHS are: i) burns the food; ii) argues with him; iii) goes out without telling him; iv) neglects the children; and v) refuses to have sex with him. NBS et al. (2011).

Figure 1 illustrates the wide range of acts identified by PFG participants as examples of gender-based violence, categorized according to community perceptions of their acceptability. In the outer sphere are those acts that, while considered forms of GBV, were described by PFG participants as “normal,” “common,” and/or “acceptable” within their social context. For many, behaviors such as insulting or yelling at a woman, restricting her freedom, having an extramarital affair, or imposing different forms of economic violence against women do not constitute violations of a woman’s rights. The middle sphere includes forms of GBV that were described by PFG participants as common but less acceptable within their communities. The refusal to pay child support or acknowledge a child, in particular, are acts that are likely to invoke a response from local leaders. The inner sphere of the diagram illustrates those forms of GBV that were consistently described as unacceptable when they were included in the free-listing exercises. The forms of violence underlined in red in the diagram were among those prioritized *a priori* for exploration through this study.

Figure 1: Community Definitions of Gender-based Violence



2. Acts of GBV Perceived to be Common or Acceptable

Among the acts of violence that were widely considered to be common, acceptable, and/or normal, there was a range of emotional, economic, physical, and sexual violence. Participants’ views on the social acceptance of four frequently mentioned forms of violence—extramarital affairs, being beaten by a partner, economic violence, and public humiliation—are discussed in detail in this sub-section.

Extramarital affairs

Extramarital affairs were identified by PFG participants as a common but widely accepted behavior, and overwhelmingly this was framed as men having mistresses or multiple partners. The classification of this act ranged from being seen as showing disrespect towards a woman to a form of GBV.

Having mistresses, that is direct disrespect.

Female PFG participant (18-24 years old), Dar es Salaam

In our area I have seen problems and even our elders have seen them. There is a relative of mine, I have witnessed him saying that if you see a woman is a nuisance to you then you marry another. After that she will respect you and all the problems she was causing will end.

Male PFG participant (25+ years old), Mbeya

As illustrated by the quotes above, female participants were more likely to label having mistresses or taking second wives as unacceptable but common. In contrast, male participants described it as normal and even expected behavior, particularly as a lesson to wives who were seen to be “misbehaving.”

Being beaten by a partner

Physical violence is largely viewed as part of marriage. Women explained that they come to expect and even accept this violence because of prevailing community norms. Women who divulge an experience of physical abuse to friends or family members quickly learn that their experience is not an anomaly.

Yes, it's normal, being beaten, yelled at. If you tell (anyone), your peers will ask you, "Is this your first time to be beaten?" Some of us are used to it, just like the way we are used to eating ugali.¹⁵

Female PFG participant (25+ years old), Mbeya

(If you say) Mama I have been beaten, you will be told, "Very sorry, that has been there for a long time." If you are hit, the response will be that it is normal, just bear with it.

Female PFG participant (18-24 years old), Dar es Salaam

Both male and female participants raised the issue of provocation and blame in domestic abuse. Across gender and age groups there was a shared perception that any time a woman goes against her husband (disobeys him), she risks being beaten. At issue is the man's degree of “tolerance” for her behavior. At the core of this idea is a sense that women are at fault for any violence they experience because they have somehow provoked their partners into beating them:

A man will not accept to see a woman who is not giving him respect or is disobeying his commands. This leads to misunderstanding which leads to throwing words at each other or fighting.

Male PFG participant (25+ years old), Mbeya

It is very common if you refuse his orders you will be beaten. When he denies to start a business and you do it anyway, you will be beaten. If you conceive/give birth and defend yourself that it wasn't your plan but God's, you will be beaten. Whatever you do that seems to be wrong to him will lead into you being beaten up.

Female PFG participant (18-24 years old), Dar es Salaam

¹⁵ *Ugali* is a ground maize meal, a traditional staple food in Tanzanian culture.

It depends how angry I am. You can control her by simple slapping because she has gone against your former routines and how you live. You start by yelling at her and if she reacts then you change the style and slap her a bit.

Male PFG participant (25+ years old), Mbeya

Economic violence

Participants described a number of forms of economic violence; the most frequently mentioned was depriving a wife of basic needs, including clothing and food. In the female PFGs, participants shared a sense that the expectation for a man to be the provider and breadwinner are now changing, and, as a result, the failure to provide for his family isn't viewed as an unusual occurrence.

Not being provided with clothes and food is really seen as only a normal thing; nobody sees that you are being harassed, being abandoned. He abandons you, he goes away. Next day if he sees things are smooth he comes back in the evening, and caring for the family.

Female PFG participant (25+ years old), Iringa

For example, a man can leave you with the responsibility of taking care of the family and when you tell somebody she tells you, "It's normal, bear with it."

Female PFG participant (18-24 years old), Dar es Salaam

As mentioned earlier, the Law of Marriage Act requires men to provide maintenance for their children. However, neglecting to do so is not deemed a criminal offense. In addition, proof of paternity can be difficult, particularly for women with limited resources and knowledge of testing procedures. This disconnect in the legal framework may help to explain the growing trend of economic violence, as men are gradually absolved of the responsibility of providing for their wives and children.

Being humiliated in public

Insults, name calling, yelling, and threats were all listed as forms of GBV, most prominently in the female PFGs. When these acts were carried out within the home, they were seen as normal and widely accepted. However, when carried out in public, these acts cross a threshold into unacceptable behavior because they are a form of public humiliation for the woman.

Being harassed in public is common and threats are also common. Being beaten in public is also a common thing.

Female PFG participant (25+ years old), Iringa

Similarly, the issue of denying a child's paternity was mentioned in several groups as an act of violence (in the form of humiliation) that is common but for which there is a locally accessible recourse for the woman. As defined by female PFG participants, this act escalates into unacceptable GBV when it is done publicly and causes a woman embarrassment:

That is his legally married wife, that means he has children with her, if he denies them saying they are not his children, then in front of the community he is humiliating her.

Female PFG participant (25+ years old), Iringa

It is important to note that there was some disagreement across and even within groups about where to draw the line of defining verbal abuse as violence. For some, this critical line is crossed only when it becomes a physical act carried out in public:

It depends with the mind of a man; he may be your husband but follows you to your place of working and starts beating you in public; that is violence.

Female PFG participant (25+ years old), Mbeya

3. Acts of GBV Perceived to be Unacceptable or Intolerable

In contrast to the types of GBV largely viewed as acceptable within community norms, PFG respondents across sex and age group described a common set of violent acts regarded as "unacceptable" or "extreme" within their communities. These unacceptable acts require a response such as reporting the incident to the police or other forms of help-seeking. Unlike other types of violence, survivors of these "unacceptable" actions often experience community support and greater receptiveness to help-seeking. While the specific acts listed varied across the PFGs, overall, there was an emphasis on severity and frequency of the act, as well as whether or not it occurred in public.

Rape

Rape by a stranger was defined by all groups as an unacceptable form of violence, especially rape of a child, which was explained as deserving of harsh penalties. However, across all groups, a critical distinction that determines help-seeking was made between being raped and forced sex, as illustrated by the quote below:

Rape is for someone who you are not related to, but being forced to have sex is when your sex partner can decide to have sex with you without your consent. When it is done by someone who is a stranger to you it becomes a big issue but if it is your sex partner you have to tolerate it because marital issues should remain inside.

Female PFG participant (25+ years old), Iringa

While both men and women overwhelmingly agreed with this distinction, one female PFG participant put forward the controversial idea that forced sex within a relationship should also be considered rape.

If I don't feel like having sex and he forces me, won't that be rape? Even if he is my husband, I don't feel like having sex and if he forces me then that is rape.

Female PFG participant (25+ years old), Mbeya

Given the Tanzanian legal and social contexts, which do not recognize marital rape, it is perhaps not surprising that the views expressed by this participant were not agreed upon by other members of her focus group.

Threats or use of a weapon

When threats or use of weapons was mentioned in PFGs, there was consensus that such acts crossed the threshold into being unacceptable forms of violence. This perception was attributed to the severity of the act itself as well as the risk inherent in the threat or use of a knife or other weapon:

To hold any weapon against somebody is not perceived as normal, holding a knife, machete, axe, all that is not normal... when it comes to holding a knife you leave and escape the possibility of being killed.

Female PFG participant (25+ years old), Mbeya

Being forced to have anal sex (even within a relationship)

In contrast to forced sex within a relationship, forced anal sex was viewed as completely unacceptable. This is due in large part to societal norms that make anal sex, even if consensual, a taboo. The degree to which it is considered unacceptable was underscored by the quote below, which describes that a woman's family would encourage and support her decision to leave a relationship in which forced anal sex had occurred:

If you are forced to have anal sex, that is not ok. Even your parents will tell you to ask for a divorce immediately and go back home. And they will stand by you all the way through.

Female PFG participant (25+ years old), Dar es Salaam

The subject of anal sex, forced or otherwise, was mentioned only in the female PFGs.

4. Differences in Participants' Perspectives on GBV by Sex and Age

Throughout the PFGs, several differences in the perceptions of participants by sex and by age emerged that were suggestive of changing attitudes towards violence. These patterns are described below.

Younger women are less tolerant of GBV

Younger women are less accepting of GBV as "normal" and more likely to take action if they are mistreated by men.

By the time a woman reaches 30 years she has gone through a lot of things. She has been beaten a lot, and I know that if she were to be slapped she would just sulk. But for a 17 year-old she would leave...She will no longer want to be with you. These [women] have a lot of problems. They are not tolerant.

Male PFG Participant (25+ years old), Dar es Salaam

The difference is that if she is 17 years old then the marriage will not last because of her lack of tolerance. That is why they [the marriages] end very fast. But if the woman is 30 years old up to 60 years most of these people when they are in a marriage are more tolerant and that is why I think that the marriage is more likely to last longer.

Male PFG participant (25+ years old), Dar es Salaam

As illustrated by the quotes above, there is a perception that older women get used to being beaten and so accept it, while younger women will leave if slapped by their partners. Interestingly, older women in PFGs had more difficulty in naming different forms of GBV unprompted and identified fewer acts as GBV. This resonates with the perception many younger women have, that older women are more likely to tolerate different forms of GBV, due in large part to the commitment already made and length of time in the relationship.

An older woman will just have to tolerate that because she already has a family.

Female PFG participant (18-24 years old), Dar es Salaam

She [a young woman] will go somewhere she has been advised to because she feels humiliated that she hasn't been able to do anything about it. The 60 year-old will basically keep quiet about it as she has lived with her partner for a long time and the community might be surprised if she does anything about it because of her age.

Female PFG participant (18-24 years old), Iringa

Younger men have knowledge about GBV

Generally, young male PFG participants were knowledgeable about GBV and were able to produce a list of violent behaviors and acts.

My understanding of what GBV is...for example...you can find a man is humiliating a woman, punishing her by cutting her and forcing her to do things that are not right to do or you give her a lot of responsibilities to do because she is a woman; that is my understanding of what GBV is.

Male PFG participant (18-24 years old), Mbeya

While this awareness among young men is likely a positive sign that national campaigns have been effective in increasing awareness of GBV, it does not mean that young men are intolerant of such violence or that they see it as a violation of a woman's rights. In fact, male PFG participants did not see all forms of GBV as problematic or worthy of action. They reported that sometimes men in their age group will use the prevailing social norms to get away with GBV against their girlfriends.

On my understanding if a boyfriend and a girlfriend are just friends, they are not married yet, therefore if you find her with another man and because your relationship is not yet recognized...So there is no other decision you can take rather than beating.

Male PFG Participant (18-24years old), Mbeya

As illustrated by this quote, young men are not worried about girlfriends reporting physical violence against them because having a boyfriend is not socially sanctioned behavior.

Violence against men is an overlooked concern

Men in both PFGs in Mbeya raised the issue of violence against men as a social problem that is common in Tanzania but is not talked about because of stigma and norms around masculinity.

You have said that GBV is only encountered by women but there are men in the same situation. The government preaches equal rights for all; we ask the government to consider men as well because nobody believes you if you say your wife has beaten you up.

Male PFG Participant (25+ years old), Mbeya

There are some women that have been very harsh towards their husbands. We cannot talk about it because it is believed that men are stronger than women.

Male PFG Participant (25+ years old), Mbeya

These norms create expectations that men will be strong and dominant in their relationships, making them invulnerable to abuse from their partners. While violence against men was not included as part of the scope of the present research, it is important to recognize that it occurs but is also veiled by a culture of silence.

B. Existing Services and Sources of Support

This section describes the profile of GBV services and types of support that emerged from the key informant interviews in Dar es Salaam, Iringa, and Mbeya. As described in the methodology, the research team interviewed service providers from civil society, health, legal and justice, and government sectors, as well as “informal” resource persons such as respected community elders and local leaders.¹⁶ While there is considerable variation in the services available across locations, the analysis below outlines the package of expected support for each provider type. Subsequently, in Sections C and D, the paper will discuss the socio-cultural and structural barriers to help-seeking as well as adequate service provision.

1. Family and Social Networks

Key informants consistently described the family as the first source of help-seeking for survivors of GBV. The family’s role is to offer advice, emotional support, and, in the case of domestic violence, help mediate between the woman and her husband. In general, married women are expected to first speak with their husband’s family members before reporting violence to the police. A frequent pathway reported by both service providers and community members begins with the marital family (often fathers, mothers, and brothers-in-law). If the issue remains unresolved, a survivor may then consult members of her natal family, and, subsequently, a family meeting can be arranged between both families. Other members of one’s social network—for example friends, neighbors, and respected elders—can participate in these meetings, acting as mediators and providing advice. While the structure and mechanisms of a family meeting differ by community, ultimately the goal is to find a solution and reconcile the marriage. Only when a problem cannot be solved within the family or immediate social network is it socially acceptable to approach external sources of support. For example, the following quotation illustrates the centrality of the family in addressing GBV.

She [a GBV survivor] was told to keep quiet because it will bring shame, and going to the police will humiliate their son. I intervened as a social worker but they [her in-laws] wanted to deal with it within the family, then I had to let go.

Duty Bearer, Mbeya

For unmarried women who experience intimate partner violence their source of help was not so much the family but rather, friends since their relationship was considered “not formal.” In cases of stranger violence the role of the family is primarily concerned with emotional support (rather than reconciliation) and linking the survivor to formal help-seeking channels.

¹⁶ While precise definitions of “formal” versus “informal” providers varied across informants, overall unpaid individuals or volunteers who do not work out of an office were most often described as informal, for example elderly members of the community considered to be “wise” and “respected.”

2. Local Government Authorities

Tanzania has a decentralized, multi-sectoral governance system which extends from the village to the regional level. While Tanzania has a long history of local governance, the current system is relatively new, based largely on the CCM election manifesto (1995) and the Local Government Reform Agenda (1996). According to a GoT policy paper on local government reform, LGAs have the following responsibilities: “social development and public service provision within their jurisdiction, facilitation of maintenance of law and order and issues of national importance such as education, health, water, roads and agriculture.” The discussion here includes only LGAs responsible for the direct provision of social services.

Survivors of violence turn to their local leaders primarily for advice, referrals (within the local government hierarchy as well as to healthcare facilities), and marital reconciliation services. In addition, some officials provide “temporary shelters,” although these are informal arrangements that often pose risk to both the survivor and provider (see subsection 5 below for more details). The system is clearly structured; the entry point for a help seeker is often the lowest-level representative, the Ten Cell Leader, who is selected from among a cluster of ten houses (more common in rural areas). While Ten Cell leaders were often cited as resource points for GBV services during the interviews, they are typically considered to be “informal” sources of support. As the hierarchy suggests, Ten Cell leaders offer the most basic level of care. If a help seeker is unsatisfied with the recommendations given by the Ten Cell leader, she can begin the process of appealing up the chain (with referral letters required at each step)¹⁷—to the village (Village Executive Officer or Street Leader in urban areas), ward (Ward Executive Officer and Ward-level Community Development Officer) and district levels (Social Welfare Officer). As one moves through the system, the LGAs become more powerful in terms of negotiating settlements, mandating payments (e.g., to compensate a woman whose property has been destroyed, or as a token reparation for the violence, for example, giving the survivor a *khanga* or *kitenge*¹⁸), and requiring an alleged perpetrator to attend reconciliation sessions. This process is summarized in Table 2.

¹⁷ While women may occasionally receive assistance from an LGA without a referral letter, in general, this hierarchy is respected and the established protocol is followed. Without a referral letter, a higher-level official will offer services only if adequate justification can be given and extenuating circumstances presented.

¹⁸ The *khanga* and *kitenge* are traditional printed cotton garments worn by women wrapped around the chest or waist, over the head as a headscarf, or used as a baby sling.

Level	Relevant official	Role and responsibilities related to GBV
Sub-village	Ten Cell leader	<ul style="list-style-type: none"> • Advice • Marital reconciliation/mediation • Provide referral letter to VEO • May offer temporary shelter
Village	Village Executive Officer (VEO) or Street Leader (urban areas)	<ul style="list-style-type: none"> • Advice and counseling¹⁹ • Marital reconciliation/mediation, including suggesting compensation • Provide referral letter to WEO • May offer temporary shelter
Ward	Ward Executive Officer (WEO)	<ul style="list-style-type: none"> • Advice and counseling • Marital reconciliation/mediation, including mandating compensation • Detain alleged perpetrator and/or send alleged perpetrator directly to a police post or station • May guarantee loans to a healthcare facility in the event that a survivor cannot afford services • Provide referral letter to WRC • Provide referral letter to police • Mandate the WRC to convene and hear a case • Make referral to District Social Welfare Officer
District	Social Welfare Officer	<ul style="list-style-type: none"> • Advice and counseling • Reconciliation/mediation, including negotiating child support • Mandate payment of compensation • May offer exemptions for medical bills/other payments • Provide referral letter to district court • Provide referral letter to police

¹⁹ Throughout the fieldwork respondents mentioned “counseling” services. In the vast majority of cases this does not refer to psychosocial support by a trained counselor, but rather as a synonym for “advice” or “legal counsel.” Occasionally psychosocial counseling was also mentioned. However, except when noted, this support is offered based on personal insights and experience rather than formal training.

An important finding that emerged strongly from the interviews with LGA officials was that the entire system is largely focused on restoring marital unions and preventing divorce. For example:

Some [women] do not even go to their Ten Cell Leader. They go back home to their parents to report that they are being beaten everyday by their husband...The parents [of a wife] will call the husband's parents for discussion... "Why is your son beating our daughter every day?"... but finally they reach compromise.

Service Provider, Mbeya

Apart from the health sector, what I know is that if a woman can go to the Ward Reconciliation Council and report that she is always beaten by her husband...but she doesn't want to take him to police, and that she wants to go back home [meaning back to her parents] then they [WRC] will say to her: "You cannot go back home without doing something, let us call him [husband] for reconciliation"... Then they (husband and wife) will reach compromise.

Service Provider, Mbeya

3. Legal and Justice Sector

Legal providers identified during the field work primarily include Ward Reconciliation Councils, Primary and District Courts, police officers, and legal aid services. Legal aid is most often accessed through private NGOs and is discussed under the civil society sub-section below.

The WRC is a dispute resolution body and is considered to be the most locally accessible tier in Tanzania's court system. The WRC mandate is, among other things, to provide marital reconciliation and mediation. They cannot handle divorce cases, however, matters unresolved in the WRC can be referred to Primary Courts.

Primary Courts—presided over by appointed magistrates—have limited jurisdiction and are mostly concerned with the application of criminal and customary laws. Divorce can be granted by Primary Courts and these courts also have the right of appeal. District Courts offer similar services as those provided in Primary Courts and their mandate includes arbitrating cases of sexual and physical violence. Because the country has no separate court for family matters, GBV cases are tried in general courtrooms alongside other criminal cases.²⁰ District Court appeals are heard in High Courts.

Police posts and police stations are also central to the legal system. With respect to GBV services, police stations are responsible for issuing a Police Form 3 (PF3) when an act of violence or a criminal offense has occurred. This form is required if the victim of a crime intends to take legal action against the alleged perpetrator/s, for example, through detention, mandating an individual to appear in front of the court, or arrest. For GBV, a survivor who files a PF3 will be asked to describe and document the incident at the police station and this form will be used as the basis of her case against the perpetrator. In 2008,

²⁰ Betron. (2008).

the police department piloted Gender and Children's Desks at police stations in Dar es Salaam in an attempt to offer more "woman-friendly" services. Gender and Children's Desks, staffed by male and female police officers, provide private locations for discussing sensitive matters—including GBV—and officers frequently offer escort services (for example, to the hospital), represent survivors in court, and may also provide temporary shelter at the police station or to a female police residence. However, the program has only recently expanded to districts beyond Dar es Salaam. Access for rural women remains limited.

4. Health Sector

Tanzania's public health system, administered by the MoHSW, is also decentralized. Community Health Workers (CHWs) operate at the village level; however, they are generally considered to only provide advice for maternal and child health issues. They were not mentioned in relation to formal GBV services during the course of this research.²¹ Health dispensaries provide the most basic level of care, and can assist a survivor with first aid for minor injuries. Most often they will refer GBV cases to a higher-level health facility with more comprehensive services. Health centers offer the next level of care and can treat a wider range of injuries, for example, those requiring incisions and drainage. While District Hospitals offer both inpatient and outpatient care and some basic laboratory testing, comprehensive services for GBV survivors are available only at selected health centers, District Designated Hospitals (DDH), District Hospitals, as well as referral hospitals. Depending on the capacity of the facility and the availability of supplies, these services can include post-exposure prophylaxis (PEP), HIV and STI screening and treatment, collection of forensic evidence, and counseling for cases of sexual assault. For physical injuries resulting from GBV, survivors will receive medical management of their injuries, including stitches, antibiotics, and wound dressing, and, in rare cases, counseling. Survivors who report GBV will be required to obtain a PF3 before they receive this care. However, a woman can choose not to report that her injuries were due to violence and will still be able to receive the necessary services.

In contrast to government-supported health facilities, private clinics and hospitals are not authorized or mandated to complete PF3 forms. As a result, their capacity to respond to cases of GBV is very limited. This is a serious constraint, given that an estimated one-third of health services in Tanzania are provided outside of the public system. The range of services provided by NGOs, FBOs, and other private organizations that operate health facilities varies according to the mandate of each organization and the specific center. In addition, Tanzania also has several Voluntary Counseling and Testing (VCT) centers that provide services for GBV survivors. However, to date, GBV has not yet been systematically integrated into these facilities.²²

According to the Tanzania Service Provision Assessment (SPA) conducted in 2006, the number of medical personnel (including doctors and assistant medical officers) per 10,000

²¹ No CHWs were interviewed for this study.

²² While no independent VCT centers were interviewed for this study, interviews with hospital-based providers who offer VCT highlighted the importance of including GBV-related services in VCT.

people is only 0.73 in Tanzania. While the density is substantially higher in Dar es Salaam (3.25), it is below the national average in Iringa (0.50) and Mbeya (0.32).²³

5. Civil Society

As efforts to address GBV continue to gain momentum, both at local and national levels, survivors of GBV are increasingly able to access support through civil society organizations. For example, several small NGOs, such as the Women's Legal Aid Centre (WLAC) and Kivulini, are highlighted in the USAID assessment as demonstrating promising practices in providing comprehensive services to survivors.²⁴ In particular, religious leaders and FBOs were often cited as offering advice and counseling to survivors. In addition, a number of women's rights, legal aid, and GBV-focused NGOs are offering targeted services for women who experience violence. Most commonly mentioned were legal aid providers (NGOs as well as community paralegals). These groups provide a range of services for women, such as offering legal advice/council, helping to complete PF3s, preparing documents for court, and providing legal representation. Many of these groups are focused on vulnerable women and offer waivers for court fees and other services. These are an important source of support for women who are aware of these services but the availability of such organizations is inconsistent across the study sites.

CBOs such as women's groups were also mentioned during the key informant interviews, specifically in providing access to loans for survivors who may not be able to afford services or may not report instances of GBV due to their economic dependence on men. However, such groups were mentioned only infrequently, and were not cited by PFG participants as serving a primary role in GBV service provision.

As described above, different avenues of support exist for survivors of GBV. However, variations in awareness of services, availability, and numerous other barriers often prevent women from help-seeking, and, for survivors that do seek assistance, from effectively navigating the system and receiving the care they require. Moreover, while referrals do take place within the government system (for example, a WEO may refer a survivor to the hospital or a nearby police Gender and Children's Desk), formal referral networks that integrate across services are virtually non-existent. Sections C and D explore common pathways of help-seeking and the myriad constraints identified by this research.

²³ National Bureau of Statistics (NBS). (2006) *Tanzania Service Provision Assessment Survey 2006*. Dar es Salaam, Tanzania: NBS and Macro International Inc.

²⁴ Betron. (2008).

C. Pathways of Help-Seeking

Given the context of limited services and a normative environment that is largely accepting of GBV, it is not surprising that violence is infrequently reported to medical personnel or the police. According to the 2010 TDHS, while nearly half of survivors of physical or sexual violence sought help to stop the violence, the majority sought this help from their own family (47%) or religious leaders (33%). Tanzanian women reported that they seldom seek help from the police, lawyers, or medical personnel (6%, 1%, and 1% respectively).

The present study further explores the complex decision-making process that survivors of GBV face when seeking help. Specifically, the analysis sets out to answer the following research questions:

- What are typical help-seeking behaviors in the study sites, and are there any discernible pathways?
- To what extent does help-seeking differ based on the type of violence experienced?
- To what extent does help-seeking differ in urban as compared to rural areas?
- How do communities perceive existing GBV services and what needs do they express?

The findings draw largely on the “Pathways of Help-Seeking” maps created by PFG participants (a selection of these drawings is presented in **Annex 5**). In each PFG, participants were separated into two groups and given an open-ended story about a fictional GBV survivor. One group received a scenario based on repeated physical violence by a husband, and the second group was given a story about a survivor of rape by a non-intimate male acquaintance. Subsequently the facilitator prompted each group to draw a map of available services and the survivor’s most likely path through these options. Respondents were initially asked to create a map for a “thirty-something” woman. Once the illustration was complete, the facilitator probed to ask how the map would change if the survivor was age 17 or age 60 (see **Annex 4** for the full PFG guide). It is important to emphasize that the vast majority of GBV survivors do not enter formal channels of help-seeking; the discussion below should be interpreted as indicative of the pathways taken by the small sub-set of survivors who choose to pursue GBV-related services in spite of multiple barriers.

1. Typical Patterns of Help-Seeking

Study findings are consistent with TDHS data that indicate the low prevalence of help-seeking among survivors of GBV in Tanzania. While the reasons for the gap are varied (Barriers to Help-Seeking are discussed in detail in Part III Section D below), the following quotation reflects the extent and cultural relevance of the issue:

You know, what kills the society is the issue of secrecy. An individual can be abused yet keeps silent, can be beaten yet keeps silent, can be harassed yet keeps silent...To a woman who is married...a real wife has to keep quiet...others are afraid that, "If I speak, how will people see me, how will the society see me?" You know the problem is, and I would like to share it with you, the problem is that there is a concept of shame upon the victim, and not shame upon the perpetrator. There is a need of changing the society.

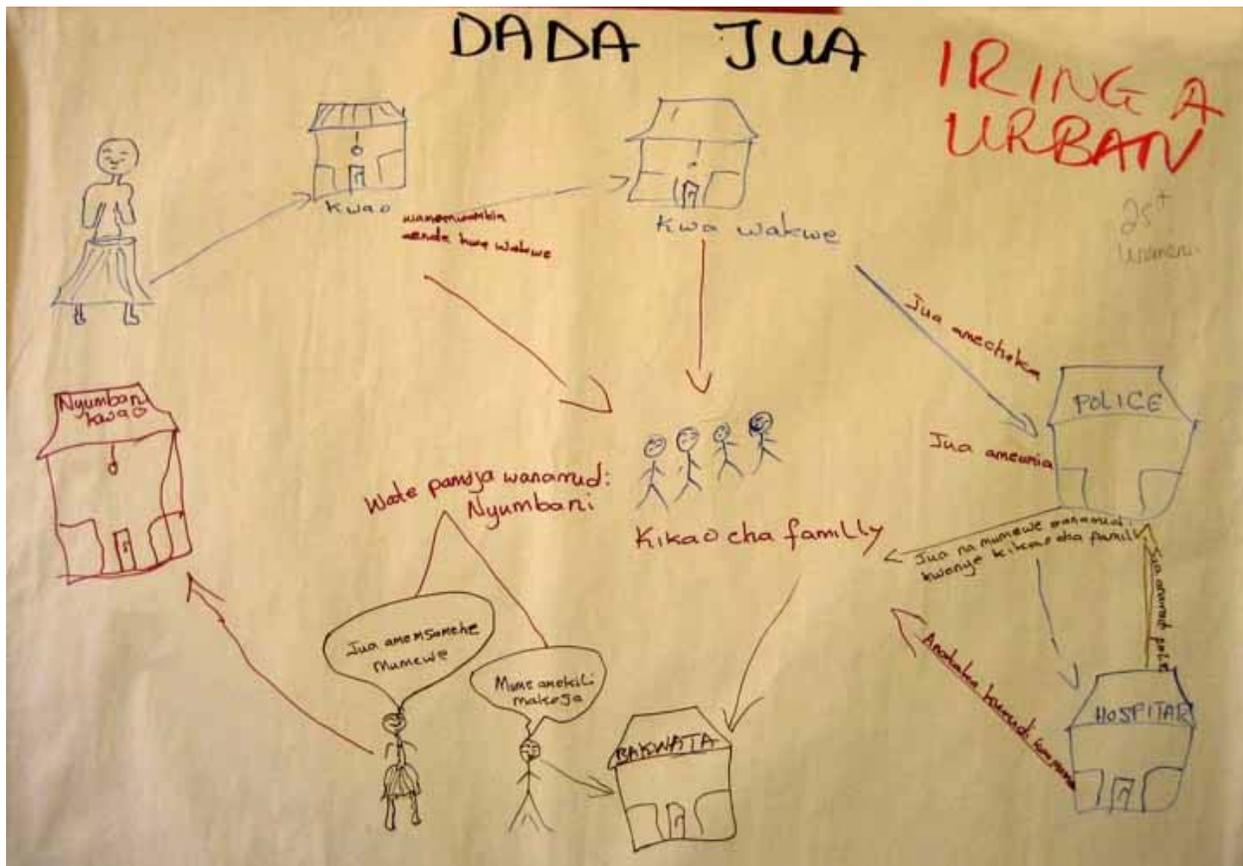
Service provider, Mbeya

Pathways begin with the family

Given the context of infrequent help-seeking, it is not surprising that across the PFG maps the initial step is almost always an informal source of support, most often the family or another member of the survivor's close social network. A map created by a women's PFG in Iringa is consistent with the common pathway presented by many of the groups (see Figure 2 below). The survivor of domestic violence, named Jua for the exercise, initially goes to her parents where she is sent back to her in-laws, and subsequently to a family meeting. When the violence continues, Jua tires of this routine and goes to the police. From the police, she may be sent back to the family for another attempt at reconciliation, or, "if she is hurt," Jua may go to the hospital. The map depicts a loop between the hospital and the police to signify that she may need to navigate between these two channels in order to obtain, complete, and finally submit a PF3. From there, the pathway suggests that Jua can again return home, or perhaps seek help from a local FBO. Annotations on the diagram explain that the FBO is where the husband "admits he is wrong" and Jua "forgives him." Despite the different options depicted on the map, the family is dominant and all routes eventually lead back to the marital home.

Notably the map does not show a court of law, or present divorce as an option for Jua. When included, courts are consistently presented as a final pathway, when all other options have been exhausted and the survivor has persevered against significant obstacles.

Figure 2: Map Drawn by Participants in Women’s PFG (25+ years old), Iringa



Pathways are circuitous

Another common theme that is visually apparent on several of the maps—and also emerged from the ensuing PFG discussions—is that help-seeking frequently follows a circuitous pathway. Referrals are required at each step, creating bottlenecks and exposing survivors to potential re-traumatization as they are required to narrate their experience on repeated occasions. The result is an exceedingly slow, cumbersome process that neither prioritizes GBV nor responds to violence as an emergency situation. As one female respondent explained in relation to a hypothetical case of domestic violence:

They went to a Ten Cell Leader who couldn't solve the matter, and [then] went to a chairman. He gave them a letter to take to a police station for PF3. From the police station, where she received a PF3, she went to hospital and found herself in a long queue.

Female PFG Participant (18-24 years old), Iringa

The maps also reveal how survivors must choose to continue at every point along the path, and how any option can become a dead end. Given the circuitous nature of help-seeking and the lack of resources to help women navigate the process, the full onus of responsibility to obtain care and/or access justice falls on the survivor. The survivor herself must decide how best to continue, and whether to press forward and confront the next obstacle in her

path. Unsurprisingly, study participants revealed a sense of fatigue and frustration when discussing help-seeking options.

You can go and report to your parents, then they help you to reconcile until they get tired. Then you go to Ten Cell Leader and they also get tired of you. They tell you to go to the police station, but at the police station they [police officers] need money.

Female PFG participant (18-24 years old), Iringa

Some existing services are underutilized

Many of the existing services (see Part III Section B) were depicted throughout the maps, most notably family, village, and ward-level leaders, the police, and healthcare providers. Somewhat less frequently, WRCs, courts, and district-level officials (e.g., the social welfare officer) were also drawn. It is noteworthy, however, that several services were included either rarely or not at all. For example, CSOs of any kind were rarely depicted, and no group illustrated a shelter or drop-in center. While police appeared across the illustrations, no map explicitly included the Gender and Children's Desk, and subsequent conversations indicated that awareness of Gender and Children's Desks outside of the district headquarters is low.

2. Differences in Entry Points

The "Pathways of Help-Seeking" maps reflect notable differences in entry points and key gatekeepers based on type of violence, age of the survivor, and a woman's primary motivation for entering particular channels of help-seeking.

The family is central

As shown through the example of Jua above, the family or a close member of the family's social network (such as a *mshenga*, who is a person responsible for negotiating a marriage) is often the most active resource for a survivor of GBV. This is particularly the case when a survivor's pathway emphasizes resolution (either based on her own desires or due to fear of negative consequences from pursuing legal action). The following quotes are illustrative of the family's dominant role.

She cannot go the police because the relatives of the husband will say, "What type of a woman are you?"...She will decide to remain at home with pains.

Female PFG participant (25+ years old), Dar es Salaam

What I mean is that after a woman is beaten, especially in the rural areas, in most cases she runs back home to her mother. There they treat her with warm water and some local herbs...If she has some cuts they treat the wounds.

Service Provider, Mbeya

Local leaders serve as gatekeepers

Local leaders also featured as key gatekeepers and maps often describe a VEO or Ten Cell Leader as the second stop (after the family) on the path:

It's the same steps of the local government, that is where we start, because even at the police nowadays, they [let you] go straight there. A letter should be written for you by the chairperson, that so and so has been beaten.

Female PFG participant (25+ years old), Iringa

However, these leaders rarely have any GBV training. Hence, the quality of service provided is dependent on the individual leader. As described in Part III Section A, some leaders take it upon themselves to provide shelter for a survivor, whereas others provide little assistance or act as bottlenecks.

Pathways depend on age

After the maps were finalized, the facilitators probed to find out if and how the diagram might change if the survivor was young or old. Generally the men's groups did not emphasize age-based differences, but several patterns emerged from the PFGs with women. Overall, older women were characterized as more reliant on traditional sources (e.g., elders and religious leaders) whose support was frequently characterized by an emphasis on maintaining silence and "enduring."

But if the mother is 60 years old, she cannot go to the police. She will be afraid because she will be humiliating herself. Perhaps she has children and grandchildren. Directly she will use traditional ways of calling elders, people of the same peer group, or use religious leaders to solve the couple's problems.

Female PFG participant (25 + years old), Iringa

But for a woman who is 60 years old, she is already old. She does not see any reason to complain that she has experienced something bad from a husband, because even people will be surprised as she has lived with her husband for a long time. It is like she is degrading herself, therefore, she will decide to keep silent because of her age.

Female PFG participant (18-24 years old), Iringa

For a woman who is 17 years old, [she] will follow the whole process—she will go to parents, to close relatives, to friends, to the police up to the court... but for a woman who is 60 years old it is rare [for her to seek help through various channels].

Male PFG Participant (18-24years old), Mbeya

Sometimes after a woman gets beaten by husband, she can go to the elders who will tell her to endure. An elder may advise her, "If you have been beaten just take it easy." It is rare to tell her to go and report to the police. They [elders] are most likely to say endure.

Duty bearer, Dar es Salaam

In contrast, younger women appear to experience support and encouragement to seek help from their cohort of friends.

There is a difference in seeking help between a woman who is 17 years old and one who is 60 years old. A 17 year-old woman who experiences an act like this [violence from her partner] will feel very bad, and because she has many friends who are young they will advise her to go to several places to get help.

Female PFG participant (18-24 years old), Iringa

Options for unmarried women are restricted

For unmarried girls, the available options are even more restricted given that the relationship is not formally recognized. Should a survivor in this situation disclose an incidence of GBV, she risks stigmatization, which reinforces the tendency to refrain from help-seeking. The following quote suggests that even seeking support from family or elders in the community may not be a viable option for unmarried survivors.

When you have a girlfriend, it means you are not married and hence you cannot call any elders, because your relationship is not official. No parents of any side know of your relationship officially.

Male PFG participant (18-24 years old), Mbeya

3. Differences in Help-Seeking Based on Type of Violence

Overall, there was a high degree of consistency across the “Pathways to Help-Seeking” maps, even when two hypothetical scenarios—domestic violence and rape by a stranger—were considered. This is noteworthy especially in light of the finding that rape by a stranger was consistently identified as an “unacceptable” act of GBV, while most types of physical and sexual violence within relationships were considered “acceptable” (see Part III Section A). However, several important distinctions did emerge as described below.

Physical violence by a husband

In the maps depicting responses to spousal violence, there was a clear emphasis on reconciliation. Participants’ comments indicated that help is generally sought only in extreme cases resulting in injuries or after frequent episodes of violence. Help-seeking pathways also differed significantly based on the age of the survivor. Older women were characterized as more likely to “keep quiet” and “not attract the attention of providers.” Participants often explained this pattern as older women being “accustomed to” violence. Since an old woman had already been with her husband many years, reporting violence would also be a poor reflection of her. In contrast, comments suggest that a younger woman would be more likely to pursue formal help-seeking, and potentially even attempt to prosecute her husband.

It is not very often [to seek legal assistance]; most cases [that involve married women] are resolved at the local government offices. If you see her going to a police station it means she is severely wounded and needs a PF3 for medical attention.

Female PFG participant (18-24 years old), Iringa

Sometimes if she has been beaten by her husband...she will go to the ten cell leader or neighbor...the ten cell leader will solve your case but if he didn't manage to do so, then you go to your husband's parents to report. If he [husband] doesn't listen to them, then you pack your things and go back to your parents.

Female PFG participant (25+ years old), Mbeya

...they [elders] will say that this is your man. They will sit down and resolve it by telling the man [husband] that you should stay like this and this with your wife and that is it.

Female PFG participant (25+ years old), Mbeya

Rape perpetrated by a stranger

The maps depicting rape by a stranger are slightly more likely to highlight the legal and justice sector, although the differences were not dramatic. Even in the case of rape, the diagrams suggest that because of shame and stigma, pathways may still end at the level of family or friends. While rape of a child is clearly a reportable offence, once again age appears to be a barrier to help-seeking for older women:

For a woman who is 60 years old, she will feel shy to report rape. She might not report it anywhere, fearing that people might think that they had an agreement before and she is now trying to pretend she was forced. It is a big shame for a woman of 60 years old to report that she was raped.

Male PFG Participant (18-24years old), Mbeya

Healthcare reserved for "severe" physical injuries

While hospitals and other health facilities were consistently included in the maps of survivor pathways, ensuing discussions made it clear that survivors seek help from healthcare providers only for severe physical injuries, or, in cases of rape, when they require forensic evidence to pursue legal action. The circuitous route described above, however, may delay a survivor from quickly accessing the care she needs and compromise collection of the required evidence, as reflected in the following quote.

In some cases after going to the police, they might require some evidence which can be facilitated at the hospital. As you can see...a person might go on the next day, and the hospital might not be able to pick the evidence required.

Service Provider, Dar es Salaam

4. Differences Based on Urban/Rural Location

Certain patterns of help-seeking were noted based on urban and rural locations. During the field work, the research team observed that there is often less police presence and a lower concentration of available services in rural areas. As a result, the WEO assumes a greater role as an entry point for service provision. Moreover, rural women appeared to be less likely to see the legal and justice sector as a legitimate option. While not explicitly discussed in this study, it is likely that this difference may be due to the critical importance of social networks in rural areas, and, hence, the consequences for violating cultural norms and expectations may be more severe. It is also likely that the more intensive social capital in a rural community places greater influence on women to conform to expectations and not cause social or familial problems by reporting their experiences of violence. Taken as a whole, the maps illustrate the fairly limited options for survivors of GBV. Even those services that do exist are provided by individuals with little specific training. In consequence, the quality of support a survivor receives is entirely dependent on the individual provider's attitudes and experience.

The common pathways depicted were focused on first aid for severe injuries (in health facilities) and marital reconciliation rather than reacting to GBV as a human rights violation. This prioritization of "saving" the marriage distracts providers from addressing the core issue and can frequently lead to repeated offences, circuitous response patterns, and fatigue on behalf of both the survivor as well as providers. Very few alternatives exist for women who want to seek justice for the violence they have experienced. Survivors who try to persevere face numerous bottlenecks and dead ends. The system itself is lethargic and not designed to respond seriously to instances of GBV. The many barriers to help-seeking are examined in greater detail in Section D below.

D. Barriers to Help-Seeking

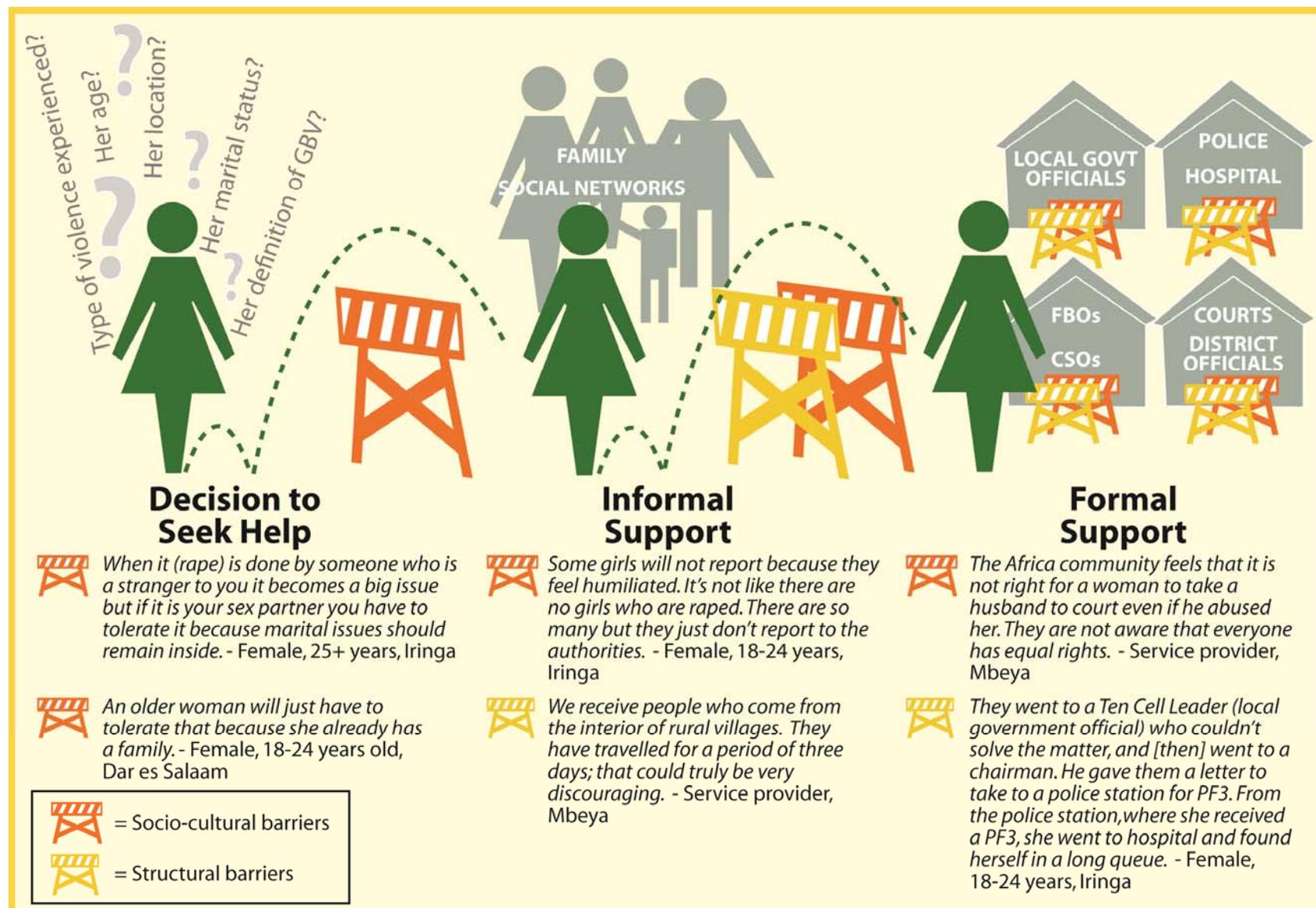
The circuitous pathway for obtaining appropriate care and support is compounded by numerous socio-cultural and structural barriers that prevent survivors from seeking help when they experience GBV and from obtaining appropriate services once they enter the various channels of help-seeking. Socio-cultural barriers are those that are imposed upon a survivor by the values, attitudes, and norms that are prevalent within the survivor's community. These barriers may be due to survivors' perceptions of the gender roles and expectations that govern their identity as Tanzanian women, or may be due to a fear of the social consequences of reporting GBV through official channels or divulging it within their familial and social networks. Structural barriers are determined by the systems, processes, and legal frameworks in place that govern how and where services are provided and to whom.

Together, these barriers contribute substantially to the low rate of help-seeking observed among women. As illustrated by Figure 3, before even deciding to seek help from informal or formal sources, individual survivors confront a number of barriers. Primary among these are a survivor's personal definition of violence (i.e., whether she conceives of the act in question as a violation of her rights, or as something "normal" that should be endured), the type and severity of the violence experienced, and her own understanding of how reporting or help-seeking will be received by others. As noted in the previous section, reporting the violence or help-seeking can be further complicated by a survivor's age (e.g., Is she "too old" to be believed if she reports being raped?), her location (e.g., Are any services available if she did seek help? Does the provider have a relationship with the perpetrator?), and her marital status (e.g., Will she invite even more stigma for reporting violence in an unsanctioned relationship? Should she accept the violence as part of her marriage?).

As Figure 3 also illustrates, even among those GBV survivors who can overcome the first layer of barriers and decide to seek help, many will face socio-cultural and structural barriers that hinder them from accessing services from informal and formal providers alike. It is important to note that the diagram above illustrates typical pathways for help-seeking, but that the exact entry point and steps taken depend on the individual survivor's profile, experience, and decision-making process. The PFGs and KIIs revealed that the barriers to help-seeking beyond the survivor's family and immediate social network are particularly challenging. Moreover, for the few survivors who do enter the formal help-seeking channels, the research identified a common set of barriers that exist regardless of the type of support or service GBV survivors may seek. As depicted in Figure 3, GBV survivors may have to endure a lengthy, circuitous, and often back-and-forth path in accessing help from formal sources of support.

The following sub-sections discuss the barriers identified by study participants in detail. Sub-section 1 describes the common socio-cultural barriers encountered by survivors, sub-section 2 analyzes the structural barriers, and sub-section 3 discusses specific challenges around different types of support including family and social networks, local government authorities, the legal sector, the health sector, and civil society.

Figure 3: Pathways and Barriers to Help-Seeking



1. Common Socio-Cultural Barriers

Participants identified a wide array of key socio-cultural norms that can act as barriers to help-seeking by women who experience GBV. The barriers that were found to be common across different sources of support are discussed below.

Lack of awareness of women's rights

Among the most fundamental barriers identified by study participants is a lack of awareness and knowledge among women about their own rights, i.e., that they are entitled to live lives free of violence and to seek justice in cases of violence. Many respondents attributed this lack of awareness to traditions within their culture.

The African community feels that it is not right for a woman to take a husband to court even if he abused her. They are not aware that everyone has equal rights.

Service Provider, Mbeya

Our traditions come from in the past; women were like the oppressed...They were instructed or advised that if a man harassed you in any way you do not go anywhere because he is your husband, he paid dowry for you...

Service Provider, Mbeya

Even among women who might want to seek help after experiencing GBV, they may not feel entitled to do so, and are unlikely to know where they should go to access support or services.

There is also poor knowledge among people about their rights and where exactly they can get help whenever they face difficulties.

Duty Bearer, Mbeya

The ones that do not ask for help are many because of their understanding and also because they are not aware that these services are there.

Service Provider, Dar es Salaam

Younger women reported that they and their peers do, in fact, recognize that GBV is a violation of their rights. They would be willing to report it if they felt that there were support structures in place to help them and to place some sanctions on the perpetrators.

We know [that GBV is a violation of our rights] but we do not know where to go for assistance. That is why we just bear with the pain. They also think it is okay to hurt us. If there was a place where we could go, they [men] would also be afraid.

Female PFG participant (18-24 years old), Iringa

Violence is accepted as “normal”

As discussed in Part III Section A above, many types of gender-based violence are viewed as normal and even acceptable within Tanzanian communities. This directly impacts women’s willingness to report violence to formal or informal sources of support. This barrier may be particularly powerful in preventing women from reporting physical abuse by their husbands.

There are traditions in which they believe that the beating of wives is a normal thing. Therefore, one cannot make accusations because to whom will she go to make the accusations because elders or grown-ups will be surprised by her. So she herself cannot even get up, for they know that those are traditions.

Service Provider, Mbeya

They are hiding because of the patriarchal system. Some of the women think in marriage you have to tolerate everything; a parent is telling her daughter that she had also experienced abuse from her husband and whatever happens has to be kept a secret, you cannot tell other people about your husband’s behavior.

Service Provider, Iringa

While this acceptance of violence as a part of relationships prevents women from feeling they can report violence, even those who may want or try to report their abuse will be faced with obstacles. In the face of the system’s non-responsiveness to their needs, women learn to “get used to” being beaten and “keep quiet.”

...they are already used to the habit of being beaten. Even if they report them and nothing is done, she will just keep quiet because he isn’t changing...she will just continue with her business while her wounds heal.

Female PFG participant (18-24 years old), Iringa

Fear of partner’s reaction

Another reason that women are unlikely to report spousal abuse is that they fear the reaction of their husbands. According to respondents, there is a sense that what happens within marriage, even if this includes violence, is something private that should not be shared with others outside of the relationship. Women are made to feel ashamed for talking about their experiences with others.

The man will say, “Why have you gone to announce what happened in bed?” They (the women) feel ashamed.

Duty bearer, Dar es Salaam

Women also have a very real fear that reporting violence to local authorities will lead to an escalation in the violence by their husbands.

He (the husband) will be called and warned, but he will feel like you have humiliated him. And when you go back home, things will get worse by shouting at you because he thinks you are stupid.

Female PFG participant (18-24 years old), Dar es Salaam

Fear of being blamed for reported rape

In cases of rape by a stranger or acquaintance, young women in particular are very reticent to report the crime to authorities. They expect that their claim of rape will not be believed, and that their own behavior will be called into question.

If I were raped, the first question will be, "In which circumstances were you? Hasn't this person approached you before?" But children and aged people will not be asked those questions. They will end up saying we had an agreement or I took his money.

Female PFG participant (18-24 years old), Iringa

A woman of my age won't be listened to because our stories are not believed. They might think we met in a bar and consented to the act.

Female PFG participant (18-24 years old), Iringa

This fear is founded in the frequently expressed social norm that women are to blame if they are subjected to unwanted sexual advances or sexual assault. As illustrated in the words of an older male PFG participant, a woman is likely to be raped if she wears a short skirt, and, as such, the rape is "intentional," i.e., the woman invited the rape.

Sometimes the rape that occurs does so intentionally. A young person may leave her parent's house wearing only a kanga and when she is out there then she already has her bag and then she folds that kanga and remains with her short skirt. Honestly, will you escape being raped?

Male PFG participant, (25+ years old), Dar es Salaam

As a result of this blaming and stigmatization of women for the rapes they experience, young women feel they cannot report such GBV if there is a single perpetrator as it will not be believed. If, however, they experience a gang rape, this claim is more likely to be accepted by local authorities.

Rape cases of women of our age are only considered when you have been raped by three or more people. If it is only one person they will say we had an agreement and they won't do a thing. It is shameful to report that [someone] has raped you while you (and him) live in the same street.

Female PFG participant (18-24 years old), Iringa

It is important to note the stigma that is folded into the blame placed on women. Even if she is raped, it is her reporting of the rape that brings dishonor and shame rather than the violent act itself. This sense of humiliation and shame is a significant barrier to help-seeking of any kind, which explains why so many rapes go unreported.

Some girls will not report because they feel humiliated. It's not like there are no girls who are raped. There are so many but they just don't report to the authorities.

Female PFG participant (18-24 years old), Iringa

She is a just a human being and she feels that talking about it will degrade her humanity. She better keep it her secret.

Duty Bearer, Mbeya

Fear of social consequences

Another socio-cultural barrier that was common across help-seeking pathways was a fear of the social consequences that result from reporting spousal abuse to the authorities. In particular, they fear that reporting abuse will lead to divorce, which will leave the woman without any financial support.

That is a challenge because when women experience GBV they are afraid to report their husbands to the police because doing that will break the marriage totally and sometimes you might find that a woman has no income so they think of where they will go after the marriage breaks up.

Service provider, Iringa

Inherent in this fear is the additional concern that being a divorced woman will render her an undesirable partner for other prospective husbands. Similarly, women are concerned that their reporting of an incident will escalate the problem and even leave their husbands jailed.

...In wife-husband cases, if the local police arrest the offender, that might create even a bigger problem in their marriage. The husband might be arrested and confined in a jail cell while you could have solved the problem just by a simple discussion.

Service Provider, Iringa

Some are afraid to go the police for fear that the assaulting partner may possibly be jailed, and some think that going to the police is useless because nothing will be done anyway.

Service Provider, Mbeya

It is also important to highlight the latter part of the above quote, which illustrates a very common perception that the system is not built to respond to the needs of women who experience GBV. The structural barriers to help-seeking will now discussed in sub-section 2 below.

2. Common Structural Barriers

Gender inequality is perhaps the most pervasive structural barrier that Tanzanian women experience across multiple domains of their lives. Many of the socio-cultural barriers described above—women’s economic dependency, societal norms that undermine women’s agency and dictate acceptable behaviors, expectations around marriage, etc.—contribute to gender inequality at the macro-level. Inequality systemically constrains women’s options for responding to violence (and also propagates GBV in the first place).

The interviews and participatory focus groups also revealed a more specific set of structural barriers affecting survivors of GBV in the study areas. Cost, corruption, distance, gaps in services, and lack of quality care were commonly reported by participants as posing significant barriers for GBV. This sub-section describes these findings as they relate to both help-seeking and service delivery.

Poverty and inability to pay

Respondents offered compelling testimony on the multitude of ways in which costs curtail help-seeking and also negatively influence a woman’s ability to obtain services. Respondents identified both direct costs (e.g., costs of registering at the hospital and receiving treatment) and indirect costs (e.g., transport fees, costs of medical supplies, etc.). These costs act as a structural barrier that cuts across provider types including the local government, police, and healthcare system. The excerpts below demonstrate the pervasiveness of cost as a barrier to seeking help for GBV. The final quote in the series below further illustrates some of the hidden costs that further reduce the affordability of obtaining care, especially for poor and/or economically dependent women. These are in addition to indirect costs such as transport, which can be prohibitively high, especially in rural areas.

Few of them [seek help] because of their education level, and the second thing is that ... a person is unable to cover the financial costs. Thus many of them just end up maybe saying, “ If I go there, I will be asked to pay and I do not have any money.” That also is an obstacle for people when seeking help.

Service provider, Dar es Salaam

There are also challenges at a police station. Yes, they might ask for some money... [if] she doesn’t have a single cent, what will she do?

Female PFG participant (18-24 years old), Dar es Salaam

Nothing is for free, from the card, medications, syringes—even the intravenous infusions—have to be bought.

Female PFG Participant (18-24 years old), Dar es Salaam

Corruption and male bias

Even for survivors who overcome the myriad challenges and attempt to seek help, corruption and associated costs may prevent them from obtaining the services they require. Corruption is a common theme that emerged from the discussions. On the one hand, corruption acts as a barrier to help-seeking because of the additional payments (beyond the required costs of service) that are often required. On the other hand, even after a woman reports an incidence of GBV, corruption may prevent her from accessing justice if the perpetrator has the means to “pay off” the police or local government official. As illustrated by the quotes below, illegal payments are often necessary to pursue legal action against a perpetrator or to be treated at the hospital.

There are challenges at a police post...They will listen to what you want to do. If you want him arrested, that will be done. Money is what they want; they will do anything as long as you pay them.

Female PFG Participants (25+ years old), Dar es Salaam

Everything requires you to pay some money. Arrest of the criminal you have to pay. At the hospital the situation is the same, there might be an empty bed but you will not be put on it unless you pay some money.

Female PFG Participants (25+ years old), Dar es Salaam

Other quotes suggest how the payment of bribes by perpetrators of GBV acts as a further hindrance to seeking justice.

My husband might be working, and I depend on subsistence farming. Even when I go to report him, he would pay them [the police] some money and I will end up being rescheduled until I tire of the routine.

There are always challenges. I might be poor while the rapist is well off. When I'm there they will listen to me, but once I'm gone he will come, give them some money, and tell them to close the case. When I come back nothing will be done, and my case will be rescheduled with promises of tomorrow until I decide to give up.

Female PFG participants (18-24 years old), Iringa

Respondents also describe a more subtle form of corruption affecting women in the project area: male bias. On several occasions, study participants (providers as well as women themselves) explain how the relationships and status that men enjoy in their community prevent women from pursuing legal action against a perpetrator.

I had one case sent to the police. We went together with the victimized woman and we realized the husband was familiar with most of the officers. He ended up chatting and laughing with them and that was the end of the case.

Service provider, Iringa Rural, Iringa

When I took my form [PF3] to the hospital, it was not accepted and they told me to forgive him. I asked them why and they said I cannot stand in court against him. They offered me 1,000 shillings which I did not take.

PFG Female Participant (25+ years old), Dar es Salaam

Distance to service providers

Yet another barrier to help-seeking across all categories of formal support is the dearth of services and the distance that is often required to obtain adequate care. This obstacle particularly affects women in rural areas, as indicated by the following comments from service providers.

We receive people who come from the interior of rural villages. They have travelled for a period of three days; that could truly be very discouraging.

Service Provider, Mbeya

For example, a woman might be required to file a report at the police station but that is very far from here. It is 26 kilometers. We would only give her a letter but we do not escort her.

Service provider, Iringa

Gaps in services

Compounding the problem of distance to reach centers where providers are located, required services may be largely non-existent. Most notably, there is very limited psychosocial care available for survivors—a gap that was mentioned by several service providers.

For issues related to legal assistance, we normally expect that the victim is assisted at the police station. But for counseling, we had no counselors before...for issues of trauma and traumatized disorder. Unfortunately now we are really constrained because of the high number of patients, and only two of us are now training as counselors.

Duty Bearer, Iringa

The major issue is to involve the counselors we have in GBV training. This is something they've been doing using their own experience, but they haven't been trained on that.

Duty Bearer, Mbeya

The field team also noted that CSOs are concentrated in urban areas, and in some rural sites it was difficult to identify any NGO or CBO that focused on GBV.

There is no organization that helps women. We have never seen them. When you go to a police station they will tell you to fuel the car, and if you do not have money then you cannot go to another place. What are you going to pay them? You give up...so you have to bear the pain. We remain with scars like these ones [showing a scar on her face].

Female PFG participant (18-24 years old), Iringa

Lack of quality care

A final structural barrier to help-seeking of any kind that surfaced as a common theme across interviews and PFGs is the lack of *quality* services. This was most frequently described by community members in terms of corruption and delays in service provision. The three excerpts below are drawn from a PFG with young women that included a focused conversation on these issues. The views expressed, however, are representative of other discussions groups.

I took my husband to the local government about providing basic needs for the child. Up to now nothing has been done, and I haven't even received a letter to go a higher level.

There is no assistance. If there was assistance girls would have come up and reported their predicaments. A week can pass by after reporting a rape case, and yet nothing has been done. Won't you be ashamed to continue with following up?

What I think is that the [gender] desk should not be at a police station, because the environment attracts corruption. One of my friends had trouble with her husband who she has lived with for 15 years. He was arrested and slept in a police cell for a night. On the next day nothing was done.

Female PFG participants (18-24 years old), Dar es Salaam

From the perspective of service providers, this gap in quality services was emphasized through the lack of specific training in GBV as well as the absence of protocols or guidelines for treating survivors.

I work using my experience. I have not received any form of training [for GBV].

Service Provider, Iringa

No, I haven't [received any training for GBV] but I'm a lawyer by profession. Therefore, I make some judgment just by assessing the situation. We don't just rush to the court. Some conflicts can be solved just by discussing them.

Service Provider, Mbeya

3. Barriers to Specific Types of Support

In addition to the socio-cultural and structural barriers discussed above, survivors experience additional challenges depending on the type of service or support they are seeking. This sub-section summarizes sector-specific barriers that were frequently reported by key informants and community members.

Family and social networks

As described in Part III Section C, the family and social network is consistently the first step in seeking help for GBV. For the vast majority of survivors, the pathway also ends with this step, and survivors do not continue to formal channels. Comments made throughout the KIIs and PFGs provide insight into why this pattern is so prevalent; the family frequently becomes a socio-cultural barrier in itself. For example, norms related to shame and the privacy of family matters (discussed above) serve as an obstacle to disclosing incidents of GBV outside of the family and immediate social network. The following excerpt from a duty bearer is illustrative:

These [rape] cases are usually not reported, although they happen. There is a tendency of affected individuals to keep this as a secret because it is associated with shame and discrimination. The victim's family will sit down and decide to keep this a secret for fear of ruining the family reputation, and they think by doing this they are protecting the victim's psychology.

Duty bearer, Dar es Salaam

Local government authorities

As depicted by the “Pathways to Help-Seeking” maps drawn by PFG participants (see **Annex 5**), the local government structure is hierarchical and referrals are required to pass from one level to the next. Community members commented on the difficulty of accessing officials and securing the proper referrals; navigating the local government system is both cumbersome and time consuming. Moreover, the constant opportunity to refer survivors up the chain facilitates a reluctance by lower officials to assume responsibility for an individual case. As a result, survivors are often channeled through the system—moving from one level to the next—and no official actively manages the case or resolves her needs. Unsurprisingly, this structural barrier leads to frustration and fatigue on the part of the government official and the survivor, as indicated in two quotes from a female PFG in Iringa.

Sometimes you might need a letter for referral but the chairperson is not available. This lady right here is the one we usually find at the office, but the chairman is never there. It might take you two days to find him [and receive] a letter which allows you to go to police station.

Female PFG participant, (18-24 years old), Iringa

Most of the time we will go to a Ten Cell Leader or at the [local government] office, that is where every conflict will be solved. The offender will ask for forgiveness with a promise to never do that again. When you go every now and then, it will reach a point where they will tire of you, as they know you will be back with the same issue...Therefore it reaches a point when we just have to keep quiet, despite all that is happening to us, because people have grown tired of you.

Female PFG participant, (18-24 years old), Iringa

The legal and justice sector

Pursuing legal action through the court system is extremely rare for survivors of GBV in Tanzania. As discussed in Part III Section C, pursuing justice through the court system signifies a sharp deviation from the culturally embedded emphasis on reconciliation. It is often viewed as the most aggressive pathway to help-seeking. This reluctance to prosecute, especially among married women who experience intimate partner violence, can be largely explained by the socio-cultural barriers described above. In particular, the fear of consequences related to the welfare of children appears to be highly salient, as demonstrated in the following excerpts.

For us women, when you take your husband to the court and realize that he is about to get jailed, we feel pity for him...You think, "Where will you take the children, and how will the society see you?"

Female PFG participant (18-24 years old), Dar es Salaam

There is a problem, taking the case to court to seek for a divorce will cause problems in the upbringing of the children.

Service Provider, Iringa

In addition, most women have never experienced the police system or court and may not understand the legal process. On more than one occasion during the field work, conversations suggested that survivors may avoid the legal system because they feared they would be at risk of facing prosecution themselves.

Others are just afraid...They say that they have never been to court, so when they come here they are afraid they will get jailed.

Service Provider, Dar es Salaam

Corruption was once again cited as a problematic barrier in seeking help from the legal system. Respondents in a PFG with older women in Dar es Salaam explicitly described how corruption interferes with a survivor's ability to access justice.

Sometimes the police would say, "I am not going to open a case file for you. All I have to do is to make sure this matter is resolved right here." And he will threaten you by saying that if you go to court, you will lose. That is when he has already received some bribe.

The legal entities should interfere in solving this problem. We have seen many cases not being reported, and even when reported to the police, victims might be threatened and forced to agree to a compensation which denies them justice. Money is all that matters; nothing will be done if you do not have it.

Female PFG participants (25+ years old), Dar es Salaam

Finally, the legal code itself imposes a structural barrier, in that marital rape is not a criminal offense and even other forms of violence (e.g., emotional and psychological violence) are not clearly defined in the Penal Code.

That is where the problem starts; legally you are supposed to report at a police station, but when you go there you might be told that is not a crime. So where would we go?

Female PFG participant (18-24 years old), Dar es Salaam

Health sector

As described in Part III Section C, the necessity of obtaining a PF3 before receiving specific GBV-related services has an acute effect on patterns of survivors' help-seeking within the health sector. Comments from key informants and female community members suggest that women feel they must choose: a) not to disclose that their injuries are the result of GBV and receive medical treatment specific to their injuries (at cost); or b) report the incidence of GBV, which requires obtaining a PF3 from the police and opening a file against the perpetrator. The former option results in inadequate care, and prevents the health system from accurately tracking treatment of GBV-related cases. If survivors select the latter option, the quality of care received may be jeopardized (and delayed) by the lack of payment, and, in the case of intimate partner violence, women may experience stigma and marginalization for their decision to report. Even in the case where survivors should be provided services free of charge due to their economic status, study findings highlight how corruption and institutional norms may obstruct the provision of free services.²⁵ The excerpts below provide further insight into these two options to receiving healthcare for GBV.

You cannot go to the hospital without a PF3, [but without a PF3] she cannot be treated unless she lies.

Service Provider, Mbeya

²⁵ While respondents often referred to "hospitals" when discussing barrier to receiving care, this is the generic term used to refer to any health facility including dispensaries, health centers, etc.

If you advise her to go to the police she will not accept because what she wants is treatment and nothing more. Sometimes the husband might be the one who threatens [her] not to go to hospital because he will be arrested.

Service Provider, Iringa

You can go to hospital, but you must have PF3, and when they [providers] realize that you do not have money, you can wait in the queue eight hours, and when you get tired of waiting you decide to leave.

Female PFG participant (18-24 years old), Iringa

The hospitals need to listen keenly to the patients who attend because you may go there and not be capable financially, so they will leave the victim waiting while they treat those who come and pay money. The victim is left to sit there up to evening and is eventually told to report the following day. They are following where the money is, and they have actually caused loss of many lives through this behavior.

Male PFG participant (18-24 years old), Mbeya

Since healthcare providers are required to complete the PF3, they may themselves face threats from alleged perpetrators. This barrier is especially pertinent in rural areas where community members are likely to know individual providers. As one medical provider explains:

First of all...you are supposed to fill in a PF3 showing that she has been injured, and [then] the government can take legal action against the husband. Let us say he is jailed, then the doctor will be seen as the one who has caused the problem to the husband...The husband will say, "We had already reconciled but it is the doctor who exaggerated the report that I injured my wife severely, otherwise I wouldn't have been sent to jail." So you might find that you create a dangerous environment for yourself. Therefore, in these things, you have to be careful.

Service Provider, Mbeya

Finally, it should be noted that PF3s cannot be completed by private facilities. As a result, private health clinics—which are often the most accessible option for care—are not able to provide the forensic evidence required to pursue a criminal investigation.

... it was directed [by the Ministry of Health and Social Welfare] that any client who comes to your service, either he or she had a fight with someone or has been injured or hurt, has been wounded by swords, he or she must be given the PF3, and he or she must be treated in the government hospitals.

Service provider, Dar es Salaam

According to the PF3 of the Ministry of Home Affairs, the Medical Officer is the only authorized person to complete this form. In principle, the Medical Officer is deployed at the District Hospital and levels above and not at the dispensaries that are often the nearest sources of healthcare support for survivors of GBV.

Civil society organizations

The key barriers to help-seeking that emerged with regards to CSOs were related to concerns over quality of care and the availability of appropriate services. Drop-in centers and shelters in particular were variously criticized, on the one hand, for violating cultural norms by sheltering women and children, and, on the other hand, for not accepting survivors on an emergency basis, as described in the two quotes below.

Many NGOs do not have professionals, and if they do have [them], they are inexperienced in a way that may cause conflicts with the community. For example, one (drop-in center)...they take in a wife and children and stay with them for ten days. This causes conflicts with a husband.

Service Provider, Iringa

We ask them [survivors] to go to sleep at a relative's place until the day when going to the [NGO] arrives, because they also have their own procedures...You cannot just call [the NGO] and inform them that you will be going tomorrow, her own bed and food must be prepared.

Service Provider, Dar es Salaam

CSOs that focus on GBV may not be available, especially in rural areas. Moreover, many well-known organizations are faith-based and exclude women belonging to different religions. As explained by an FBO staff member:

The marriage we recognize is the one that has been conducted in accordance with religious principles. But a person living with a woman for say 30 years, even if they have 50 children, we do not receive such a couple, we refer them to social welfare where they are listened to.

Service Provider, Iringa

In sum, the research reveals a large number of socio-cultural and structural barriers that prevent women from seeking support when they experience GBV as well as from receiving appropriate services and care if they do. These barriers are derived in part from powerful social norms and injunctions against discussing what is viewed as a private matter with people outside of the relationship and from an infrastructure and network of care that does not prioritize women's holistic needs or their rights.

Part IV: Recommendations

The study identified a number of critical gaps in service provision to women who have experienced gender-based violence. These gaps were found across geographic sites but barriers to help-seeking and access to care were especially prevalent in the rural sites and locations outside of Dar es Salaam. The recommendations presented below are drawn from participants' suggestions as well as the results of the data analysis. These recommendations reflect the highest priority gaps and proposed responses from study participants and the research team. While the present study did not focus explicitly on prevention, several of the recommendations for improving the response to gender-based violence—if implemented effectively—will strengthen Tanzania's efforts to eliminate GBV.

A. Address Socio-Cultural Barriers to Help-Seeking by Survivors of GBV

Key findings from this study cast light on the many social and gender norms that influence and reinforce the practice of multiple forms of violence against women. Therefore, as the Government of Tanzania and PEPFAR implementing partners move their GBV programming forward, the strategic inclusion of targeted awareness raising and community mobilization initiatives is strongly recommended. These efforts would aim to overcome the most prominent socio-cultural barriers that constrain women from seeking help by addressing common attitudes and norms about GBV among community members. These socio-cultural influences are likely to differ across communities, so formative research tailored to each target location is advised to inform the design and roll-out of initiatives. However, based on the results of the present study, messaging for women, men, and the general community will need to emphasize that:

1. Violence is a violation of rights and a misuse of power [*Example of SASA approach*²⁶];
2. Neither physical nor sexual violence should be tolerated or accepted, even within relationships [*Example of CHAMPION campaigns*²⁷];
3. Women who experience violence should not be blamed or stigmatized, but supported;
4. Family members, community members, bystanders, and other members of the social network should speak out against gender-based violence, encourage help-seeking by survivors, and demand that perpetrators of violence are held accountable for their actions; and
5. Services and support are available in many areas and from different types of providers.

With respect to the final suggestion above, it would be critical for service providers (as individual institutions and/or as a group or coalition)—where they exist—to increase the awareness of the support that they offer by advertising more broadly and in more widely accessible media. This would raise awareness among potential help seekers, the community

²⁶ <http://www.raisingvoices.org/sasa/index.php>

²⁷ <http://www.engenderhealth.org/our-work/major-projects/champion.php>

at large, and (potential) perpetrators, which can serve as an effective prevention method as well as an improvement in the response to GBV.

As part of the sensitization effort, structured guidance about how to support survivors will need to be provided to family members, who are usually the first line of help. This sensitization effort should be linked to wider violence prevention initiatives. To encourage the sustainability of activities that target social norms, implementing partners should consider identifying influential individuals or local groups already working to promote awareness about health, rights, and social issues. These champions could then be trained and fostered to disseminate more gender-equitable ideas and messages relevant to the prevention of and adequate response to gender-based violence. Groups that might be targeted include Village Social Services Committees, CBOs, relevant faith-based groups, youth and peer educator groups, and other civil society actors. Given the powerful influence of stigma on decisions to report violence and seek help, it will also be important for prevention and response efforts to intentionally incorporate efforts to reduce stigma against women who experience GBV. Important lessons can be learned from HIV-related stigma reduction initiatives and research conducted by ICRW.²⁸

B. Address Structural Barriers to Help-Seeking by Survivors of GBV

This study also identified numerous structural barriers that frequently serve as insurmountable obstacles to both seeking and receiving care for GBV. Chief among these are the distance required to obtain services, the multiplicity of steps in the help-seeking pathway, and corruption. In order to improve upon and eliminate these barriers, it is recommended that the GBV programming of GoT agencies and PEPFAR implementing partners focuses on three priorities:

- Bringing services closer to survivors;
- Reducing the number of steps in the help-seeking process; and
- Eliminating corruption and bribery from the service provision system.

Recommended strategies under each of these priorities, all of which would dramatically improve women's access to services and support after experiences of GBV are listed below. Implicit in all recommendations is the need to ensure that services and sites throughout the referral chain are appropriate and responsive to the needs and realities of women experiencing violence.

²⁸ Several publications on these models and lessons learned can be found on www.icrw.org by searching the library for the keyword "stigma."

1. Bringing services closer to survivors

- a. Introduce a model that integrates GBV screening²⁹ and support into the care provided by Community Health Workers [*Example of Pathfinder Tanzania's proposed model*³⁰];
- b. Develop a model using Survivor Advocates, i.e., women who are survivors themselves, to accompany and support help seekers [*Example of the MIFUMI model of Independent Domestic Violence Advocates in Uganda*³¹];
- c. Establish more safe havens to provide accommodation for survivors on a short-term basis. It will be critical to consider whether the existing model of formal shelters in Tanzania should be duplicated or if a more informal structure—such as the provision of emergency accommodation by community leaders, which was noted by participants of this study—would be more viable and appropriate.

2. Reducing the number of steps in the help-seeking process

- a. Have services located in one place and more readily accessible to potential help seekers [*Example of the Marie Stopes International "one stop clinic" model*³²];
- b. Establish a network of trained resource people at the local level who can orient help seekers about the steps required for accessing appropriate healthcare, pursuing legal options such as the arrest and prosecution of perpetrators, and/or seeking reconciliation. [*Examples of paralegals and legal aid CBOs*³³];
- c. Create a uniform reporting format that can replace or contain the multiple letters required from local, ward, and district level officials.

3. Eliminating corruption and bribery

Eliminating the systemic forms of corruption and bribery uncovered through this research would require a concerted and coordinated effort by each of the sectors involved (health care, police, local government), and the commitment of the legal sector to enforce penalties for providers or duty bearers who are reported for requesting or requiring bribes for facilitating services for survivors of GBV. Such

²⁹ International Planned Parenthood Federation (IPPF) defines GBV screening as :“Asking women about experiences of violence/abuse, whether or not they have any signs or symptoms.” Bott, S., Guedes, A., Claramunt, M.C., & Guezmes, A. (2004). *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York, New York: IPPF, Western Hemisphere Region [WHR].

³⁰ While this model has not yet been implemented in Tanzania, it will draw on Pathfinder's existing integration and CHW models in other countries. More information about these can be found on the Pathfinder International website: http://www.pathfinder.org/our-work/projects/community-health-worker-study_mozambique.html ; <http://www.pathfinder.org/our-work/projects/aphiaiinairobiandcentralkenya.html>

³¹ <http://www.pathfinder.org/our-work/projects/aphiaiinairobiandcentralkenya.html>

³² In many country contexts, MSI offers one-stop clinics that are smaller and more centrally located than its large clinical centers. Some information about the services offered by MSI can be found here: <http://www.mariestopes.org/what-we-do/centres>

³³ For example two such organizations in Tanzania are WLAC: <http://www.wlac.co.tz/> and TAWLA: <http://www.tawla.or.tz/>

efforts might be grounded in structured advocacy, awareness-raising, and training initiatives, as described in several of the recommendations presented in this paper.

C. Improve Quality of Care for Survivors of GBV

While few services exist that are specifically designed to respond to GBV, the research identified an array of services that can and do provide care for the small proportion of GBV survivors who enter channels of help-seeking. Across these available sources of formal and informal support, however, our findings suggest that the quality of care varies greatly. This is due in large part to a lack of training among service providers and duty bearers on the needs and appropriate response mechanisms for women who experience violence. In order to improve the quality of the care received by survivors across all sectors, PEPFAR implementing partners and the Government of Tanzania should focus on improving the training provided, and on integrating GBV screening and comprehensive care into existing structures. Specific recommendations for improving training and care are listed below. It is essential to note that GBV screening should be introduced only when appropriate support and services are in place for women who are identified as survivors.

1. Improving training for duty bearers and providers

- a. Utilize a training approach that promotes supportive attitudes toward survivors of violence and strongly challenges the forms of shame and blame placed on survivors of GBV [*Example: "In Her Shoes" methodology, which has been adapted for use in Sub-Saharan Africa and translated into Kiswahili³⁴*];
- b. Require training for all formal service providers (from the lowest to highest tiers) that incorporates the elements above but also encompasses the technical aspects of their specific services and the Tanzanian laws, regulations, and guidelines that pertain to GBV;
- c. Offer periodic refresher trainings (additional "in service" learning opportunities) for providers at all levels and in all sectors;
- d. Provide specific training to HIV/family planning/antenatal care providers (as below) to screen for and respond appropriately to cases of GBV;
- e. Expand the basic components of GBV services to include a holistic response to the physical, psychosocial, and economic needs of survivors.

2. Improving the provision of comprehensive care for GBV survivors

- a. Ensure the new *National Policy and National Management Guidelines for the Health Sector Prevention of and Response to GBV* are disseminated down to the lowest tier of healthcare providers (e.g., dispensaries) and adhered to, including by making sure that the protocols and necessary materials (e.g., forensic kits, reporting forms) are made available to providers in an accessible format;
- b. Integrate screening for and response to GBV into HIV testing and counseling, family planning service provision, and the standard package of antenatal care

³⁴ <http://www.preventgbvafrica.org/adaptation-her-shoes-sub-saharan-context>

and maternal and child health (well baby) visits [*Example of USAID and IGWG guidance on best practices for these integration approaches*³⁵];

- c. Ensure the availability of psychosocial care for survivors. This recommendation could be pursued as part of the “one-stop” model, or through a well-coordinated referral network.

D. Develop a Well-Coordinated Referral System to Respond to Survivors’ Needs

In addition to improving the quality of care available to survivors of GBV, the establishment of a well-coordinated system of referrals for survivors is critical. An efficient referral system will improve both the quality and timeliness of care and support that survivors are able to receive through formal pathways. Together with community awareness raising campaigns, a referral system that is structured around survivors’ needs is expected to enhance the care and support that survivors receive through informal channels.

1. Establishing a strong referral system

- a. Organize joint opportunities for training of key stakeholders, including traditional structures, local government authorities, and civil society;
- b. Create inter-sectoral mechanisms for the development of a strategy to establish and manage a referral system and to apply the existing GBV-related laws at the local, ward, and district levels;
- c. Explore options for strengthening the capacity of existing duty bearers (for example, Social Welfare Officers and Community Development Officers) to take on the role of coordinating and monitoring services among providers in their districts;
- d. Seek and foster partnerships between existing organizations and service providers working on GBV (and other forms of violence, including violence against children), and strengthen coordination across these groups to ensure a tighter network of services and care.

For the final two referral recommendations, the research team notes that in many districts, the Social Protection Officer is already the focal point for coordinating the various actors and agencies engaged in the child protection system. As the MoHSW continues to roll out this model to other districts, one option for maximizing coordination and efficiency would be to integrate protection from and response to GBV into this existing service delivery mechanism.

³⁵ <http://www.igwg.org/Publications/GenderHIVSelectedResources.aspx>

E. Increase Access to Justice for Survivors of GBV

The research also revealed numerous challenges that survivors face when attempting to access the justice system and seek legal remedy in response to gender-based violence. The most prominent challenges include the current penal code and the complex and circuitous GBV reporting mechanisms. For example, the PF3 was found to be a barrier to both the reporting of GBV and the provision of medical care to survivors. It is important to note that the new management guidelines for GBV explicitly state that a survivor who seeks treatment without a prior police statement should receive the care required.³⁶ The study data, however, show that this change has not yet begun to influence reporting or help-seeking among survivors. This is not surprising, as the new guidelines have not yet been widely disseminated.

If dissemination and implementation efforts are successful, this change should reduce the PF3's role as a barrier to help-seeking. This is one of several promising steps the GoT has taken towards creating a more supportive policy environment for responding to GBV. Awareness about the prevalence of violence has grown over the last decade, due in part to two large-scale studies that provided sobering evidence of the high prevalence of GBV in Tanzania. As a result of this increased attention, national policies have been updated and adapted to better respond to the needs of survivors. Also encouraging was the creation in 2008 of Gender and Children's Desks at police stations in Dar es Salaam, each of which receive specialized training on GBV.³⁷ In spite of these advances in the legal framework, there remain a number of important opportunities within current national policies to mobilize and reaffirm the country's commitment to preventing and responding to GBV.

1. Strengthening the legal structure for responding to GBV

- a. Scale up advocacy efforts to have coerced sex by partners (including marital rape) as offenses in the penal code;
- b. Reconsider the requirements for the PF3, for example, consider whether this form can be provided at the clinical site, and/or be completed by a broader range of medical providers (including those working at private facilities) [*See example of Uganda's recent changes to address similar PF3 challenges*³⁸];
- c. Address cost as a barrier to seeking and receiving appropriate legal support [*Example of Kivulini model of eliminating fees for GBV cases within the WRCs*³⁹];

³⁶ See *National Management Guidelines for the Health Sector Response to and Prevention of Gender-based Violence* p. 10. "Survivors that experience violence should report to any of the facilities that offer GBV services (health care facility, police, drop in centre, safe house, social welfare centre). If the survivor reports to a health care facility first; he/she should be treated without making a prior police statement and later report to a police station/post. If the survivor reports to the police first he/she should from there go to a health care facility."

³⁷ Betron. (2008).

³⁸ Some information about the PF3 as a barrier to help and justice seeking and the changes to the requirements for this document can be found here: <http://mail2.unfpa.or.ug/pub/GBVKaramoja.pdf>

³⁹ <http://www.kivulini.org/advocacy>

- d. Remove structural challenges to providing required evidence in rape cases, including those related to the burden of proof through forensic evidence⁴⁰;
- e. Increase efforts to provide GBV-specific training to Ward Reconciliation Committees to ensure legal procedures are followed and the rights and safety of survivors are protected within the lowest tier of the justice system. The Government and PEPFAR should consider the example of legal aid groups such as the Women's Legal Aid Center and the Tanzania Women Lawyers Association (TAWLA), who have provided training to WRC members. However the curricula of these organizations are not explicitly focused on responding to GBV.

Consistent with the suggestions above, the study recommends that training be widely instituted to raise awareness among government authorities, civil society, healthcare professionals, and the general public about laws that protect women's rights and punish perpetrators of violence.

F. Further Research

Additional research would offer valuable contributions to the design and scale up of Tanzania's response to gender-based violence.

1. Use the current data set to further explore the perceived motivations and justifications for partner abuse;
2. Use the current data set to develop messages for media and community-based campaigns about GBV and inform the design/content of other approaches for prevention of GBV;
3. Evaluate the promising/effective practices, for example, by testing some of the models and initiatives mentioned above and/or by evaluating ongoing models;
4. Study the magnitude and nature of the problem of violence against men.

⁴⁰ SOSPA has been criticized for requiring proof of penetration—a difficult stipulation given that many healthcare facilities lack the supplies necessary to collect forensic evidence—as well as the failure to address other forms of sexual assault aside from vaginal rape. See Betron. (2008).

Part V: Conclusion

The results from this study illuminate an array of socio-cultural and structural barriers to help-seeking for Tanzanian women who experience gender-based violence. As a result of these barriers, few women seek or receive appropriate support services. In response, the current research has developed a set of recommendations based on participants' input and data analysis to improve the response to GBV across all sectors and all levels of government. It is hoped that the findings will inform the efforts of the CHAMPION Project, other PEPFAR implementing partners, and the Government of Tanzania as they work together to design an effective, empirically-based strategy for increasing the availability, quality, and utilization of GBV services in Dar es Salaam, Iringa, and Mbeya.

Annexes

Annex 1: Key Research Questions

Building on the key questions listed in the scope of work provided by CHAMPION, ICRW proposes that the following research questions be explored in the field work:

How do communities define GBV, and what distinctions are made between different forms of violence (e.g., rape versus forced sex)? How do these perceptions differ among various groups?

- How do communities respond to violence? What kinds of violence are most likely to be reported? What are typical help-seeking behaviors, and are there any discernible patterns of help-seeking?
- How do communities perceive existing GBV services and what needs do they express?
- What barriers to accessing services exist in the communities, including: social/attitudinal (e.g., stigma, acceptance of violence, restrictions to women's mobility, etc.); logistical (e.g., distance, cost, hours of operation, etc.); and informational (e.g., lack of awareness of services, lack of knowledge regarding the importance of services, etc.)

The research questions focused on assessing the availability and quality of services for survivors of violence, as well as geographic coverage, coordination among providers, and monitoring efforts. The assessment also addressed existing gaps, promising practices, and lessons learned. Specific questions included the following:

- What medical, legal, and psychosocial services (both formal and informal) are available in the area? What organizations offer services and what is provided? How do users – especially women and girls – perceive the quality of these services? Is any other type of services provided within the community for survivors (e.g. gender empowerment, economic support, etc.)? Are they effective?
- How do survivors access these services? For example, what kind of advertising is in place? Where are services located? Are fees required?
- Are there any referral systems and, if so, how are they structured? How do organizations monitor their activities, including referrals (if applicable)?
- Are there any innovative or promising practices in the implementation of GBV services? What are the key challenges and lessons learned?

Annex 2: Key Informant Interview Guide – Service Providers

ICRW Guide for Key Informant Interview with Service Providers

KII Identification Number:	_____	District:	_____
Community/District:	_____	Date:	_____
Time Started:	_____	Time Ended:	_____
Participant Summary:	_____ Female	_____ Male	

My name is _____ and I am from the University of Dar es Salaam. [Introduce research team]. We are here to do a study about violence in the community where you work. We want to understand what kinds of violence people experience and what sources of help are available to them in this community. We are speaking to you because of your role as a [service provider, government official or local leader] in this community. We would like to invite you to be a part of our study so we can learn from you and better understand how the community provides support to survivors of violence.

Informed Consent:

Before proceeding, interviewer must read consent statement and sign to verify that verbal consent has been obtained.

1. Services offered at this site:

- a. What is the full range of services that you provide at this site?
 - i. Which services are for women who have experienced violence? (*Probe for specific information about services for those who have experienced physical or sexual IPV and those who have experienced other forms of sexual violence.*)
 1. What is the typical client profile for these services?
 2. Who are most of the clients you see? (*Probe: for social demographics, e.g., women, married, over age of 25, etc.*)
 3. Are most of your clients seeking support after experiences of intimate partner violence? Violence by a stranger? By someone else?
 4. About how many of each type of client does this site see in a day? A week? A month?
 5. What are the typical costs for these services?
 - b. What can you tell me about the protocols and policies that exist at this site for providing services to women who have experienced physical and sexual violence? (*Probe for institutional policies and knowledge of national policies.*)
 - c. What sort of training have you or other staff members received to provide services to women who have experienced physical and sexual violence?
 - i. As a provider, what services do you personally provide to people who have experienced these types of violence? (*Probe for medical, legal, and psychosocial service; probe to find out how clients are screened for violence*)
 1. About how many of each type of client do you see in a day? A week? A month?
 2. What kind of documentation do you use to monitor the clients who use this facility?
 - ii. Which services do you provide most frequently to clients who have experienced these types of violence? (*Probe for medical, legal, and psychosocial services*)
 1. What is your typical client profile for these services? (*Probe using demographic questions above.*)
 2. Are there other services you would like to be able to provide? Which?
 3. Why would you like to provide these services?
 4. Why does this site not provide these services now? (*Probe for staff capacity, costs, space limitations, etc.*)
 5. What other barriers do you face when providing services to clients who have experienced violence?
 - iii. Are there any services that clients have been asking for in particular?

1. How do these requests differ by the client profile (probe for differences by gender, age, type of violence, etc.)?
- d. How do you promote the services offered at this site?
 - i. How do clients find out about your services? (*Probe for advertisements outreach activities, community mobilizers, etc.*)
 - ii. Where do most clients live who use your services? (*Probe to get information about the geographic regions this site serves.*)
 - iii. What kind of system or documentation do you have to keep track of how clients are referred to your site for services?
 - e. If I were a client coming here for the first time, what would my experience be like from the time I arrived here? (*Probe for differences between clients seeking care for IPV vs. stranger violence*)
 - i. Who would be the first person I'd speak to?
 - ii. How much time would this person spend with me?
 - iii. What information would I be asked to provide?
 - iv. Would I have to take any tests or give any samples?
 - v. Would I have to write or sign a report?
 - vi. Who would I speak to next? (*Probe with same questions ii-v above.*)

2. Other services in the community:

- a. In addition to the services offered at this site, what other sources of support are there in this community for people who have experienced these types of violence?
 - i. Are there (other) health clinics? Where?
 - ii. Are there (other) sources of psychological support? Where? (*Probe for NGOs, CBOs, church-based groups, support groups, shelters/safe houses, etc.*)
 - iii. Are there (other) sources of social support? Where? (*Probe for NGOs, CBOs, church-based groups, support groups, shelters/safe houses, etc.*)
 - iv. Are there (other) sources of legal support? Where? (*Probe for police and criminal justice structures, NGOs, CBOs, paralegals, church-based groups, support groups, etc.*)
- b. In addition to these formal support structures, are there people or places that also provide support to people who have experienced these types of violence?
 - i. Do they seek support from community leaders? Which leaders?
 - ii. Do they seek support from community elders? Who are these elders?
 - iii. Do they seek support from family and friends? From whom?
- c. Does your site provide referrals to other sources of support?
 - i. To which sites or people do you refer clients?
 - ii. How do you keep track of whether your clients seek additional support from these other sites/people?
 - iii. What additional services would you like to be able to refer your clients to?

1. Why aren't you able to do this now? (*Probe for legal, medical, psychosocial and other sources of support.*)
2. Do you know of other sources of this kind of support? Where?

3. Barriers to help-seeking:

- a. In your opinion, what percentage of people who experience physical and sexual violence seek help?
 - i. From formal sources of support? (*probe using formal support service described in 2.a above*)
 - ii. From informal sources of support? (*probe using informal support services described in 2.b above*)
 - iii. Seek no support after experiencing these types of violence?
- b. What are the main reasons that more people don't seek help?
 - i. From formal sources of support?
 - ii. From informal sources of support?
Probe for interpersonal barriers (fear of stigma, fear of a partner, fear of renewed violence, embarrassment, etc.); structural barriers (transport issues, lack of service availability, the reputation of providers/sites); and resource-related barriers (cost of services, lack of childcare, etc.)

4. Best practices:

- a. Of all the services you know about for people who have experienced physical and sexual violence, which do you think are of the best quality? Why?
 - i. From formal sources of support?
 - ii. From informal sources of support?
 - iii. In this community?
 - iv. Elsewhere?
- b. How do you think your site could adopt some of the lessons from this model?

5. Referrals

- a. Are there any other providers in this community that you recommend we speak to?
- b. Are there any other institutions or facilities that you feel we should visit?

Annex 3: Key Informant Interview Guide – Duty Bearers

ICRW Guide for Key Informant Interview with Duty Bearers

KII Identification Number:	_____	District:	_____
Community/District:	_____	Date:	_____
Time Started:	_____	Time Ended:	_____
Participant Summary:	_____ Female	_____ Male	
Informant title:	_____		
Interviewer:	_____		

My name is _____ and I am from the University of Dar es Salaam. [Introduce research team]. We are here to do a study about violence in the community where you work. We want to understand what kinds of violence people experience and what sources of help are available to them in this community. We are speaking to you because of your role as a [service provider, government official or local leader] in this community. We would like to invite you to be a part of our study so we can learn from you and better understand how the community provides support to survivors of violence.

Informed Consent:

Before proceeding, interviewer must read consent statement and sign to verify that verbal consent has been obtained.

1. Role and responsibilities:

- a. Would you please describe your current role and responsibilities?
- b. How is your work related to GBV service provision and programming?
- c. Do you collaborate with any partners in this work?

2. GBV services in the district/community

- a. What sources of support are there in this district/community for people who have experienced violence, including medical care and other support services?
 - i. Are there health clinics? Where?
 - ii. Are there sources of psychological support? Where? (*Probe for NGOs, CBOs, church-based groups, support groups, shelters/safe houses, etc.*)
 - iii. Are there sources of social support? Where? (*Probe for NGOs, CBOs, church-based groups, support groups, shelters/safe houses, etc.*)
 - iv. Are there sources of legal support? Where? (*Probe for police and criminal justice structures, NGOs, CBOs, paralegals, church-based groups, support groups, etc.*)
- b. In addition to these formal support structures, are there people or places that also provide support to people who have experienced gender-based violence?
 - i. Do they seek support from community leaders? Which leaders?
 - ii. Do they seek support from community elders? Who are these elders?
 - iii. Do they seek support from family and friends? From whom?

3. Barriers to help-seeking

- a. In your opinion, what percentage of people who experience gender-based violence seek help?
 - i. From formal sources of support? (*probe using formal support service described in 2.a above*)
 - ii. From informal sources of support? (*probe using informal support services described in 2.b above*)
 - iii. Seek no support after experiencing gender-based violence?
- b. What are the main reasons that more people don't seek help?
 - i. From formal sources of support?
 - ii. From informal sources of support? *Probe for interpersonal barriers (fear of stigma, fear of a partner, fear of renewed violence, embarrassment, etc.); structural barriers (transport issues, lack of service availability, the reputation of providers/sites); and resource-related barriers (cost of services, lack of childcare, etc.)*

4. Multi-sectoral coordination

- a. How would you describe efforts to coordinate GBV-related services in this community?
 - i. Are there any existing referral networks between different providers? How do they function and who is responsible for this coordination?
 - ii. Are there any existing partnerships between healthcare providers and civil society, the education sector, the legal sector, and/or law enforcement? If yes, please describe.
 - iii. Are you aware of any guidelines, protocols, and/or formal trainings that have been implemented to improve GBV services in the health sector? The education sector? The legal sector including for police, judges, magistrates, and/or local officials? Civil society?
 - iv. Are you aware of any efforts to obtain specific funding for GBV programs or services? If yes, please describe.

5. Policy and advocacy

- a. Do you know of any recent GBV-related policies or legislative changes that have been implemented? (*Probe for national policies related to protection, reporting, punishment, etc.*)
- b. Are you aware of any advocacy efforts currently underway around GBV prevention, treatment, and programming? (*Probe for efforts at the national/district and local level.*)

6. Monitoring and tracking

- a. What kind of records or documentation are kept regarding GBV incidents?
- b. Do you know of any other ways that GBV services are formally monitored or tracked? (*Probe for efforts at the national/district and local level.*)

7. Best practices

- a. Of all the services you know about for people who have experienced gender-based violence, which do you think are of the best quality? Why?
 - i. From formal sources of support?
 - ii. From informal sources of support?
 - iii. In this district/community?
 - iv. Elsewhere?

8. Referrals

- a. Is there anyone else that you recommend we speak to about this study?
- b. Are there any specific institutions or facilities that you feel we should visit?

Annex 4: Participatory Focus Group Guide

ICRW Participatory Focus Group and Activity Guide

PFG Identification Number:	_____	District:	_____
Community/District:	_____	Date:	_____
Time Started:	_____	Time Ended:	_____
Participant Summary:	_____ Women age 18-24	_____ Women age 25+	
	_____ Men age 18-24	_____ Men age 25+	
Facilitators:	_____		
<p>My name is _____ and I am from the University of Dar es Salaam. [Introduce research team]. We are here to do a study about violence in your community. We want to understand what kinds of violence people experience and what sources of help are available to help them. We are speaking to you because you are a member of this community. We would like to invite you to be a part of our study so we can learn from you and help improve the services that are provided for people who experience violence in their lives.</p>			

Informed Consent (10 minutes)

Before proceeding, facilitator must read consent statement and sign to verify that verbal consent has been obtained from all PFG participants.

Introduction (10 minutes)

1. Introduce facilitators
2. Introduce community members
3. Explain why we are here: "We want help in understanding some health and security problems in your community. We will be doing similar activities with [other groups] both here and in [other districts]."
4. Explain ground rules: All information shared during the discussion should be treated confidentially; only one person should speak at a time; respect opinions that differ from your own; etc. Ask participants to suggest other ground rules that will help them feel comfortable sharing their ideas during the group discussion.

Activity Guide

1. *Community definitions of sexual and gender-based violence (30 minutes)*

Activity: Free listing, ranking, and discussion

"We know that women experience many types of violence at home and in the community. Let's start by talking about the fact that every married or dating couple will have disagreements from time to time. We are curious to discuss what kinds of actions might happen in these situations and how you feel about them. Let us build a list of all the kinds of actions that can happen in these situations."

Steps:

- Free listing: Facilitator seeks a list of types of violence from group members and compiles in a location visible to all
- When responses slow, facilitator probes about any of the types of violence from the prepared list (see box below) that were not previously mentioned:

Prepared list of actions:

- Yelling at or humiliating in public;
- Throwing things;
- Having affairs outside of marriage;
- Demanding sex from your partner when she doesn't want it;
- Threatening to hit;
- Threatening to withdraw financial support;
- Destroying objects that belong to the partner (such as clothes, dishes, radio);
- Not paying for household expenses;
- Pushing or shoving;
- Slapping;
- Blows with the fist, on any part of the body except the head, that don't leave a scar;
- Beating up with bruises or swelling;
- Saying constantly that your partner is stupid or worthless;
- Controlling your partner's activities (work, visits, friends);
- Beating up with wounds or fractures;
- Blows with a fist to the head;
- Blows during pregnancy;
- Threats with a gun or knife

(from WHO/PATH Guidebook on Researching Violence Against Women)

- Discussion/Ranking: Which actions are *common* in this community, in terms of frequency?
- Discussion/Ranking: Which actions does the community consider *normal* in relationships? Which go “too far?”
- Discussion/Ranking: We have been talking about actions within married or dating couples. Let’s now discuss these items imagining if they were done by a stranger or mere acquaintance. Which are *common*? Which are *normal* and “too far?”
- Discussion/Ranking: For which actions on this list would a survivor likely seek help afterward? Would a survivor seek help from family members? From professionals? From someone else?

Output of activity 1: Free list of types of violence, categorized by all of the above topics of discussion: which are common, which are normal, which are “violent,” how this changes outside intimate partnerships, and which prompt help-seeking (plus transcripts).

2. Help-seeking options and behaviors (30 minutes)

Activity: Open-ended story and mapping

“Thank you very much for all the information you’ve already shared with us. Your input is already very helpful. You have said that after experiencing certain actions, a survivor would be likely to seek help. We’re now going to discuss how the survivor seeks help and where she can go in your community.”

Steps:

- Divide PFG participants into two groups.
- Each group receives an open-ended story prompt about “Martha.” For one group, Martha is a survivor of repeated physical violence by her husband. For the other group, Martha is a survivor of rape by a non-intimate male acquaintance. (Story prompts have been adapted from *WHO/PATH guidebook on Researching Violence Against Women*, page 145, “Rosita’s story”)
- Groups receive question prompts that establish how and where Martha will seek help. Facilitators guide participants in making a physical map of available services and Martha’s path through them. Prompts include:
 - Where does Martha go to ask for help? What do they say to her? What will she decide to do next? (repeat through whole path)
 - If Martha feels very sad, depressed, or scared about the experience, what will she do? Where can she go for help?
 - If Martha fears that she has serious health consequences, what will she do? Where can she go for help?
 - What would be different if Martha were age 17? 60?
- Each group presents its map in plenary and the facilitators guide a brief comparative discussion to elicit the differences in help-seeking between the two types of violence experienced.

Outputs of activity 2: Hand-drawn maps of the participant’s community including available services and Martha’s path through them (plus transcripts).

3. Perceived barriers to accessing services (15 minutes)

Activity: Discussion

"In the stories of Martha, you discussed various sources of support, information, and health care that Martha could seek in the case of having this experience. Let's talk some more about these services."

Discussion questions:

- How common is it in this community that a person like Martha would actually seek out all of those sources of support? How common is it that a woman like Martha wouldn't seek *any* services or help? Why? Would it make any difference if Martha were age 17 or age 60? How common is it that a woman like Martha would seek *all* the services and sources of help we discussed? Why?
- How easy or difficult is it for a person like Martha to find out where she can go for help? Does *everyone* in your community know about (name of service/resource/clinic/NGO/auntie) and how (same) can help them? How do people find out that (same) exists?

Outputs of activity 3: Additional sticky notes on map representing barriers to seeking particular services (plus transcripts).

4. How to improve service delivery (10 minutes)

Activity: Discussion/Ranking

"You are the experts on this topic. You've just told us all about some problems that exist in your community and also how people can receive support if they experience these problems. Now let's close our conversation by thinking of how this situation could be improved."

Steps:

- Free listing: Tell us now, what could be done to improve the services available for survivors of violence? What could be done to help survivors access these services?
- Ranking: This is a great list of options for improving services. Which do you think is the most important of these options? Can we identify the top two or three priorities for your community in this regard?

Output of activity 4: Ranked list of top options for improving services (plus transcript).

Closing (10 minutes)

1. Thank participants for their time and ideas, and express how helpful it has been for the facilitators.
2. Explain the next steps: "We will look at all the information and will make a presentation to representatives of the CHAMPION project and other groups working in your district. They will use this information in making their plans for the next few years of work in this area."
3. Make referral sheets available. "This is a sheet of additional information for you in case today's conversation has made you want to talk more about these issues with someone individually, for any reason."
4. Re-emphasize need for confidentiality.

Annex 5: Selection of "Pathways to Help -Seeking" Maps Drawn by PFG Participants

