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GENDER-BASED VIOLENCE IN TANZANIA:

AN ASSESSMENT OF POLICIES, SERVICES, AND PROMISING INTERVENTIONS

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EXECUTIVE SUMMARY

Gender-based violence (GBV) is a grave reality in the lives of many women in Tanzania. It results from gender norms and social and economic inequities that give privilege to men over women. There is a mounting recognition in Tanzania of gender discrimination and gender equity in different facets of life. This awakening includes a growing acknowledgement of how prevalent gender-based violence is and the ways and extent to which it harms not only women and girls but also men and boys and, furthermore, the country's developing economy and health and social welfare systems.

The findings of this report are based on a qualitative gender-based violence assessment conducted in Tanzania in 2005 and a follow-up visit in 2008. Methods used include key informant interviews and focus group discussions in the 2005 and key informant interviews only in 2008.

The findings from the assessment indicate that many forms of gender-based violence, including intimate partner violence and rape, are seen as normal and are met with acceptance by both men and women—although the justifications for acceptance differs between women and men, as discussed below. Women and girls are also frequently blamed for causing or provoking gender-based violence. In part due to blame and shame, women and girls rarely report gender-based violence to authorities or seek other kinds of treatment or support.

On the other hand, at the policy level, there are signs of support to actively address GBV. For example, President Kikwete has publicly stated that gender-based violence should be included as one of the Millennium Development Goals.¹ Furthermore, Tanzania's Poverty Reduction Strategy Papers (PRSP), the National Strategy for Growth and Poverty Reduction, lists violence against women as one of its indicators of poverty—a feature that is rare among PRSPs in other countries.

Tanzanian law has shown some progress in preventing and punishing GBV crimes. For example, the Sexual Offence Special Provisions Act of 1998 poses harsh penalties for perpetrators of sexual violence. However, gaps remain in the legal system. In particular, domestic violence is only minimally and vaguely addressed in The Law of Marriage Act—although without specified penalties—and through the penal codes on general violence and assault. There is no law against domestic violence, specifically.

Recent institutional reforms in government also point to promising paths toward responding to and preventing GBV. For example, each ministry has a gender focal point, and the Ministry of Community Development, Gender, and Children has initiated efforts to train the focal points on ways to mainstream gender in their ministry workplans and budgets. Also noteworthy, the Inspector General of the Tanzanian Police Force, Saidi Ali Mwema, has instituted reforms to make the police more accessible to the community and more responsive to the community's needs. Out of this initiative, the Tanzania Police Female Network (TPFNet) was created, and with it came the creation of gender desks to respond to cases of GBV at police stations.

Despite these incipient reforms, the key informant interviews revealed that the number and quality of services and resources available to survivors of gender-based violence is minimal. While service providers interviewed, including doctors and police, said that they respond to GBV when presented with a case, there are no protocols for working with survivors. Likewise, little training on proper protocols is available to service providers. Legal aid services run by small nongovernmental organizations (NGOs) with limited budgets are available in cities throughout the country, but there is a wide gap in health, counseling, and social welfare services for GBV survivors. There are just two known established shelters for GBV survivors—the Young Women Christian Association and House of Peace—both located in Dar es Salaam.

¹ Interview with UNIFEM representative Salome Onyote. September 18, 2008.

A handful of promising interventions have been or are being implemented by NGOs. Yet, they are limited in scope and number. For example, in refugee settings in northwestern Tanzania, the International Rescue Committee provides comprehensive GBV services, including medical treatment, provision of post-exposure prophylactics and emergency contraception, counseling, and legal aid. Kivulini, an NGO in Mwanza, conducts awareness raising, advocacy, and community mobilization with local government leaders, police, health workers, and other civil society organizations to help them recognize their roles in responding to GBV and develop strategies to take action.

These activities are beginning to gain momentum, suggesting that Tanzanian society is ready to take on gender-based violence prevention and response efforts. Building on the momentum of existing activities is necessary—as is working to ensure that each intervention is coordinated with others and ensuring that communities are involved in planning, owning, and implementing activities. This assessment aims to highlight some of the most promising GBV interventions and identify the most important gaps and opportunities for intervention and coordination. Based on the findings, the following key interventions emerge as strategic and reasonable interventions:

Legal and policy environment

- Advocate for a specific law on domestic violence
- Incorporate GBV into HIV policies and plans
- Assist the Ministry of Community Development, Gender, and Children’s Affairs (MoCDGC) to revise the GBV plans of action to include strategies for health, HIV, and education
- Support the MoCDGC to develop a multisectoral GBV network
- Support the MoCDGC to advocate for budgets in order to implement GBV plans of action
- Facilitate dialogue among parliamentarians about the health, development, and social impacts of GBV
- Assist gender focal points in ministries with addressing GBV issues and developing sector-specific action plans on GBV
- Work with local government leaders to translate the GBV plans of action into concrete components of community by-laws

Services

- Reform health centers systematically to address GBV, starting with how-to policies, protocols, and guidelines
- Incorporate GBV screening and referrals into HIV counseling and testing programs
- Pilot a one-stop service center for GBV survivors
- Incorporate a GBV response into HIV counseling and testing programs that have adequate capacity and resources
- Incorporate GBV curriculum into university health, justice, and legal programs and/or continuing education programs for health professionals
- Support the TPFNet to train police on GBV and further expand gender desks throughout the country
- Form peer support and counseling groups by training community members as facilitators

Awareness-Raising and Community Mobilization

- Raise awareness on the problem of GBV and gender equality in the community
- Engage men and boys in efforts to mobilize communities against GBV
- Link GBV and HIV in HIV awareness-raising programs and mass media campaigns
- Research further the varying types of GBV in Tanzania

ABBREVIATIONS

AFNET	Anti-FGM Network
AIDS	acquired immune deficiency syndrome
CDC	U.S. Centers for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIDA	Canadian International Development Agency
FAWE	Forum for African Women Educationalists
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
HIV	human immunodeficiency virus
IEC	information, education, and communication
IRC	International Rescue Committee
KIWAKKUKI	Kilimanjaro Women’s Group Against AIDS
KIWOHEDE	Kiota Women’s Health and Development Organization
KWIECO	Kilimanjaro Women Information Exchange and Consultancy Organization
LHRC	Legal and Human Rights Centre
MEWATA	Medical Women Association of Tanzania
MoCDGC	Ministry of Community Development, Gender and Children’s Affairs
MoJ	Ministry of Justice and Constitutional Affairs
NGO	nongovernmental organization
PEP	post-exposure prophylactic
PF3	police form #3
PRSP	Poverty Reduction Strategy Paper
STI	sexually transmitted infection
SOSPA	Sexual Offences Special Provisions Act
TAMWA	Tanzania Media Women’s Association
TARWOC	Tanzania Rural Women’s and Children’s Association
TAWLA	Tanzania Women Lawyers Association
TGNP	Tanzania Gender Networking Program
TPFNet	Tanzanian Police Female Network
UMATI	Chama Cha Uzazi na Malezi Bora Tanzania (family planning association)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization
WILDAF	Women in Law and Development in Africa
UNHCR	United Nations High Commissioner on Refugees
WLAC	Women’s Legal Aid Centre
WoWAP	Women Wake Up

I. OVERVIEW OF GENDER-BASED VIOLENCE

The objectives of this research and report are to

- Identify who the stakeholders are with regard to gender-based violence (GBV) in Tanzania;
- Assess the government’s commitment (resources, political will, visibility) in addressing GBV in Tanzania;
- Identify existing policies in Tanzania that address women’s legal protection against GBV and assess their level of implementation;
- Provide a summary of existing structures and services available to survivors of GBV, as well as the community context (including perceptions, norms, and attitudes) within which these structures operate; and
- Highlight promising and suggested interventions for both the prevention of and response to GBV in Tanzania for all sectors, including health, legal, justice, and education.

This report provides concrete and practical recommendations for stakeholders (government, civil society organizations, faith-based groups, enforcement agencies, watchdog groups, and others) on how to improve the policy environment to address GBV. It also provides recommendations for USAID Tanzania on how to focus its policy and advocacy funding where it will make the most impact.

Definitions

Gender-based violence is “any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (gender) differences between males and females” (IASC, 2005). GBV has a greater impact on women and girls, as they are most often the survivors and suffer greater physical damage than men when victimized (WHO, 2005). In fact, the term “gender-based violence” is often used interchangeably with the term “violence against women.”² The term is also used to point to the dimensions within which violence against women takes place: women’s subordinate status (both economic and social) makes them more vulnerable to violence and “contribute to an environment that accepts, excuses, and even expects violence against women” (Heise et al., 2002; cited in Betron and Doggett, 2006, p. 7). Also important, however, is the fact that men and boys also are survivors of GBV, such as rape as a method to de-masculinize men or sexual abuse of boys. Gender roles also contribute to the fact that men and boys not only feel pressured by their male peers to express their masculinity through acts of violence against women but also against other boys and/or men, as is often the case with gang violence. Given the overwhelming evidence that GBV disproportionately affects women, however, this assessment focuses primarily on GBV against women (Betron and Doggett, 2006).

Gender-based violence takes many forms, including physical, sexual, psychological, and economic violence. Defined here are the types of violence discussed throughout the assessment (Betron and Doggett, 2006, p. 7–13):

Intimate partner violence—“any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Such behavior includes

- Acts of physical aggression—such as slapping, hitting, kicking, and beating;
- Psychological abuse—such as intimidation, constant belittling, and humiliating;
- Forced intercourse and other forms of sexual coercion;

² The United Nations General Assembly defined violence against women as “Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life” (United Nations General Assembly, 1993).

- Various controlling behaviors—such as isolating a person from his/her family and friends, monitoring his/her movements, and restricting his/her access to information or assistance” (Krug et al., 2002); and
- Economic abuse—such as withholding funds, controlling survivor’s access to healthcare, employment, and so on (WHO, 2005).

Sexual violence—“any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the survivor, in any setting, including but not limited to home and work” (Krug et al., 2002).

Female genital cutting (FGC)—full or partial removal of girls’ external genitals—often performed under dangerous, unsanitary conditions and without anesthesia for cultural or non-therapeutic reasons (Garcia-Moreno et al., 2000).

Early child marriage—marriage of a person at an age at which she/he is not fully able to consent to the marriage and/or marriage at an age which results in vulnerability to reproductive health problems, psychosocial damage, or denial of education. Many married children and adolescents have been forced into marriage or may be “too young to make an informed decision about their marriage partner or of the implications of the marriage itself” (UNICEF, 2001, p. 2). Early child marriage is both a risk factor for GBV and a form of gender-based violence in and of itself.

Human trafficking—“the recruitment, transportation, transfer, harboring, or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs” (U.S. State Department, 2005, p. 10).

Health Impacts of Gender-Based Violence

Intimate Partner and Sexual Violence

Although violence can have direct health consequences, such as physical injury, evidence suggests that experiencing violence also increases a woman’s risk of future ill health (Krug et al., 2002)—for example through harmful behavioral outcomes like drug and alcohol abuse or unsafe sexual practices. International research, including research in Africa, shows that women who experience physical and/or sexual abuse by an intimate partner experience ill-health more frequently than other women—with regard to physical functioning, psychological well-being, and the adoption of further high-risk behaviors, including smoking, physical inactivity, non-use of contraceptives and condoms, and alcohol and drug abuse (Krug et al., 2002; Koenig et al., 2004). Table 1 lists the major health consequences of intimate partner and sexual violence.

Table I. Health Consequences of Intimate Partner and Sexual Violence

Fatal Outcomes	Non-Fatal Outcomes		
<ul style="list-style-type: none"> • Femicide • Suicide • AIDS-related mortality • Maternal mortality 	<ul style="list-style-type: none"> • Physical injuries and chronic conditions • Fractures • Abdominal/thoracic injuries • Chronic pain syndromes • Fibromyalgia • Permanent disability • Gastrointestinal disorders • Irritable bowel syndrome • Lacerations and abrasions • Ocular damage • Sexual and reproductive sequelae 	<ul style="list-style-type: none"> • Gynecological disorders • Pelvic Inflammatory disease • Sexually-transmitted infections, including HIV • Unintended pregnancy • Pregnancy complications • Miscarriage/low birth weight • Sexual dysfunction • Abortion • Psychological and behavioral outcomes • Depression and anxiety 	<ul style="list-style-type: none"> • Eating and sleep disorders • Drug and alcohol abuse • Phobias and panic disorder • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Self harm • Unsafe sexual behavior

Source: Bott, Morrison, and Ellsberg, 2005.

Studies from around the world suggest that HIV/AIDS and GBV have a dangerous, complex relationship and may each increase the risk and impact of the other. The important interfaces of HIV and violence are summarized within the following (Campbell, unpublished):

- Epidemiological studies showing significant overlap in prevalence (Greenwood et al., 2002)
- Studies showing intimate partner violence as a risk factor for HIV among women and men (e.g., Dunkle et al., 2004; Greenwood et al., 2002)
- Studies showing violent victimization increasing HIV risk behaviors, including injecting drug use (e.g., Abdool, 2001; Choi et al., 1998; Gilbert et al., 2000; Wyatt et al., 2002)
- Emerging research showing immune system alteration from violence victimization in women (Woods et al., in review)
- Studies showing violence or fear of violence impeding or as a consequence of HIV testing (Gielen et al., 2000; Maman et al., 2001; Maman et al., 2002)
- Studies showing partner violence as a risk factor for sexually transmitted infections (STIs), which increases the rate of transmission of HIV (Campbell, unpublished)
- Data indicating that abusive men are more likely to have other sexual partners unknown to their wives (Garcia-Moreno and Watts, 2000)
- Studies showing that abused partners have difficulty negotiating safe sex behavior (Davila and Brackley, 1999; Wingood and Clemente, 1997)

“In addition, there are hypothesized but as yet untested relationships between increased HIV transmission and IPV [intimate partner violence] through intimate partner forced sex, known as a frequent form of intimate partner violence (Campbell and Soeken, 1999; Maman et al., 2000). Forced vaginal sex may cause trauma, which increases the chance of HIV transmission. In addition, abused women report forced anal sex as a frequent form of forced sex in violent intimate relationships, and anal sex is known to increase HIV transmission because of the same direct to blood transmission” (Campbell, unpublished, p. 1).

Female Genital Cutting

The consequences of FGC for women’s health can be severe, including obstetric problems (antenatal, labor, delivery, postpartum, pregnancy outcome, maternal mortality, and neonatal mortality); gynecological problems, such as menstrual problems and infertility; psychosexual problems; urinary problems; and psychological morbidity (Garcia-Moreno et al., 2000). Given these serious and sometimes fatal impacts of FGC, its significance as a form of GBV should not be overlooked. Human rights concerns aside, the documented impacts on maternal and child health are plentiful (see Table 2).

Table 2. Maternal and Child Health Consequences of FGC

Obstetric Sequelae of FGC in Earlier Life		Childbirth Sequelae of FGC in Pregnancy	
<i>Antenatal Effects</i>	<i>Effects During Labor and Delivery</i>	<i>Antenatal Effects</i>	<i>Effects During Labor and Delivery</i>
<ul style="list-style-type: none"> • Pregnancy in presence of pinhole introitus • Fear of labor and delivery due to small size of introitus • Difficulty in performing antenatal vaginal examination • Painful scar 	<ul style="list-style-type: none"> • Urine retention during labor • Difficulty assessing progress of labor • Prolonged labor and/or obstruction • Fetal distress • Episiotomies and perineal tears • Postpartum hemorrhaging • Maternal death • Fetal death • Post-partum genital wound infection 	<ul style="list-style-type: none"> • Hemorrhaging • Infection • Fetal injury 	<ul style="list-style-type: none"> • Pre-term labor • Obstruction requiring caesarean section • Difficult labor • Maternal death • Fetal death

Source: Garcia-Moreno et al., 2000.

Human Trafficking

By definition, human trafficking entails coercion, which typically includes physical and psychological abuse. Research has demonstrated that violence and abuse are at the core of trafficking for prostitution. For example, a nine-country assessment of sex work concluded that 73 percent of women used in prostitution were physically assaulted, 89 percent wanted to escape, 63 percent were raped, and 68 percent met the criteria for post-traumatic stress disorder (Farley et al., 2003). Moreover, experts believe that sex trafficking is contributing to the global spread of HIV and to the mutation of the HIV virus, as well as the development of drug-resistant strains of other STIs. In brothels in Indonesia, for example, 89 percent of female prostitutes with gonorrhea were resistant to penicillin and 98 percent to tetracycline, thus increasing the risk of HIV infection (U.S. Department of State, 2007).

Economic and Social Costs of Gender-based Violence

Intimate Partner Violence

GBV has significant costs for the economies of developing countries in terms of lower worker productivity and incomes and lower rates of accumulation of human and social capital and its strain on healthcare and judicial systems. Studies measuring the economic costs of GBV have not been conducted in Africa. However, using the accounting method to estimate costs of GBV, the U.S. Centers for Disease Control and Prevention estimated expenditures on medical and mental healthcare services for the 5.3 million incidents of domestic violence reported in 1995 in the United States to be US\$5.1 billion (CDC, 2003; Waters et al., 2004). Since services for GBV survivors are minimal to none or are often not

solicited in developing countries, measuring indirect costs, or the value of foregone earnings as a result of violence in both paid and unpaid work, may be more appropriate (Morrison and Orlando, 2005). Data are limited, but in Nicaragua, for example, researchers estimated the indirect costs due to GBV to reduce the Gross Domestic Product by 1.6 percent or US\$32.7 million (Waters et al., 2004).

The social costs of gender-based violence, although not always as apparent as the health-related or economic costs, are just as grave. Indeed, social costs also include health-related and economic costs—in that they are a detriment to society as a whole, not just the individual involved. For example, when children miss school, it is both a social as well as an economic cost to the long-term growth of society due to lost productivity. Moreover, declining health status may also be considered a social cost due to its implications in terms of decreased productivity or participation in society. However, the experience of gender-based violence, regardless of the health status of the survivors, can hinder participation of women and children in the community and society simply due to embarrassment, stigma, or mental and emotional trauma (Duvvury et al., 2004). Lastly, the inter-generational effect of violence should also be recognized as a major social cost. Children witnessing violence perpetuate violence in future generations and are at greater risk for becoming survivors themselves (Duvvury et al., 2004). Overall, GBV creates a culture of violence in society that has major costs when considering the numbers above are multiplied.

Female Genital Cutting

There has been no rigorous research done on the economic impacts of FGC. The costs of managing and treating the above-listed health consequences, whether it be obstructed labor or hemorrhaging, would surely be significant.

Human Trafficking

There are tremendous economic costs resulting from trafficking. For example, the International Labor Organization conducted a study on the benefits of eliminating the worst forms of child labor, which by definition include child trafficking. The organization concluded that the economic gains from eliminating the worst forms of child labor amount to tens of billions of dollars annually worldwide because of the added productive capacity a future generation of workers would gain from increased education and improved public health (U.S. State Department, 2008).

II. GBV ASSESSMENT IN TANZANIA

Methodology

Two researchers and an interpreter conducted a rapid situation assessment during October 19–November 3, 2005. The assessment included interviews with 37 representatives of government offices, public services, and nongovernmental organizations (NGOs) that work with survivors of gender-based violence; and five focus group discussions with men, women, boys, and girls. The interviews and discussions were conducted in Dodoma; the large, urban center, Dar es Salaam; and the peri-urban town of Kibaha.

The 2005 research team conducted 28 interviews with key informants in Dar es Salaam and in Dodoma in each of the relevant sectors of GBV prevention and response (health, legal, justice, psychosocial and education), as well as in refugee communities. The interviews identified institutional attitudes toward GBV and any support mechanisms and services or prevention activities that may exist. Key informants also made recommendations to address the problem of GBV. Key informants included government officials, doctors, nurses, midwives, psychiatrists, a police officer, social workers and lawyers, as well as representatives from donors, NGOs, gender networks, networks of people living with HIV, and faith-based organizations (see Appendix A). Due to time constraints, two were conducted by telephone from Dar es Salaam to rural areas of Tanzania and one was conducted by telephone from Washington, D.C.

The 2005 team conducted five focus group discussions with

1. Adolescent boys who were program beneficiaries of the Mikumi Youth Centre in Dar es Salaam, the most populated city in Tanzania, as well as the country's political and business center;
2. Adolescent girls who were program beneficiaries of the Mikumi Youth Centre in Dar es Salaam;
3. Adult female program beneficiaries of the Tanzania Women Lawyers' Association's (TAWLA) legal aid program, also in Dar es Salaam;
4. Male community leaders in Kibaha, a peri-urban township outside Dar es Salaam; and
5. Adult women in the capital city of Dodoma, a smaller city surrounded by farm land. These women were beneficiaries of the Women Wake Up (WoWAP) program. Focus groups were conducted in Swahili, with the assistance of a translator.

During the focus groups, the researchers asked participants about the nature and scope of GBV in Tanzania and how they are affected by the violence, what response mechanisms and resources for GBV survivors exist for the individuals and at the community level, and the help-seeking behavior of survivors. Participants were also asked for their recommendations on ways to address the problem of GBV in their communities. These focus groups were used to obtain greater insight into the Tanzanian context of GBV.

For data collected during the 2005 visit, a professional translator/transcriber translated and transcribed tape-recordings of the discussions and key informant interviews for the preparation of this report. This report also makes use of previously existing literature and data.

In 2008, one researcher conducted interviews with 18 key informants in Dar es Salaam—many of which represented the same government offices, public services, and NGOs interviewed in 2005 (see Appendix A). Key informant interviews were limited primarily to government representatives, donors, and NGOs in Dar es Salaam that were identified as key players in the response to GBV-based on the 2005 assessment and recommendations by the National Coalition of Gender-Based Violence for Civil Society Organizations (formed in 2007).

The research methods and areas for investigation were adapted from situational analysis techniques described in the Reproductive Health Response in Conflict Consortium's *Gender-based Violence Tools Manual: for Assessment, Program Design, Monitoring and Evaluation in Conflict-Affected Settings*, as well as an interview guide adapted from the Uganda-based GBV prevention organization, Raising Voices.

Conceptual Framework and Organization

To compile this report, activities were sorted by sector and/or target population and then by the type of intervention. Sectors and/or target populations include health/psychosocial, legal, security, education/youth, and multisectoral programs. These categories are combined and adapted from the conceptual frameworks of two global reviews of promising interventions related to GBV (Bott et al., 2005; Guedes, 2004). The classifications for interventions (also drawn from Bott et al., 2005 and Bott and Betron, 2005) include the following:

- *Laws and policies*—drafting legislation, advocating for legislative and policy changes, and educating policymakers, including parliamentarians
- *Delivery and/or reform of services*—training staff or volunteers, expanding services, improving the quality of services, and strengthening institutional policies and protocols and referral networks.
- *Community mobilization*—raising overall community awareness and mobilizing community-based efforts and mass media campaigns
- *Individual behavior change*—improving knowledge, attitudes, and practices of community members

The assessment found that not all levels of intervention in each sector are addressed in Tanzania. Still, the framework allows for the identification of gaps in the response to GBV. On the other hand, although interventions are presented under individual sectors and/or levels of interventions, several programs address more than one sector. The report outlines such programs in each relevant sector and then describes multisectoral programs in a separate section. A multisectoral approach is key to preventing gender-based violence.

Limitations

Due to budgetary and time constraints, the research team stayed in Tanzania for three weeks during the 2005 visit, which coincided with elections and a three-day religious holiday, posing difficulties for scheduling interviews with those affected, particularly government employees. Similarly, the 2008 visit was only two weeks, and few meetings were scheduled in advance.

In 2005, due to a recent media scandal in which an NGO released research that shed light on weaknesses of the government-run school system and was banned as a result, many Tanzanians were suspicious of research and fearful of sharing information on system gaps. This held true for government workers in particular. This is also the main reason the assessment was unable to include information on the education sector.

The researchers being foreigners may have also inhibited informants in their response more generally. While individuals are sometimes known to confide more to outsiders from a community, often culture precludes open discussion with external visitors. Likewise, language may also have been a barrier. Focus group discussions in the community were conducted in Kiswahili, recorded, transcribed, and translated. Through these steps, some information may have been lost.

Finally, but perhaps most importantly, gender-based violence is a fairly new topic of debate for Tanzanians. Cultural norms around gender violence, coupled with shame and discomfort make discussing

GBV difficult for some. This discomfort, as well as fear of revealing gaps, may have affected the responses of focus group participants and key informants.

Gender in the Tanzanian Context

Gender inequity is the norm in Tanzania. Many women in Tanzania do not have the same opportunities as men for education and economic independence. The 2004 Demographic and Health Survey found that 64 percent of men complete primary education, while only 58 percent of women do the same (National Bureau of Statistics and ORC Macro, 2005). Focus group participants affirmed that, especially in poor families, boys' education tends to be valued more than girls and that girls may be taken out of school to assist with domestic responsibilities or to marry:

“Girls in the family, we have been placed as workers. Therefore a girl, even if she goes to school and gets more knowledge, the parents believe that if she continues she will be a mother of a house, she'll get pregnant... and there will be great loss. Therefore the parents don't see the importance of continuing the education of girls to go farther to help their future lives. Each parent thinks their girls will go and get pregnant and have a baby, that is it.”

~ Adolescent female focus group participant

Due both to inequities in access to education and to social norms of women caring for the family rather than working outside the home, many respondents cited that women tend to be economically dependent on men. A full 87 percent of women were economically active in comparison to 90 percent of men as of 2002 (National Bureau of Statistics and ORC Macro, 2005), but focus group participants suggested that women tend to work part-time and still depend on their husbands financially. For example, one female participant said that she runs a small business making doughnuts in the evening to sell to a vendor the next day. A few key informants noted that women's economic dependence on men may be a factor in women's vulnerability to GBV, as women might not have the financial resources to leave abusive situations and still provide for their families.

Women's economic activities also tend to be in addition to full workloads at home, as their husbands rarely help with domestic chores:

“A woman can go to work and when she comes home, she is tired from work and then coming home she has to do more work. So there's no rest. I come home to wash my clothes, hang them out, have the food cooked. I don't have a girl to help me, so I have to cook it myself.”

~ Adult female focus group participant

Many focus group participants noted that consciousness of gender discrimination and disparities is increasing and that, at many levels, norms and structures are beginning to change to redress inequities. Male focus group participants insisted that unequal division of domestic labor is changing slowly, although most men agreed that women do more work, all in all, than men.

“We have learned during this day and time that a woman is not just something to be used. This means that I must share everything with her and help her.”

~ Adult male focus group participant

Despite women's role as the primary domestic worker, women have little influence in household decisions. In both focus groups with adult women, participants unanimously agreed that men make the decisions in the family, including decisions about finances, property, and childrearing. Girls and women often need permission from their husbands to leave the home and to work outside of domestic responsibilities.

On the other hand, some male focus group participants said that although it is still unequal, this power balance is changing; in some families, women and men make decisions together. Other men voiced resistance to such change and acknowledged that such change is a slow process:

“Everything is now shared with the wife and you can’t have your own field and sell it without first discussing it with your wife. Ah, the children see the father agreeing with the ideas of the mother. Long ago, it was the father only. The woman didn’t say anything. But, today, that doesn’t exist. Because, these days, the woman has rights in the face of her husband. In the light of the law, the woman has rights. So, if it goes to the authorities, the man may lose everything to his wife if she is seen to be in the right. So that is why we care for our wives these days. They are just like us.”

~ Male focus group participant

“We can’t say that everything from the past has ceased. Now women have been given rights, it is true. But still we see these manners from the past continuing. People are still learning.”

~ Male focus group participant

Similarly, the focus groups participants agreed that men make most of the decisions in the community. A few respondents stated that women are too afraid or shy to speak in public. “Those of us who are girls do not get involved in discussions of any kind at home or anywhere,” remarked one young female participant. In formal decisionmaking positions, the government of Tanzania has established quotas for women’s participation. It set goals in 2000 for women to comprise 33 percent of local government councils and 20 percent of the seats in the Union Parliament. The government set a goal to have women in 30 percent of parliament seats by 2005, and as of 2004, the proportion was at 21 percent (Ashford and Clifton, 2005). While these are certainly important advances, it is unclear how much power the women representatives truly have, as they are selected by their party and must run on a party line ticket.

Women in Tanzania have limited access to property and inheritance rights. The Tanzanian constitution, CEDAW, the Land Acts and the Law of Marriage Act, stipulate that women and men in Tanzania have equal property rights, but customary legal provisions and common cultural practice tend to undermine women’s ability to acquire, inherit, maintain, and dispose of property (TAWLA, 2004). Some focus group participants and several key informants considered women’s lack of property and inheritance rights to be a form of gender-based violence in and of itself.

Access to healthcare is limited in Tanzania, as hospitals are mostly concentrated in urban areas; dispensaries and health centers are available in rural areas, but they may lack medical staff and supplies. Moreover, user fees hinder use of services. This difficulty in access affects everyone but is likely to pose particular strain on women, who have limited access to family finances, increased healthcare needs because of pregnancy and childbirth, and responsibility for the healthcare needs of their children. Furthermore, women’s mobility is often restricted, and they may have extremely large domestic workloads—sometimes in addition to formal employment.

Focus group participants, particularly women and those working with women, expressed grave concern over the growing HIV epidemic, which tends to affect women disproportionately. As of 2004, 6.3 percent of men and 7.7 percent of women were HIV positive in Tanzania (TAWLA, 2004). This disparity may be due to, as focus group participants unanimously reported, girls and women having little control over the terms of sex and often experiencing sexual violence.

“The situation [of women] is worsening, because, for example, the problems we have with sickness. You see, [of] all those sick with AIDS, the one who suffers most with AIDS is the woman. She takes care of the sick. We say that AIDS has the face of the woman; she bears all the burden.”

~ Female focus group participant in Dar es Salaam

Gender-based Violence in Tanzania

Intimate Partner Violence

Intimate partner violence is highly prevalent in Tanzania: a study by the World Health Organization (WHO) in 2001/2002 of 1,820 women in Dar es Salaam and 1,450 women in the Mbeya District found that 41 percent of ever-partnered women in Dar es Salaam and 87 percent in the Mbeya District had experienced physical or sexual violence at the hands of a partner at some point in their lives. In both areas, 29 percent of those experiencing physical intimate partner violence experienced injuries, with over a third of them having been injured in the past year (WHO, 2005).

Participants of focus groups conducted as part of this assessment affirmed that it is common for women to experience violence at the hands of their husbands or partners:

“Because you can have a man who takes good care of you or who does not take care of you. Some husband may be drunk and beat you and then afterwards ask for forgiveness and you forgive him.”

~ Adult female focus group participant

“There may be something the man does and hides it, for example, beating his wife. Still men today have the nature of beating their wives. It’s not something that is discussed openly.”

~ Adult male focus group participant

When probed as to why husbands beat their wives, respondents cited the following:

“Men get very angry, and they will beat their wives for any reason. If she cooks or doesn’t cook, whatever, he has to beat her.”

~ Adult female focus group participant

“Maybe someday their husband has another wife. And he don’t like you to ask him questions. Why he’s sleeping out, why he’s not leaving food, no clothes, no care of children.”

~ Adult female focus group participant

While the respondent above said that intimate partner violence is not talked about openly, the practice is seen as an acceptable means of resolving family conflicts (or, in other words, “punishing” or “educating” women for behaviors considered deviant), at least by men. On the other hand, women almost unanimously agreed that it is never a good thing for a man to beat his wife. Women in the Dodoma focus group stated that intimate partner violence is a form of discrimination against women.

“What I know is that one has the ability to punish his wife after she is seen to have done wrong. But you man, if your wife has wronged you, I think it best that she be educated. And there you take the step of beating her, this is to say you have taken the law into your own hands, and it will be too bad for you if the law takes you into its hands.”

~ Adult male focus group participant

“Maybe I will say that often, especially, the wives are stealing or they think they are going with another man. He is then ready to beat her. Perhaps the foundational reason is that he has forbidden her from going to a certain place, and the woman in her pride decides to go there...”

~ Adult male focus group participant

Sexual Violence

In both sites of the above WHO study, 15 percent of women reported that their first sexual experience was forced (WHO, 2005). Many in Tanzania view rape as acceptable behavior for men and boys under various circumstances, as focus group discussions indicated. Reasons cited for rape included men not having enough money to convince women to marry or have sex with them, hormones, girls’/women’s

acceptance of gifts from men, and alcohol use (by both women and men). Sexual violence does not appear to be limited to rape by strangers and acquaintances. Although not generally seen as rape, young women especially may be coerced into having sex by being lured by potential economic gains, including money and gifts.

“In our community if you approach a girl [for sex] and she refuses for more than three times, you have to do any effort until you get her, be it by use of tricks or even raping her. You may even use another man to seduce and then do a rough game when she gets into a trap. This is known in our community as “*mande*,” that is, a number of men doing sex to one girl simultaneously. This is to give her a lesson.”

~ Adolescent male focus group participant

“When a woman is given money, it is as if there is some kind of agreement. And the money the man gives and the woman receives it, she knows there is an obligation. It is understood. She will pay in one way or another because she received the money. If she doesn’t repay that money, and she doesn’t give the things that he needs, then rape will occur.”

~ Adult male focus group participant

Forced sex within marriage is not criminalized by the law and was not considered rape by male community leaders participating in a focus group. Wives are expected to provide sex to husbands, and both men and women acknowledged that wives who refuse sex can expect to be beaten and/or raped.

“Truthfully, you will be beat.”

~ Adult female focus group participant,
when asked what happens when a wife refuses sex with her husband

“[I]t’s not rape because she went into the marriage. You see? The one who is in the marriage has already agreed. If you have a contract with her and go out of the contract, without a foundational reason, you as a man have been attacked with shame...it’s a shame.”

~ Adult male focus group participant

Most focus group participants agreed that there are cases in which a girl or woman can be at blame for causing men to rape her. For example, drinking alcohol, wearing revealing clothes, and accepting money are all seen to be behaviors that provoke rape. It is important to note that both men and women cited these reasons to justify rape of a woman.

“[It] depends on the character of the lady in light of drinking and getting drunk. If a girl knows that after five drinks or so she can do whatever, the men will look to get her drunk. Men try to get women drunk so they can do whatever. The fault is on the woman because she knows her weakness to alcohol and goes to drink anyway. The fault is on the woman.”

~ Adolescent female focus group participant

“Sometimes the ladies are the ones to blame. [If] you find a girl taking gifts from different men, as a result...the men conspire to do a rough game to the girl to teach her a lesson.”

~ Adolescent male focus group participant

“The girls in town wear clothes that are not worthy. They cause the men to look. So the man gets that lust, he rapes her.”

~ Adult female focus group participant

Although little empirical evidence exists to measure sexual violence against men and boys, focus group participants reported that sexual violence against boys does occur. Most participants knew of cases where

boys had been raped in their community. For example, respondents cited a famous musician that had gained publicity for being charged for sexual violence against boys. Although sexual abuse of boys is a serious crime and warrants further study, most known cases of violence in Tanzania that can be characterized as gender-based (as opposed to general violence, gang violence, youth violence), are perpetrated against women. Likewise, programs addressing GBV focus largely on women.

Harmful Traditional Practices

Female Genital Cutting

The harmful traditional practice of FGC is illegal in Tanzania. As Tanzanians raise awareness about the harms of FGC, fewer people are practicing it. Still, 15 percent of women ages 15–49 in Tanzania had experienced FGC as of 2005 (National Bureau of Statistics and ORD Macro, 2005). Representatives from the Anti-FGM Network (AFNET) and Christian Council of Tanzania, groups working to eradicate FGC, report that as legal and public acceptance of FGC declines, the practice is performed more secretly—sometimes under unsanitary conditions and at younger ages to avoid being caught.

Early Child Marriage

In Tanzania, girls can legally marry as young as 15 years old, while the legal age of marriage for boys/men is 18. Adolescent focus groups confirmed that girls marry at younger ages than boys. Moreover, girls often marry at very young ages. In reality, girls are deemed mature enough for marriage once they begin menstruating, while boys are not considered marriageable until they can financially provide for a family. They also noted that girls are sometimes forced to marry men much older than themselves. Focus group participants, both male and female, stated that girls have less power to decide when and who they marry than do boys.

“It doesn’t depend on age. If she has had her period, she can get married. About 13 or 14, I think from age 15 and on.”

~ Adolescent female focus group participant

“A man can get married to a girl of his own choice, but to women, the position is different. It is difficult for a girl to choose a husband she likes, because her parents have to be satisfied if that man has money or not.”

~ Adolescent male focus group participant

Bride Price and Other Harmful Traditional Practices

Other local beliefs and practices with potentially harmful health outcomes for women cited by respondents include payments at marriage made by the groom to the bride’s family³ and women’s lack of property and inheritance rights.

“The parents normally agree and receive money from the husband. So, when you go there, you don’t know who you are going to meet and what will be the fate of your life. They are just after the bride price.”

~ Adult female focus group participant

Some focus group participants mentioned other harmful traditional practices, such as widow inheritance, in which a woman is “inherited” by her husband’s family upon his death; widow cleansing, wherein a widow is urged to have sex with a man to cleanse herself of evil spirits; harmful nutritional practices whereby, for example, women may not be allowed to eat eggs while pregnant; and so-called same-sex marriage, wherein infertile or older women pay bride wealth for a girl and force her to be a surrogate mother. Only one or two participants mentioned these practices, however. While it is important to note

³ This type of payment is sometimes referred to as “bride price” or “bride wealth.” Historically, however, it did not involve a type of commercial transaction that is now understood by the use of the word “price.”

the practices and their potential harmful effects on women, it is not clear how prevalent these practices are. More research is needed to fully understand the contexts in which they operate.

Trafficking

According to the U.S. State Department report on trafficking, Tanzania is a source, transit, and destination country for men, women, and children trafficked for the purposes of forced labor and sexual exploitation (U.S. State Department, 2008) Tanzanian girls from rural areas are trafficked to urban centers and the island of Zanzibar for domestic servitude and commercial sexual exploitation. Some domestic workers fleeing abusive employers fall prey to forced prostitution. While statistics on trafficking are difficult to obtain because of the underground nature of the phenomenon, existing evidence indicates that it is a significant problem in Tanzania. For example, in 2007, the Ministry of Labor withdrew nearly 1,100 victims from forced child labor situations (U.S. State Department, 2008).

Tanzanian Laws and Policies on Gender-based Violence

Legal protection from GBV in Tanzania is limited. The Law of Marriage Act prohibits a spouse from inflicting corporal punishment on his/her spouse. The law has little impact, however, because it does not protect unmarried couples from domestic violence; and it does not define corporal punishment, thereby excluding many forms of domestic violence, such as economic deprivation (Tanzanian Women Lawyers' Association, 2004). Legal advocates propound that a specific law on domestic violence is necessary for many reasons. First and foremost, a law especially for domestic violence would make a political statement that domestic violence is wrong. Such a law could also allow for means of punishment besides imprisonment of the perpetrator, which for many women is a threat to their livelihoods because they are economically dependent on their husbands.

As highlighted in Box 1, Tanzania's Sexual Offenses Special Provisions Act (SOSPA) criminalizes various forms of GBV, including rape, sexual assault and harassment, female genital cutting, and sex trafficking. However, GBV advocates point to the many weaknesses of this act: the exclusion of marital rape, except for separated couples; the need to prove penetration for rape, which can be nearly impossible to prove in many cases where forensic evidence is lacking; the failure to address other forms of sexual assault besides rape; and punishment—30 years imprisonment—that survivors may consider too extreme in rape cases wherein typically, the perpetrator is the survivor's relative.

Box 1. Sexual Offences Special Provisions Act (1998)

The legal framework to address gender inequality and gender-based violence in Tanzania is limited but growing. Although Tanzania does not have legislation against domestic violence, it passed revisions to the SOSPA in 1998, which did the following:

- a. Increased penalties for convicted rapists to 30 years in prison, with corporal punishment and fines. Convicted gang rapists are sentenced to life imprisonment.
- b. Redefined rape to include
 - Marital rape *only if husband and wife are separated*;
 - Instances in which consent was obtained by force, threats, intimidation, or if the woman was held in unlawful detention, and provides consent while she is in a state of “unsound mind,” or if she is intoxicated;
 - Girls under age 18, unless they are married to the rapist, are 15 or more years old, and are not separated from the man; and
 - Instances in which a traditional healer commits rape for “healing purposes.”
- c. Requires evidence of penetration to prosecute a rapist.
- d. Stipulates penalties for non-penetrative sexual assault (20–30 years of imprisonment and compensation to the survivor for injuries).
- e. Considers sexual harassment to be sexual assault.
- f. States that FGC is illegal.
- g. States that procuration (with or without consent) for sex work and sex trafficking to and from Tanzania is punishable by 10 years of imprisonment and/or fines.

Key informants cited other laws that contribute to the environment of gender inequality and the perpetuation of GBV. In particular, customary laws can contradict constitutional laws. For example, the Land Acts recognize women’s rights to own property; yet customary laws and traditional courts may deny women these rights (TAWLA, 2004).

National and local policies provide important opportunities to address gender-based violence. The Ministry of Community Development, Gender, and Children (MoCDGC) has demonstrated leadership in this area, despite its limited resources. First, the ministry worked to ensure that the National Strategy for Growth and Poverty Reduction has strong gender components, including, of particular significance, a goal and corresponding activities on the elimination of sexual abuse and sexual violence. More specifically, under governance and accountability—one of three cluster areas of the strategy—one goal is “Improved personal and material security, reduced crime, eliminate sexual abuse and domestic violence.” The strategy also links GBV in schools with girls’ limited access to education (Tanzanian Vice President’s Office, 2005, p. 35).

The MoCDGC also collaborated with relevant service providers and NGOs to draft a National Plan of Action for the Prevention and Eradication of Violence against Women and Children (see Box 2), as well as a National Plan of Action on the Eradication of Female Genital Mutilation (FGM). These plans call for the reform of systems for both the prevention of and response to GBV in all ministries and related sectors. However, the plans predominantly focus on the legal sector. Moreover, the budgets specified for the activities in the plans have not been given funding allocations. Thus, the MoCDGC has not implemented many activities in the plan.

Box 2. National Plan of Action for the Prevention and Eradication of Violence against Women and Children (Stated Objectives)

1. Legal
 - To amend laws that directly affect women's and children's rights.
 - To adopt legislative measures to ensure the protection and removal of all forms of discrimination against women and children.
2. Social, Economic, Cultural, and Political Measures
 - To build the capacity of grassroots women's and men's groups on the eradication of traditional norms, religious beliefs, practices, and stereotypes, which exacerbate violence against women and children.
 - To increase gender awareness on violence against women and children.
3. Services to the Victims/Victims of Violence
 - To provide easily accessible information on services available to women and children victims/victims of violence, including the disabled.
 - To provide efficient and effective police response, gender-sensitive prosecution services, and health and social welfare services; and to establish specialized units to address cases of violence against women and children.
 - To provide affordable, accessible, and specialized legal aid services to ensure justice and speedy resolutions of matters on violence against women and children.
4. Education, Training, and Awareness Building
 - To conduct gender sensitization and training of all service providers engaged in the administration of justice in the country.
 - To conduct localized research and systematically gather information on different types of causes, prevalence, and the impact of violence against women and children.
 - To conduct dissemination activities (seminars, advocacy campaigns, symposia, and focused discussions) to share information on prevalence and the consequences of violence against women and children.

Source: Ministry of Community Development, Gender and Children. 2001. A National Plan of Action for the Prevention and Eradication of Violence Against Women and Children. Dar es Salaam, Tanzania

Although this assessment did not carry out a review of government policies in all sectors, a review of the National HIV/AIDS Policy and the National Multisectoral Framework on HIV/AIDS (2003–2007) revealed that gender is recognized as an important factor in prevention strategies. For example, the HIV/AIDS policy states, “Therefore, addressing issues of gender equity and promoting equal participation of men and women in negotiating safer sexual practices is highly desirable, and women have the right and should be encouraged to say NO to unsafe sex” (p. 25). It also calls for activities to address issues of unequal power relations between men and women; multiple sex partnership; gender and reproductive rights; equal access to health services for men and women; and inheritance and customary laws that are not gender equitable. Still, there is no specific acknowledgement of GBV as a factor in the spread of HIV, and there are no strategies in the framework on HIV/AIDS that incorporate GBV.

Current Response to Gender-based Violence

“And in most cases, when this [domestic violence] situation happens, uh, the wives normally do keep quiet, and they don't take the actions any farther so to keep quiet, [to] symbolize that they are like begging the husband... apologizing to the husband. So, they keep quiet because they know they have misconducted, done something which is not admissible to the family.”

~ Adult male focus group participant

Shame seems to affect women's help-seeking behaviors, but an important factor in not seeking help may be that women who wish to report GBV and/or leave abusive situations have few places to go where they can get support. Such sources in Tanzania are inadequate but expanding. This section of the report will summarize the programs and services identified that address GBV in Tanzania (see Appendix B for a summary of selected current initiatives within the public and NGO sectors).

As noted above, services and interventions are categorized into five sectors: health/psychosocial, security/justice, legal, youth/education, and multisectoral. Within each sector, the report summarizes initiatives or interventions (where they exist), according to the following: laws/policies, delivery and reform of services, and finally, community mobilization and/or individual behavior change.

Health and Psychosocial Support

Legal/Policy Reform

While several policy reforms are necessary to address GBV in the health sector, few initiatives are taking place. The gender focal point at the Ministry of Health was not aware of any policies and protocols on GBV for the health sector. However, the WHO, which works with the Ministry of Health, has recently developed guidelines for integrating gender into HIV programs, which were piloted in Tanzania. Because the guidelines have yet to be released, the extent to which they address GBV is not known. Nonetheless, the guidelines could be a starting point for a specific policy or protocol on GBV.

Delivery and Reform of Services

The health system in Tanzania does not have formal protocols or procedures for caring for survivors of gender-based violence. Nor are health providers trained on the proper procedures for responding to GBV, ranging from the provision of privacy and confidentiality to the collection of forensic evidence, the conducting of safety plans, and the referral of survivors to other services such as legal aid or counseling. Training in medico-legal procedures for sexual violence cases is available in medical school, but it is not clear if this is a required course. Even if required, it is only one course with no on-the-job training in forensic procedures, legal responsibilities of healthcare providers, and other relevant medico-legal issues. According to the doctor interviewed at the Dodoma Regional Hospital, there are no specialists in forensics at most hospitals.

Each doctor interviewed agreed that when a woman goes to a hospital for GBV-related injuries, particularly rape, health providers do little more than treat the physical effects of violence, usually only in the most extreme cases when survivors do attend health centers. Although there is no formal procedure for treating rape patients, doctors interviewed stated that they usually conduct the following for rape victims:

- Examine her for bruises, scrapes, and cuts
- Administer a vaginal swab (for rape survivors)
- Take a medical history

According to various key informants, more than likely, patients do not report that their injuries resulted from violence they experienced by their husbands or partners. In most cases, women are ashamed and do not admit that they are being abused. Similarly, children who have been abused rarely come forward due to shame. Although some doctors may ask the woman about abuse if he/she suspects that violence is the cause of the injury, there is no protocol to screen women for GBV. Thus, more often than not, violence will go undetected. Nonetheless, some doctors and nurses are aware of the tremendous strain GBV puts on survivors' health and take every measure they know to address it. Unfortunately, this is not done in a systematic manner, and with limited recourse or services for victims, effects of this support are limited.

When a woman does present her injuries as a result of intimate partner or sexual violence, doctors record forensic evidence using an incident report form, “Police Form 3” or PF3, and may be required to testify in court based on the evidence that she/he recorded on the PF3. The form is available only from police stations, so that survivors must report to the police before seeking healthcare if they want to press charges. Once the doctor completes the PF3 form, the survivor may decide to file it with the police department to press charges but in many cases may not.

In some rape cases seen at hospitals, health providers screen survivors of sexual violence for pregnancy, STIs, and/or HIV. Whether they do depends on the facility and is not standardized in some hospitals. Some hospitals offer post-exposure prophylactics (PEP) or emergency contraception to rape survivors, but limited availability of these drugs usually prevents their distribution in cases of rape.

Some, but not all, hospitals use the physicians’ logbooks to compile data on diagnoses and treatment, according to key informants. Thus, data on GBV at hospitals are generally unavailable or unreliable.

Once the physical exam is complete, most women are sent home with little other than a completed PF3 form. The doctors interviewed stated that they do not offer safety planning, and they knew of no formal register of referrals for survivors of GBV to counseling, legal aid, shelter, or social services in the hospitals visited.

Although it is not legally required, some doctors reported that they will not treat a GBV patient unless she/he has already been to the police department to obtain a PF3. While the importance of reporting and prosecuting GBV cannot be undermined, survivors also should not be forced or pressured to report or press charges. If a health provider refuses to treat a woman who does not have this form, the doctor is essentially forcing the patient to make at least an initial contact with police. Women’s fear of the justice system, shame of being abused, and limited mobility are all reasons that woman may not obtain a PF3 form. This unofficial requirement in hospitals may cause women to cover up the cause of their injury or even prevent women from seeking care.

Other doctors do not require a PF3 to treat a GBV patient. However, the widespread belief that this is a requirement may still prevent women from seeking care. For example, a doctor from the Muhimbili National Hospital noted that women are sometimes stopped at the hospital’s reception area and told to return with a PF3 form—even though this is not a requirement at that hospital. This misinformation speaks to the need for a systems approach—comprehensive reforms that include training for everyone who might have contact with survivors of GBV; reforms of policies and protocols; and in some cases, additions to infrastructure and resources (see Box 3).

Box 3. Best Practice: The Systems Approach

According to Heise and others (1999), addressing GBV in the health sector requires a systems approach that includes “reforming organizational policies and protocols to properly address GBV; making infrastructure upgrades to ensure privacy and confidentiality; training of all staff—from top-level managers to receptionists, not only on treating GBV, but also in danger assessment safety planning and emotional support; ensuring staff have adequate resources, such as screening tools and directories to refer survivors to other services, such as legal or counseling services; and providing STI prophylaxis and emergency contraception” (Betron and Doggett, 2006).

There is a dearth of formal psychosocial services for GBV survivors. According to doctors there, the Muhimbili National Hospital (a government-sponsored hospital) in Dar es Salaam offers a counseling program for survivors of GBV. However, the program focuses on child sexual violence survivors. Other

doctors said that counseling is available in public hospitals, but they were in fact referring to counseling related to HIV, not GBV.

In general, psychosocial support is not a formal area of training for health providers. This gap indicates that formal counseling services are not yet incorporated into Tanzanian society. In fact, anecdotal evidence from the assessment indicates that most women go to their families for emotional support regarding their experience of GBV, if at all.

Clearly, much needs to be done both in terms of policy and institutional reforms in the health and psychosocial service sectors. Overall, policy and institutional responses in these sectors present more gaps than actual responses to GBV. Among public health services, the assessment did not identify any reform efforts to address GBV in particular. The gender focal point at the Ministry of Health did, however, indicate that health providers at referral hospitals (which are few in number) are being trained on gender. In the NGO sector, Chama Cha Uzazi na Malezi Bora Tanzania (UMATI, a family planning association of Dar es Salaam) implemented a small six-month initiative to sensitize board members, staff, service providers, and select community members on GBV, with a special focus on sexual violence. According to a representative from UMATI, the organization would like to scale up this effort by further training health providers on systematic screening for sexual violence and referral of patients to police. UMATI is also interested in sensitizing the police on the health needs of survivors, including PEP, to ensure that the police refer survivors back to health centers.

Community Mobilization/Individual Behavior Change

Surprisingly, the assessment identified only two health programs that implement behavior change activities to change norms and practices related to gender-based violence. One program, by UMATI, works with young men to educate them on reproductive health issues and to promote healthy decisionmaking. In 2008, the assessment identified a new initiative by the Mennonite Church, which works to counsel perpetrators so that they become non-violent. Although it is possible that the assessment failed to capture other health programs addressing GBV through community mobilization or behavior change, given the range of actors that the researchers interviewed, there appear to be major missed opportunities to address GBV through health outreach programs. Reproductive health and HIV, which are impacted by GBV, are program areas that could link GBV into their messages.

Legal

Laws

Several NGOs work for legal reform from outside the government system. Notable past and current efforts include the following:

- Several NGOs, including TAWLA and WoWAP, lobbied and advocated for revising the SOSPA to include marital rape and sexual assault outside of rape.
- Legal aid agencies, including TAWLA, WoWAP, and the Women's Legal Aid Centre (WLAC) have advocated for revising the Law of Marriage Act so that the legal age of marriage for girls is 18 instead of 15.
- WLAC has been a leader in advocating for a law against domestic violence.
- WLAC worked to draft an inheritance bill to put into law women's right to inherit property after the death of their husband or father. The bill is under government review.

According to the gender focal point at the Ministry of Justice and Constitutional Affairs (MoJ), the MoJ is gathering public opinion on women's property rights, which will inform the revision of laws on inheritance, marriage, and property rights. Also of importance, Tanzania's Cabinet approved a national anti-trafficking bill in January 2008, which is awaiting the President's signature.

Delivery and/or reform of services

One of the most important ways to ensure that laws protect and serve women is to help women negotiate the legal system. Legal procedures can be intimidating, especially for rural women who may be illiterate or poorly educated and who, because of gender roles and norms, may not be accustomed to speaking for themselves (or speaking publicly at all). Language may also be a major barrier. Key informants stated that court documents are all prepared in English—although verbal court proceedings may be conducted in Swahili). Furthermore, hiring lawyers can be expensive.

In response, several NGOs assist women with negotiating the justice system and advocating for fair treatment. Organizations such as the Legal and Human Rights Centre (LHRC), the Tanzania Media Women Association (TAMWA), TAWLA, WoWAP, Kivulini, and WLAC help individual women interpret and fill out legal documents and offer legal advice. In some cases, TAWLA and WLAC represent women in court and accompany them through the legal proceedings (see Box 4). Most organizations have limited coverage, but the LHRC and WLAC have trained paralegals all over the country to offer legal aid to women.

Box 4. Promising Program: Women’s Legal Aid Centre

WLAC’s vision is a society that treats women, men, and children justly. Its programs include legal aid and outreach, networking and advocacy, and research.

1. *Legal Aid and Outreach.* WLAC holds twice-weekly legal aid clinics during which paralegals (trained by WLAC) give women legal advice and help women prepare court documents. Paralegals also accompany women to courts to assist them with arguing their cases. Outreach activities include radio programs to raise awareness of women’s legal rights and paralegal training and training seminars for GBV survivors and widows.
2. *Networking and Advocacy.* Advocacy activities include monitoring implementation of CEDAW and the Copenhagen Declaration on Social Development, as well as lobbying for a law against domestic violence and an Inheritance Bill, which has been submitted to the MoJ. In terms of networking, WLAC is a member of various coalitions and forums, including the National Coalition on Gender-based Violence for Civil Society Organizations.
3. *Research.* WLAC’s research initiatives include studies on domestic violence, early marriage, marital rape, and women’s property rights.

Key informant: Florence Tesha, Legal Aid Officer, 2008.

Still, legal aid clinics usually cannot represent a woman in violence cases, which are considered criminal offenses, and thus, must be represented by a state attorney. While some legal aid clinics refer cases to state attorneys that belong to their networks, or act as watchdogs of cases, women are often left to navigate a highly intimidating court system where GBV cases (except for children’s cases) are heard in general criminal courtrooms along with many other types of cases. This type of setting may add to women’s fear of being in court.

TAWLA is currently advocating for the MoJ to institute a family court that could better serve women who choose to take cases of gender violence and other family issues to court. According to the gender focal point at the MoJ, the ministry is seriously considering this petition but is first assessing the modalities of such a court. Legal aid organizations such as TAWLA and WLAC further argue that a family court could also allow for an alternate set of laws with punishment that may be more appropriate for domestic violence cases, such as protection orders and temporary separation with child support.

Community mobilization/individual behavior change

Several NGOs conduct education on legal issues and rights related to gender and GBV: TAMWA, WLAC, TAWLA, WoWAP, AFNET, and the Tanzania Rural Women and Children Development Foundation (TARWOC). This education is done through trainings for various groups at the community level; legal aid client contacts; media advocacy; and grassroots information, education, and communication (IEC) campaigns.

Security

Delivery and/or reform of services

In general, police receive only general training for dealing with survivors of violence, not training related specifically to GBV. This means that women's experiences in seeking help from police vary. Women who report to police stations to obtain PF3 forms are likely to be questioned to the point of harassment. Female focus group participants also report corruption in the police system, including taking bribes from perpetrators to ignore GBV reports or requiring women to pay police to file the form. According to key informants, the number of female police officers is increasing and attempts are made for female officers to attend to rape survivors. However, this is not always possible.

There are confidential spaces in police stations that can be used for attending to GBV survivors, but again, there is no protocol to ensure that survivors have access to these spaces. Police records are also kept confidential, with disciplinary actions taken against officers who breach confidentiality. Police record "crimes against morality," but these data are not disaggregated in order to identify cases that are GBV-related.

One civil society initiative identified is also worth highlighting here. The Kiota Women's Health and Development Organization (KIWOHEDE) has set up structures in communities of the 10 districts in which it works, which identify and/or report trafficking and child sexual abuse. These structures range from peer educators, teachers, and business owners to more formal institutions such as the police, churches, and local government.

In 2005, TAWLA advocated for the MoJ to add gender units to police stations for GBV and other gender-related cases. While the direct success of this advocacy is difficult to determine, this 2008 assessment found that these gender units are indeed being established. The Tanzania Police Female Network (TPFNet), a network of female police officers, has been leading an effort to institute gender units that attend to GBV survivors. In September 2008, units began operating in 18 police stations throughout Dar es Salaam.

As part of this effort, TPFNet is supporting NGOs to train police on how to handle GBV cases. Thus far, the network has collaborated with WLAC and the United Nations Development Fund for Women (UNIFEM) to train 180 police officers on what constitutes GBV, international treaties and national laws pertaining to GBV, proper response to GBV survivors who are filing a police report, and counseling for GBV. The MoCDGC and UNIFEM, with the help of WLAC, are planning to develop a GBV training manual for the police (pending funding). The ministry also hopes to design similar curricula for judges and local leaders.

Community mobilization/individual behavior change

The 2008 assessment did not identify any programs or efforts to improve safety or security through community mobilization or behavior change. However, TPFNet is working with NGOs, schools, prisons, and other community-based organizations to connect the police with the community to help ensure safer spaces—through, for example, neighborhood safety watch programs.

Education

The 2008 assessment team collected little information on GBV in the education sector. However, one notable policy development does address GBV in schools. The National Strategy for Growth and Poverty Reduction includes in its goal increasing equity in access to education among girls and boys for both primary and secondary education and “universal literacy among women and men and expansion of higher, technical and vocational education” (p. 42). To attain this goal, the strategy recognizes the role GBV, particularly that experienced in the school setting, as an important factor that may limit girls’ access to education, especially secondary education. To meet this goal, the strategy objective is an “improved learning environment for all children in all schools, with all education institutions safe, violence free, child friendly and gender sensitive” (Tanzanian Vice President’s Office, 2005, p. 42).

Multisectoral Interventions

The assessment team identified several relatively comprehensive, small-scale multisectoral interventions that provide coordinated services to survivors across sectors. Likewise, the team identified a few small-scale programs that conduct community mobilization interventions.

Policies

The MoCDGC plays a key role in policy development around GBV and also has the potential to play a coordinating role in advancing the GBV agenda. In particular:

- The ministry collaborated with relevant service providers to draft a National Plan of Action for the Prevention and Eradication of Violence against Women and Children and a National Plan of Action on the Eradication of FGM. Seven years into the plans, however, the MoCDGC has only implemented several activities, including awareness campaigns and participation in trainings, all sponsored by donors.
- The ministry worked to ensure that the recently released National Strategy for Growth and Poverty includes the goal of reducing sexual abuse and violence. To achieve the goal, the strategy outlines efforts for institutional reform in all government sectors, including police and courts. Activities include training police on human rights; addressing the security needs of vulnerable groups, including women and children; and increasing the capacity of courts to hear a higher volume of cases. The strategy also identifies involving communities in the activities as key to ending sexual violence and, thus, calls for educating the public on constitutional and human rights (Tanzanian Vice President’s Office, 2005).

Delivery and/or reform of services

Comprehensive multisectoral services for providers are scarce in Tanzania. Two programs, one by the International Rescue Committee (IRC) and another run by KIWOHEDE, provide relatively comprehensive services but for just a subset of the population. The IRC provides holistic services for GBV survivors in the refugee camps of northern Tanzania (see Box 5). This program can be used as a model for replication and scaled up for the general population. KIWOHEDE provides a range of services for survivors of trafficking, and child sexual abuse survivors and child laborers, including shelter, vocational skills training, HIV testing, psychosocial counseling, and referral to hospitals and legal aid. Court advocates guide sexual abuse survivors through the court system.

Other groups are beginning efforts to develop a multisectoral response to GBV. Within the government, the MoCDGC is working with gender focal points to identify ways they can mainstream gender into ministry workplans and budgets. The ministries have yet to discuss specific plans on GBV, but with these efforts, the MoCDGC is laying the foundation for such plans. Likewise, the MoCDGC, with the help of NGOs such as WLAC, is training community development workers on women’s rights, including freedom from violence.

Box 5. International Rescue Committee's Response to Gender-based Violence in Conflict Settings

The IRC coordinates GBV programs in two refugee camps in northern Tanzania. Because of the small geographical area, re-settlement of people from different communities, and outside funding in refugee camps, the committee has been able to implement a more systematic approach to GBV prevention and response than other parts of Tanzania. This program can be seen as a model for addressing GBV for groups and institutions working with Tanzania's general population. Features of this program are highlighted below.

- In this program, women file a GBV incident form with a counselor trained in protocol of the United Nations High Commissioner for Refugees (UNHCR) and receive counseling and safety planning information.
- The IRC and UNHCR train police in refugee camps on the UNHCR protocol for responding to GBV cases.
- A reproductive health physician who is trained in forensic collection and working with GBV survivors collects forensic evidence and stamps the PF3 form. There are approximately six of these doctors in each camp.
- Legal counselors with law degrees and experience in law firms are available to advise survivors on how to testify in court.
- Survivor support groups are available.
- A focal person for sexual and gender-based violence from UNHCR in each camp implements awareness-raising activities and trains others to implement these activities.

Key informant: Divine Koge, Protection Officer, 2005.

In 2008, civil society led an effort to sensitize health, police, and local government on their roles in addressing GBV. With funding from Irish Aid, the United Nations Population Fund (UNFPA), the Canadian International Development Agency (CIDA), and Norwegian Church Aid, the Women in Law and Development in Africa's (WILDAF) Tanzania office, which works with other legal aid organizations, has been conducting these training sessions. WILDAF is currently publishing the training materials it developed for this project. The curriculum, however, does not address technical treatment and response protocols for health providers and police.

Community mobilization/individual behavior change

Several groups use media—such as leaflets, radio, video screenings, and TV programs—to raise awareness and advocate for attitude change, including AFNET, Kivulini, MoCDGC, TAWLA, TAMWA, WILDAF, and WoWAP. These groups target various grassroots audiences, including women, men, boys, girls, elders, religious leaders, as well as local and national government. Key informants described some notable programs that raise awareness and mobilize communities to implement reforms to stop GBV (also see Box 6):

- The MoCDGC (with the support of donors) is running a national campaign against violence against women as part of the global “Say NO to Violence against Women” campaign led by UNIFEM. The campaign in Tanzania, conducted from May–October 2008, included circulating a petition to get 1 million people to sign leaflets with pledges to say no to violence against women. President Kikwete launched the campaign by signing the first leaflet.
- The Ministry of Labor convened a forum on sexual harassment in 2004, which brought workers and management together to discuss sexual harassment, advised workers on how to report sexual harassment, and linked sexual harassment with the HIV epidemic.
- WoWAP uses traditional arts to advocate for gender change and provoke discussion in the community. These cultural activism methods include community theater, poems, music, dance,

debates, and discussions. These methods aim to reach everyone in the community, including people who are illiterate or those who may not access other media, such as television and radio.

- TAMWA was a leader in successfully advocating to pass the SOSPA in the 1990s. Subsequently, building on its success, the association launched a two-year campaign in 2002 to “Stop FGM.” TAMWA uses a method of media activism called “bang-style journalism,” through which journalists work together to distribute information on an event or topic through as many outlets as possible and with as many features, stories, or sites as possible. Bang style journalism also takes its information from many different sources, including people’s voices at the grassroots level with the intent of making a “bang” with its messages.
- WLAC, with support from the Health Policy Initiative, is training the media on how to report GBV cases, which has already resulted in increased stories on GBV in the news.

Box 6. Promising Program: Kivulini

Kivulini is a domestic violence agency in Mwanza that has been recognized internationally for its success in mobilizing communities to take ownership of the problem of GBV and find solutions to prevent it. Among the programs that this 2008 assessment identified, Kivulini stands out as a leading example of a multisectoral approach to addressing GBV. Kivulini’s strategies and activities fall under three main program areas.

1. Community mobilization to build a “critical mass” for change through
 - Awareness-raising campaigns at the local and national levels through debates, community dialogues, festivals, radio spots, and other public events;
 - Working with community activists, civil society organizations, local leaders, and school children, among others, to help them identify barriers to responding to or preventing violence and take action to overcome the barriers; and
 - Networking with other organizations to build a national movement to take action against GBV.
2. Capacity building on strategies to prevent or respond to GBV for
 - Other civil society organizations;
 - Health, police, paralegals, and other service providers;
 - Media; and
 - Community leaders.
3. Policy analysis and advocacy that aims to incorporate GBV in government policies, such as
 - Empowering local government to include domestic violence in by-laws (local manifestations of the national constitution); and
 - Lobbying for the inclusion of GBV in the national HIV/AIDS policy.

According to Director Maimuna Kanyamala, Kivulini’s activities have resulted in ownership of the problem of domestic violence in the community, including by community leaders. Another success Kanyamala reported is the increase of services and improvements in the quality of services available to GBV survivors in Mwanza.

Key Informant: Yassin Ally, Advocacy Directory and Maimuna Kanyamala, Executive Director, 2008.

Networking is also a key strategy to mobilizing community efforts on GBV. In 2007, a group of 20 civil society organizations led by WILDAF formed the National Coalition on Gender-Based Violence for Civil Society Organizations. Its steering committee includes the Forum for African Women Educationalists (FAWE), the Kilimanjaro Women’s Group Against AIDS (KIWAKKUKI), the Kilimanjaro Women Information Exchange and Consultancy Organization (KWIECO), Kivulini, AFNET, LHRC, TAWLA, TAMWA, WILDAF, and WLAC. This coalition exchanges information and collaborates on GBV campaigns, particularly the “16 Days of Activism Against Gender Violence” campaign. The coalition also collaborates with the MoCDGC.

III. CONCLUSIONS AND RECOMMENDATIONS

This assessment confirms that gender-based violence is a serious health, development, and human rights problem affecting the majority of Tanzanian women. Respondents confirmed that women and girls experience disproportionate levels of violence because of social and economic inequities between men and women and norms that excuse and/or fail to recognize the problem of violence against women and girls. Furthermore, resources and services for women who choose to escape abusive situations or to protect themselves and their children from violence are severely limited.

Gender-based violence is a relatively new topic of public discussion and intervention in Tanzania. The lack of programs and protocols on how to respond show that there is much work to be done to address the problem. However, it is work that is increasingly possible, given the increasing recognition of GBV and support to address the issue both in Tanzania and internationally.

Focus group participants and key informants demonstrated a high level of awareness of the existence of GBV, particularly of intimate partner violence (both sexual and physical). Some men and boys viewed these types of violence as acceptable means of resolving family conflicts, but there seems to be a growing awareness of the harmful effects of this behavior and a growing commitment to fostering gender equity within families. Women and girls, on the other hand, expressed something akin to acceptance that they, as women, experience GBV of some kind—although they certainly recognized GBV as violence and as a human rights violation.

Due to their acceptance of violence, feelings of shame and blame, and lack of resources, most women who experience GBV do not report it to any authorities. Focus group participants were not aware of some of the existing services available, such as legal aid and health care; and they distrusted others, such as the police.

The *health response* to survivors of GBV is quite limited. First, no protocols or guidelines exist for healthcare providers on the treatment and care for GBV survivors. Likewise, health providers are not trained in the proper response to survivors, including treatment, safety planning, collection, provision of PEP to prevent HIV, medico-legal responsibilities, and referral to other services, such as legal aid. Ignorance of proper procedures by health providers leads to survivors not receiving treatment; breach of confidentiality of providers and, thus, possibly putting survivors at risk for more violence; and missed opportunities to educate survivors about their rights and other services. For example, health providers, believing that it is required, often send survivors to the police to fill out a police report before providing treatment. Unfortunately, such confusion may result in women being denied medical treatment or in their being forced to report the violence to the police. Given these gaps—not to mention challenges such as lack of confidential spaces and maintenance of confidential medical records—the health system is still far from proactively screening for GBV.

Psychological services are practically non-existent in Tanzania. Tanzania has just a handful of trained counselors in the country and no university program for training psychologists and psychiatrists. Social workers receive some training on counseling but limited training related to GBV. Counseling largely focuses on HIV testing. Thus it is not a surprise that researchers found no support groups for GBV survivors in the country. This lack of psychosocial support must be addressed, as the psychological effects of GBV can sometimes be more severe than the physical effects.

Although *legal protection* against rape, FGC, and sexual harassment is newly available, there is no specific law against domestic abuse, including wife beating and rape among spouses who are not separated. This is a key gap in the system, as it affirms the norm that such violence should be accepted as normal.

Although current proceedings apply criminal laws related to violence to domestic and intimate partner violence, these laws do not address the needs specific to domestic or intimate partner violence. On one hand, survivors may not want their spouses to go to jail, as survivors are often dependent on their husbands for their and their children's livelihoods. On the other hand, when prosecuting cases, the courtroom experience of GBV survivors can be intimidating and potentially dangerous, as there is no separate court for family law, and GBV cases are heard along with every other kind of criminal case. Compounding the problem is that rape and GBV victims are represented by a state attorney who may not be experienced in handling such cases.

There are many other gaps in the legal sector. For example, women who wish to press charges on the perpetrator of GBV have little support in doing so and are not always treated with respect and given an adequate response. Police officers and judges are not trained in working with survivors of GBV and neither have protocols or special services for GBV cases. Moreover, there is still much progress to be made on the implementation of existing GBV laws, particularly due to lack of awareness of rights and fear of shame that prevents survivors from reporting their cases to the authorities.

Despite these many gaps, most current work to address GBV is centered on the legal response. Several groups conduct promising work to help make the justice system more accessible, including advocacy to revise laws, education on women's legal rights and legal procedures, and legal aid and representation for women. However, funding is often limited.

The *security sector's* response to GBV improved substantially in September 2008, with the creation of gender units at 18 police stations in Dar es Salaam. These units are trained on citizen's rights with respect to GBV. TPFNet, leading this effort, is a critical ally for future partnership with the police on improving responses to GBV. Indeed, much work still needs to be done—the establishment of formal protocols for police handling of GBV cases; expansion of gender units throughout the country; and sensitization and training to change the attitudes of police regarding GBV survivors.

Lack of information on GBV and GBV interventions in *schools* is a significant limitation of this assessment. More research is needed to understand what is happening and what gaps exist in this key sector for both the prevention of and response to GBV.

A number of groups, including the MoCDGC, Kivulini, WLAC, and WILDAF, are engaged in various *awareness-raising and education activities* on GBV. Such activities are important in changing behaviors and attitudes of community members, service providers, and policymakers around GBV. That these interventions exist speaks to the growing readiness of many sectors and stakeholders to begin and continue concerted, coordinated efforts to work against GBV. Still, much more could be done to address GBV. In particular, men and boys and the wider community must mobilize to form a critical mass needed to transform norms and power relations that perpetuate GBV.

Recommendations

The recommendations provided below are not meant to be comprehensive but rather illustrative of promising interventions in each sector. The researchers selected a few key interventions they deemed to be the most strategic and reasonable and identified groups that could potentially carry out the interventions. See Appendix C for a more comprehensive list of recommended activities.

Legal and Policy Environment

Advocate for a specific law on domestic violence. Currently, Tanzanian law does not address domestic violence specifically. The SOSPA of 1998 addresses rape, FGM, and sexual harassment, but it does not address domestic abuse in general. Thus, if a woman wishes to take legal action for domestic abuse, she

must call on criminal law on general acts of violence, which does not take into account the special circumstances and gendered context of domestic violence. For example, provisions under criminal law stipulate sometimes too extreme forms of punishment, such as long-term imprisonment, which women dependent on their husbands may find as a deterrent to pursuing legal action. A special domestic violence act, on the other hand, could allow for things such as protection orders, fines, or other stipulations regarding separation/divorce and child custody that facilitate legal action against an abusive partner and/or getting out of an abusive relationship.

Incorporate GBV into HIV policies and plans. HIV is a pressing concern for both government officials and civil society, including individual community members. Focus group participants in particular expressed heightened awareness and concern over the problem of HIV. By the same token, sexual violence is prevalent and widely accepted in Tanzania. As emerging literature confirms, GBV, is strongly linked to the spread of HIV. Sexual violence itself not only contributes to the spread of HIV; women's fear of suffering abuse by proposing condom use or revealing their HIV status may also contribute to the spread of the disease. The problem of GBV should not be taken any less seriously than that of HIV. Both are intimately intertwined.

At the policy level, HIV policies should incorporate statements recognizing the links between HIV and GBV (both sexual violence and physical abuse) and stipulate the need to address gender and GBV in HIV/AIDS programming. Likewise, HIV/AIDS strategic plans, such as the National Multisectoral Strategic Framework on HIV/AIDS, and operational plans for the recently approved HIV/AIDS law, should include objectives and activities that specifically address the prevention of and response to GBV. Kivulini, through the Policy Forum—a network of NGOs working to reform policies related to a variety of development issues—has advocated for the inclusion of HIV in Tanzania's National HIV/AIDS Policy. Kivulini and the Policy Forum would be important allies to partner with and support to achieve the inclusion of GBV issues in HIV policies.

Help the MoCDGC to revise the GBV plans of action. The National Plan of Action for the Prevention and Eradication of Violence against Women and Children and the National Plan of Action to Accelerate the Elimination of FGM and other Harmful Traditional Practices are broad, ambitious plans that were written seven years ago when minimal work was being done to address GBV outside the legal sector. Given new areas for concern, such as health, HIV, counseling, and social welfare, as well as emerging lessons learned and guidelines in these areas (such as the WHO's forthcoming guidelines on integrating gender into HIV programs), the MoCDGC should update these plans to reflect current knowledge. The plans should also focus on priority areas and/or lay out phases of action so as to make them manageable and realistic.

Support the MoCDGC in the development of a multisectoral GBV network. GBV is an issue that must be addressed within various sectors—including the health, legal, justice, and social welfare sectors—and with an eye toward prevention. Labor and educational programs should also address GBV. A GBV network can facilitate the necessary and proper coordination of services, such as medico-legal services, to ensure proper collection of forensic evidence (to name one illustrative case); and it can facilitate the exchange of information and pool often scant resources for GBV. While the National Coalition on Gender-based Violence for Civil Society Organizations was recently formed, it does not represent government. The MoCDGC, which already has a multisectoral plan of action on violence against women, has the potential to play a strong coordinating role for a multisectoral GBV network that includes government, civil society, and donors. UNIFEM reported that it has initiated efforts to form such a network. Thus, it is a critical and opportune time for interested stakeholders to get involved.

Support the MoCDGC to advocate for budgets to implement GBV plans of action. Due to a limited operating budget, the ministry has implemented few activities of the National Plan of Action for the Prevention and

Eradication of Violence against Women and Children and the National Plan of Action to Accelerate the Elimination of FGM and Other Harmful Traditional Practices. Because little has been done since the development of these plans in 2001, the budgets should be updated according to current needs and costs. Subsequently, the MoCDGC should be supported (e.g., through technical assistance and facilitation of meetings) to lobby the Treasury and other ministries to allot budgets for the activities outlined in the plans.

Facilitate dialogue among parliamentarians about the health, development, and social impacts of GBV. Related to the recommendation above, training parliamentarians and other policymakers and facilitating dialogue about GBV are not only ways of lobbying for increased funds to address GBV but also ways to improve the overall policy environment regarding the issue. In the past, public discussions with parliamentarians regarding HIV/AIDS, for example, increased attention and support for the HIV/AIDS law in Tanzania. For GBV, an issue that is still not recognized by many as a health or development issue such as HIV/AIDS, the global evidence on health, economic, and social costs of GBV should be emphasized in dialogue with policymakers.

Provide technical assistance to gender focal points in ministries on GBV and the development of sector-specific action plans on GBV. The MoCDGC coordinates gender focal points for each government ministry. Gender focal points should be sensitized and trained on GBV, especially on how it is relevant to their work. Donors could finance technical assistance to help gender focal points construct strategic plans of action to address GBV in their respective sectors as well as advocate within their ministries for mainstreaming gender and GBV into budgets.

Work with local government leaders to translate the GBV plans of action into concrete components of community by-laws. Key informants point out that local government leaders have the mandate to adapt the national constitution into by-laws that are relevant for their communities. However, they often have little guidance or capacity to do so. The local by-laws are a major opportunity to operationalize national plans of action on GBV (which are often not implemented or provided budgets) in concrete ways that are relevant to local communities, especially given that GBV is an issue that often starts within the home and affects the local community. Kivulini's past success in integrating GBV into local by-laws should be examined for replication.

Services

Reform health centers systematically to incorporate GBV services, starting with how-to policies, protocols, and guidelines. In Tanzania, health centers cannot adequately respond to the needs of GBV survivors. They lack proper protocols or guidelines to treat survivors or provide minimal support services—such as safety planning, the advising of survivors about their rights, provision of PEP, as well as referral to legal help or other support services. Health providers' lack of knowledge of proper protocols to respond to GBV results in improper handling of cases and, often, failure to provide services. For example, survivors are said to sometimes be turned away from receptionists and other healthcare staff that erroneously believe that survivors must present a PF3 form in order to be treated. When faced with this extra step or the burden of having to report the case to the police, many survivors likely do not receive the care they need. Moreover, limited availability of PEP or lack of knowledge regarding when to administer PEP may prevent health providers from administering this preventive drug. These barriers in providing GBV survivors with treatment and care are major impediments to immediate-term HIV prevention. Protocols and guidelines specific to Tanzania accompanied with proper training for GBV screening and care at the health clinic level can help overcome these barriers. With the proper technical assistance, organizations—such as the Medical Women Association of Tanzania (MEWATA), an association of leading women doctors, or UMATI, which has conducted sensitization of health providers on GBV—have the potential technical expertise to lead this effort.

Incorporate a GBV response into HIV counseling and testing programs that have adequate capacity and resources. As discussed above, GBV affects the spread of HIV, and likewise, HIV can increase a woman's risk for experiencing GBV. Thus, HIV counseling and testing programs may be important types of health centers to target for the systematic reforms described in the above recommendation. Such services would likely have PEP available and health providers that are trained to administer the drugs. In some cases, where the program is well staffed and has adequate capacity to do so, screening for GBV should be considered. Screening for GBV is valuable not only because it provides an opportunity to address GBV as a health and human rights issue, but also because it allows providers to identify GBV as a risk factor for other health conditions. In the case of HIV programs, screening for GBV may allow providers to assess a patient's ability to negotiate condom use, limit high-risk behavior, or adhere to treatment—all of which have been shown to be affected by GBV (Betron and Gonzalez-Figueroa, forthcoming). However, it is important to implement GBV screening only where there are other critical GBV services, like psychosocial support, to which survivors can be referred. Several HIV programs and existing infrastructure already exist wherein GBV can be addressed. For example, hospitals and health centers already have counseling units for HIV-infected patients; ways to incorporate GBV in these units should be explored.

Pilot a one-stop service center for GBV survivors. Already part of the National Plan of Action for the Prevention and Eradication of Violence against Women and Children and also highlighted as a promising intervention in various literature reviews, a one-stop center may help address various flaws and challenges in the current GBV response system. For example, a one-stop center strategically placed within a health clinic or hospital could eliminate the extra trip survivors have to take to pick up a PF3 form from the police before being seen for a doctor to be treated and have evidence collected. However, such a one-stop center can be costly to maintain and can sometimes serve as an excuse not to improve the response of existing services. Thus, this approach should be piloted in one to two sites in order to test and fine-tune this model for the Tanzanian context. WILDAF and TAWLA indicated that they are already, by necessity, providing counseling in addition to legal aid for survivors. In addition, UMATI indicated a desire to work with gender units at police stations to ensure that survivors receive proper health services. Inclusion of health and psychosocial services in programs and services that are traditional points of entry for survivors should be explored.

Promote policies that require a GBV curriculum in university health, justice, and legal programs. Currently, university programs do not address GBV specifically but rather address medico-legal services in general, with some mention of handling rape cases. Training for police includes a module on human rights in general but not domestic violence specifically. Including GBV as a topic in health, justice, and legal programs is an effective way of improving response to and changing attitudes related to GBV in the longer term. The inclusion of a GBV curriculum in medical, legal, and law enforcement training should be required.

Support TPFNet to train police on GBV and further expand gender units throughout the country. TPFNet is motivated to continue training more police to better assist GBV survivors and institute gender units in police stations throughout Tanzania. Civil society organizations, claiming that gender units have long been needed, have praised their formation. Because the network is still young, this is a critical time to shape the direction of its work. Moreover, TPFNet has only helped to establish the gender units in Dar es Salaam. Lessons learned from Latin America warn that maintaining female-friendly police stations in the capital city causes police stations elsewhere to believe that attending to GBV survivors is no longer their responsibility (Bott et al., 2005). Donors and NGOs should take advantage of this time to work closely with TPFNet and encourage, support, and expand their work.

Form peer support and counseling groups by training community members as facilitators. Psychosocial support in the form of peer support groups may be one of the easiest and most cost-effective ways to address

GBV. Survivors of GBV often simply need someone to listen to them. Knowing that they are not alone or the only ones suffering from such abuse often helps survivors become more empowered to take a stand against their abusers. Or, it can help abused women, often kept under tight reins by their abusers, to form networks of supporters or refuge from their abusers. In Tanzania, a glaring gap in the services for GBV survivors is psychosocial support. Although the assessment determined that universities do not offer training in counseling, peer support groups are still tremendously uplifting to survivors and can pave the way for identifying potential counselors. External technical assistance can build the capacity of community facilitators to lead such support groups. However, counseling, while a basic service for survivors, is by no means a cure-all.

Awareness Raising and Community Mobilization

Raise awareness on the problem of gender-based violence and gender equality in the community. Focus group discussions with both males and females demonstrated that there is confusion around what constitutes rape, particularly whether rape is a form of gender-based violence. Males often claimed that they do not abuse their wives or partners, and that there is a greater respect for women's rights overall. However, when probed, many men revealed that it is generally accepted that women should provide sex to a man if he wanted it. If not, he would have the right to force her. Women, on the other hand, recognized that this is rape but often acted complacently when questioned about this reality. Moreover, many respondents claimed that domestic abuse is a problem only in remote, marginal communities, such as those in the Mara region. Emerging data (e.g., WHO 2005), however, show that GBV is highly prevalent throughout Tanzania (both in rural and urban areas). Focus group participants as well as key informants also generally agreed that more awareness with respect to GBV is necessary. Thus, awareness raising should be conducted on a wider scale, with particular efforts on young men. Several women's legal aid NGOs, as discussed above, are already holding GBV awareness-raising sessions; their models should be reviewed and replicated where appropriate. One strategy that seemed particularly effective was to work with community centers so that they can also raise awareness on GBV, counsel survivors, and provide specialized services where possible.

Engage men and boys in efforts to mobilize communities against GBV. Other country experiences indicate that working with men is a key strategy to prevent GBV. Behavior change strategies in the health sector have shown that inequitable gender attitudes by men (and women) can be unlearned and that doing so can contribute to healthier relationships. Focusing initiatives on girls as "survivors" to be protected without addressing patriarchal attitudes and behavior among boys simply reinforces the notion that gender-based violence is acceptable. Throughout society and the community in general, men are often leaders and have the power to pave the way for change. MenEngage, a newly formed network of organizations seeking to further engage men in family health programs and policies, is a potential resource to mobilize men and boys against GBV.

Link GBV and HIV in HIV awareness-raising programs and mass media campaigns. Major opportunities exist to include GBV prevention efforts in HIV awareness-raising programs. For instance, UMATI has already begun addressing sexual violence in its HIV education programs for youth. Programs such as these should be scaled up. Similarly, HIV awareness campaigns are widespread in Tanzania in response to the high rates of HIV in the country. In the past two to three years, mass media campaigns have been launched by UNFPA, WILDAF, and TAMWA on GBV. However, these campaigns scarcely link HIV to GBV. On a broader level, mass media awareness-raising campaigns should link HIV and GBV in explicit terms.

Research further the varying types of GBV in Tanzania. Key informants often cited the need for more prevalence statistics on gender-based violence that are representative of all districts in Tanzania. Key informants also mentioned what they considered types of violence that are not widely known to the international community, such as exploitative marriage, widow inheritance, and harmful nutritional practices. Due to the limited information on these practices, more research is needed to clarify the

prevalence of these practices, the contexts in which they operate, as well as a broader understanding of attitudes toward the practices. Moreover, informants also seemed to have little information on the phenomenon of human trafficking in Tanzania—although some existing literature indicates that it does exist. Research should be conducted to help determine the extent of these and other types of GBV that may not be widely known. Likewise, research on the varying types and scale of sexual coercion should be conducted. Sexual violence does not appear to be limited to or even most commonly perpetrated by a stranger or even an acquaintance. Instead, although not generally seen as rape, young women especially may be faced with sexual coercion through potential economic gains. Further research is necessary to unpack and understand the dynamics surrounding these types of violence.

APPENDIX A: INDIVIDUALS AND GROUPS INTERVIEWED

2008

Key Informant Interviews

1. Kivulini: Yassin Ally (Advocacy Director)
2. KIWOHEDE: Stella Mwambenja, Edda Kawala
3. LHRC: Jane Shuma (gender focal point)
4. MenEngage/EngenderHealth: Sara Teri Ezra, Eric Ramirez-Ferraro
5. MEWATA: Dr. Sara Maongezi, Dr. Hawa
6. TAWLA: Geneveve Kato (gender focal point), Anne Marie Marenjina (legal aid officer)
7. TPFNET: Elice Mapunda (Assistant Police Commissioner)
8. UMATI: Martha Gerome
9. WLAC: Florence Tesha, Grace Daffa, Safina Hassan (legal aid officers)
10. WILDAF: Judith Odunga (National Coordinator)
11. MoCDGC: Tukae Ngiko (Director of Gender)
12. Ministry of Health: Anchila Vangisada (gender focal point)
13. MoJ: Mwendwa Malecela (gender and HIV/AIDS focal point)
14. Embassy of Ireland: Lucy Merere (Gender and HIV/AIDS Advisor)
15. UNIFEM: Salome Onyote (Program Specialist), Hendrica Okondo (Country Program Manager)
16. UNFPA: Christine Mankuzi-Kwayu (gender focal point)
17. United Nations Children's Fund (UNICEF): Jones John (Child Protection Officer)
18. WHO: Theopista John (gender focal point)

2005

Key Informant Interviews

1. Tanzania Gender Networking Program (TGNP): Mary Rusimbi and Gemma Akilimali
2. Tanzania Network of People Living with HIV/AIDS: Alex Margery (Chairperson)
3. Ministry of Health: Mr. Ngowi (Acting Director of Policy and Planning)
4. Mwanamala Hospital: Dr. Wambura and Matron (Head Nurse: Lucy)
5. Christian Council of Tanzania: Justin Nyamoga (Director), Martina Kabisama (Director of Women Development, Children, and Gender)
6. Tanzanian Network of Women Living with HIV/AIDS: Joan Chumungu (Chairperson)
7. UMATI: Walter Mbunda (Executive Director), Martha Gerome (Youth Officer)
8. Ministry of Labor, Youth and Social Welfare: Joyce Shaidi
9. Tanzania Women Media Association: Annanilea Nkya (Executive Director)
10. MoCDGC (which coordinates national plan of action on VAW): Edine Mangesho (Director of Women and Children), Dr. Kazimoto (Acting Director of Women and Children)
11. UNFPA: Christine Mwanukuzi-Kwayu (National Program Officer), Nicola Jones (Representative)
12. Private Nurses and Midwives' Association of Tanzania: Keziah Kapesa (Executive Secretary), Dr. Jane Munthahala (owner and Director of Suby Maternity Home)
13. MEWATA: Dr. Marina Njelekela (Chairperson), Dr. P.J. Ngiloi (pediatric surgeon at Muhimbili National Hospital)
14. WLAC: Scholastica Julu (Executive Director), Magdalena Aquilin (lawyer)
15. African Youth Alliance: Halima Shariff (Country Coordinator)
16. Tanzania Rural Women and Children Association: Honorable Ledian Mng'ong'o (Director and Member of Parliament)
17. Kivulini (Mwanza): Maimuna Kanyamala (Director)

18. IRC: Divine Koge (Protection Officer)
19. TAWLA: Tumaimi Slaa (Executive Director)
20. National Muslim Council of Tanzania: Mr. Suleman Lolila, (Director of Health and Social, Sophia Mruma, Women Youth, and Children)
21. Ministry of Home Affairs (Police): Joseph M. Konyo (Liaison Officer for Criminal Records and Human Trafficking)
22. Muhimbili National Hospital: Dr. Fausta Phillips (psychiatrist)
23. WoWAP: Fatma Toufiq (Convener, women's focus group)
24. Jenny Magembe (Regional Social Welfare Director, Dodoma, Government of Tanzania)
25. TAWLA member: Mary J. Nisi (lawyer, Dodoma)
26. AFNET: Stella Mchiwa (Accountant), Andrew Karama (Regional Coordinator)
27. Dodoma Regional Hospital: Eugenia Kidyala (Public Health Nurse)
28. Dodoma Regional Hospital: Dr. Masimba (Department of Obstetrics and Gynecology)

Focus Groups

1. Mikumi Youth Centre male
2. Mikum Youth Centre female members
3. WLAC female clients
4. WoWAP women in Dodoma
5. Kibaha male community leaders

APPENDIX B: WHO'S DOING WHAT?

Public Sector

Sector	Type of Intervention	Office/Ministry	Activity Description
Health/psychosocial	Legal/policy reform		
	Delivery and/or reform of services	Public hospitals	<ul style="list-style-type: none"> ○ Conduct forensic exam and evidence collection using the PF3 form. ○ Conduct medical exam and treatment of injuries. ○ In some cases, screen for pregnancy, STIs, and HIV. ○ Where available, administer PEP. ○ Record information in medical history.
		Ministry of Health	Trains referral hospitals on gender.
	Community mobilization/individual behavior change communication		
Legal/Justice	Legal/policy reform	Parliament	Passed trafficking law; awaiting President's signature.
	Delivery and/or reform of services	Courts	Hears/prosecutes sexual offense and violence cases.
		Moj	<ul style="list-style-type: none"> ○ Considering and researching modalities of a family court. ○ Conducting research on public opinion with respect to revision of laws on inheritance, marriage, and property rights. ○ Conducting ad hoc training for judges on human rights broadly (not specific to GBV).
	Community mobilization/individual behavior change communication		
Security	Legal/policy reform	Ministry of Home Affairs	<ul style="list-style-type: none"> ○ Reformed legal and human resource frameworks so that police services "work for the community."
	Delivery and/or reform of services	Police	<ul style="list-style-type: none"> ○ Filing of rape and violence cases (PF3 form). ○ Confidential spaces available for GBV survivors (but no protocol to enforce their use). ○ Training from the United Nations, ministries, and NGOs on how to identify trafficking survivors (with support from the International Organization for Migration).

		MoCDGC	<ul style="list-style-type: none"> o Planning on developing a curriculum to train police officers on GBV issues. o Goal to develop similar curriculum for judges and local leaders.
		TPFNet	<ul style="list-style-type: none"> o Instituting gender units at police stations. o Training on GBV and gender for 180 police in Dar es Salaam; training to continue for the rest of the country (pending funding).
	Community mobilization/individual behavior change communication	TPFNet	Linking police with community through networking with NGOs, ministries, donors, and prisons.
Multisectoral	Legal/policy reform	MoCDGC	<ul style="list-style-type: none"> o Developed a National Plan of Action on the Elimination of Violence Against Women. With support from UNIFEM, will lead a review process to update the plan. o Developed a National Plan of Action on the Eradication of FGM, in collaboration with WoWAP. o Promoted the inclusion of gender and sexual violence in the National Strategy for Growth and Poverty Reduction.
	Delivery and/or reform of services	MoCDGC	<ul style="list-style-type: none"> o Training and facilitation of meetings with permanent secretaries and gender focal points in ministries on mainstreaming gender in workplans and budgets. o With help of WLAC (an NGO), trains community development workers on human rights, including women's rights and violence.
	Community mobilization/individual behavior change communication	Ministry of Labor	Organized forum on sexual harassment (2004).
		MoCDGC	<ul style="list-style-type: none"> o Co-sponsors workshops and meetings on gender and GBV with women's organizations and other leaders in the Tanzanian women's movement. o Running a national campaign, "Say NO to Violence Against Women." o With support of UNIFEM, plans to form a multisectoral, multi-level stakeholder task force on GBV. (Not yet materialized.)

NGO Sector

Sector	Type of Intervention	Group/Organization	Activity
Health/psychosocial	Legal/policy reform	WHO	Developed guidelines for integrating gender into HIV programs.
	Delivery and/or reform of services	IRC	<ul style="list-style-type: none"> Conducts medical and forensic exam using a standard incident report and treatment protocol. Offers counseling, support groups, and safety planning.
		UMATI	<ul style="list-style-type: none"> Sensitized providers on GBV. Seeking further funding to training providers on comprehensive, systematic response to GBV, including screening.
	Community mobilization/individual behavior change communication	Mennonite Church	Counseling perpetrators in an effort to reform them.
		UMATI	Incorporating GBV into youth outreach programs.
Legal/Justice	Legal/policy reform	TAWLA, WLAC, WoWAP	Conducted lobbying and advocacy for legal reform, including for <ul style="list-style-type: none"> Passage of inheritance bill; Revision of law of marriage act to raise age of marriage for girls; SOSPA to recognize marital rape; Specific law on domestic violence; and Revisions/nullification of local customary laws that contradict constitution law (e.g., inheritance rights).
	Delivery and/or reform of services	TAWLA, WLAC	<ul style="list-style-type: none"> Provide legal advice. Help in document preparation and filing. Provide legal representation in court (limited capacity).
		IRC, LHRC, TAMWA , WILDAF, WoWAP	<ul style="list-style-type: none"> Provide legal advice. Help in document preparation and filing.
		LHRC, WLAC	<ul style="list-style-type: none"> Monitor implementation of GBV laws.
		WLAC, LHRC, WoWAP	Train paralegals to offer legal aid to women.
		TAWLA	Advocating for the creation of a Family Court.
	Community mobilization/individual behavior change communication	TAMWA, WLAC, TAWLA, WoWAP, TARWOC, and AFNET	<ul style="list-style-type: none"> Conduct awareness-raising activities, IEC, and media advocacy on women's legal rights. Network and advocate on GBV and legal issues.

Security	Legal/policy reform		
	Delivery and/or reform of services	KIWOHEDE	Sets up structures (church, police, teachers, peer educators, government, business owners, etc.) in the community to identify or report trafficking and child sexual abuse.
		WLAC, UNIFEM	<ul style="list-style-type: none"> ○ Assisted TPFNet with training police at gender units. ○ Plan to develop a training manual on GBV for police.
		LHRC	Developed a training course for police on women's human rights issues, including GBV.
		IRC	Trains police in refugee camps on the UNHCR protocol for responding to GBV cases.
Community mobilization/individual behavior change communication			
Multisectoral	Legal/policy reform		
	Delivery and/or reform of services	IRC	Provides medical treatment, legal aid, and counseling for survivors. Also trains and educates police and the general public on GBV.
		KIWOHEDE	<ul style="list-style-type: none"> ○ Provides shelter, counseling, HIV testing, and vocational skills training to trafficked children/child workers. ○ Refers survivors to hospitals and legal aid. ○ Accompanies children through court system.
		WILDAF	Sensitization on GBV for community leaders, health, and police.
	Community mobilization/individual behavior change communication	WLAC/Health Policy Initiative	Train media on how to report on GBV in the press.
		WoWAP	Uses traditional arts to advocate for gender change and to provoke discussion in the community.
		KIVULINI, WoWAP, MoCDGC, TAWLA, TAMWA, and AFNET, WILDAF	Use media, such as leaflets, radio, video screenings and TV programs to raise awareness and advocate for attitude change.
		IRC and UNHCR, KIWOHEDE, WILDAF	Trains peer educators or civil society groups to discuss GBV in their communities.
		AFNET, FAWE, Kivulini,	WILDAF leads the National Coalition on Gender-based Violence

		<p>KIWAKKUKI, KIWOHEDE, KWIECO, LHRC, TGNP, TAWLA, TAMWA, UMATI, WILDAF, WLAC</p>	<p>for Civil Society Organizations, which is a networking and coalition-building body. Approximately 20 organizations participate, including those listed here.</p>
		<p>Irish Aid, UNAIDS, UNDP, UNICEF, UNFPA, CIDA, Denmark, Netherlands, Norwegian Church Aid, Sweden</p>	<p>Form the Development Partners Working Group on Gender Equality, which meets to coordinate gender and GBV work. Members of the group supported a basket of funds to support a GBV prevention initiative funded by WILDAF.</p>

APPENDIX C: RECOMMENDATIONS

Sector	Legal/Policy Reform	Reform of Services	Community Mobilization/Individual Behavior change
<p>Health/psychosocial</p>	<p>Create policies on GBV that ensure an appropriate and consistent health response to survivors of all forms of GBV.</p> <p>Include GBV in the National HIV/AIDS Policy and the next strategic framework for HIV/AIDS.</p> <p>Develop policies to ensure training on GBV based on formal treatment protocols.</p> <p>Amend the National Plan of Action for the Prevention and Eradication of Violence against Women and Children to include activities to improve the health sector response.</p> <p>Develop strategies to increase the number of female doctors, such as scholarship programs for female medical students.</p> <p>Develop strategic plans on GBV for the Ministry of Health gender focal point.</p>	<p>Pass policies requiring the inclusion of GBV into medical and nursing school curricula.</p> <p>Develop and ensure implementation of treatment and referral protocols to respond to survivors, including a plan to begin screening for GBV once sufficient resources are available.</p> <p>Train health staff to provide confidential services that include counseling, examining survivors, and collecting evidence, as well as coordination with other sectors. Such trainings must include clarification on policies on PF3 forms.</p> <p>Equip health centers and clinics with the resources and training to administer forensic exams and medical certification of rape.</p> <p>Integrate GBV services into HIV counseling and testing programs that have adequate capacity and resources.</p> <p>Form peer support and counseling groups for survivors.</p> <p>Develop and maintain a comprehensive, up-to-date directory of services for survivors, including counseling, legal aid, social services, financial assistance, and shelter.</p> <p>Establish data collection systems at the service delivery level and monitor ongoing incidents.</p>	<p>Develop pamphlets, posters, and other materials on different forms of GBV and available services.</p> <p>Liaise with the education sector to develop curricula on GBV and/or peer education programs in relation to GBV and its health consequences.</p> <p>Launch a widespread campaign on the links between GBV and HIV.</p> <p>Incorporate GBV prevention into programs addressing HIV, particularly HIV prevention education programs and counseling programs.</p>

<p>Legal</p>	<p>Advocate for a specific law on domestic violence with provisions for protection orders, fines, or other stipulations regarding separation/divorce and child custody that facilitate legal action against and leaving an abuse partner.</p> <p>Advocate for the revision of the Law of Marriage Act so that the legal age of marriage for women/girls is 18 years old (same as men).</p>	<p>Incorporate GBV into law school curricula.</p> <p>Implement ongoing training for lawyers and judges on working with GBV survivors.</p>	<p>Support NGO efforts to educate the community about laws, women's rights and protections under the law, and how women can use the law to protect themselves and their children from violence.</p>
<p>Security/Justice</p>	<p>Pass policies requiring the inclusion of GBV into police training curricula.</p> <p>Develop strategies to increase the number of female police officers, judges, and lawyers.</p> <p>Develop strategic plans on GBV for gender focal points at the ministries of justice and home affairs.</p>	<p>Provide support to gender units in police stations.</p> <p>Develop protocols for police response to all forms of GBV and train officers to follow them.</p> <p>Document the enforcement of GBV laws.</p> <p>Train gender focal points in the ministries of justice and home affairs on GBV.</p> <p>Train police on the proper handling of GBV cases.</p>	<p>Work with the community to identify high-risk areas and ensure a police officers' protective presence in those areas.</p>
<p>Education/Youth <i>Due to lack of information on interventions in the education sector, these are general recommendations based on the assumption that few interventions exist and also on known gaps in other sectors.</i></p>	<p>Enact codes of conduct for both teachers and students on GBV, including sexual harassment with strict punishments for violating the codes.</p>	<p>Train gender focal points in the Ministry of Education on GBV.</p> <p>Train all staff and students on the codes of conduct.</p> <p>Train teachers to understand problems related to GBV that children may have, and train them on how to respond when they see warning signs that a child is being abused.</p>	<p>Incorporate age-appropriate information on GBV into school curricula at every grade level.</p> <p>Develop IEC for students and their families on different types of GBV, how to prevent it, and where to get help if they experience it.</p> <p>Incorporate GBV into life skills curriculum in schools.</p>

	<p>Establish protocols for staff to follow when children admit (or are suspected) of being abused.</p>	<p>Ensure that reporting mechanisms exist for violations.</p> <p>Ensure that trained counselors are on staff for children who report abuse or for those that teachers suspect may be experiencing abuse.</p>	<p>Research the impact of GBV in schools on girls' educational attainment.</p>
Multisectoral	<p>Revise national plans of action violence against women and children and FGM to reflect current needs and priorities and emerging best practices, including specific improvement of and support to health and social sectors.</p> <p>Advocate for budgets to allow for implementation of the plans of action on violence against women and children and FGC. Work with the MoCDGC to advocate for budgets to support activities as outlined in the National Plan of Action on for the Prevention and Eradication of Violence against Women and Children.</p> <p>Facilitate dialogue on GBV among Parliamentarians to improve the policy environment on GBV.</p> <p>Work with local government leaders to translate the GBV plans of action into concrete components of community by-laws.</p>	<p>Provide support and technical assistance to the MoCDGC to train gender focal points in ministries on GBV.</p> <p>Work with gender focal points in ministries to develop plans of action specific to their sectors.</p> <p>Pilot a one-stop service center for GBV survivors with comprehensive services from all sectors.</p> <p>Develop a directory of GBV services and resources from each sector. Disseminate to any practitioners and NGOs who have contact with survivors of GBV.</p> <p>Using the above directory, establish a referral network of survivor services related to GBV.</p>	<p>Link GBV and HIV in HIV awareness-raising programs and mass media campaigns.</p> <p>Raise awareness on the problem of gender-based violence and women's related rights in the community.</p> <p>Mobilize men and boys to speak out and take action against GBV in their communities.</p> <p>Research further the varying types of GBV in Tanzania, including "same-sex marriage," GBV against men and boys, and trafficking.</p> <p>Support the MoCDGC in the development of a multisectoral GBV network to ensure the necessary and proper coordination of services and to facilitate the exchange of information and pooling of resources for GBV interventions.</p>

REFERENCES

- Ashford, Lori, and Donna Clifton. 2005. *Women of Our World*. Washington, DC: Population Reference Bureau.
- Abdool Q, Karim. 2001. "Barriers to Preventing Human Immunodeficiency Virus in Women: Experiences from KwaZulu-Natal, South Africa." *Journal of American Medical Women's Association* 56(4): 193–196.
- Betron, M., and E. Doggett. 2006. *Linking Gender-Based Violence Research to Practice in East, Central and Southern Africa: A Review of Risk Factors and Promising Interventions*. Washington, DC: Constella Futures (formerly Futures Group), POLICY Project.
- Betron, M., and E. Gonzalez-Figueroa. Forthcoming. *Screening for Gender-based Violence among MSM and Transgendered Persons: A Synthesis and Review of the Literature*. Washington, DC: Futures Group International, Health Policy Initiative Task Order 1.
- Bott, S., and M. Betron. 2005. *USAID-Funded Gender-Based Violence Programming: An Assessment Report for the Bureau of Global Health*. Washington, DC: USAID.
- Bott, Sarah, Andrew Morrison, and Mary Ellsberg. 2005. "Preventing and Responding to Gender-Based Violence in Middle- and Low-Income Countries: a Global Review and Analysis." *World Bank Policy Research Working Paper* No. 3618.
- Campbell, Jacquelyn. Unpublished. *The Intersection of HIV/AIDS and Violence Against Women: Needed Research and Policy Initiatives*.
- Centers for Disease Control and Prevention (CDC). 2003. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta, GA: National Center for Injury Prevention and Control.
- Choi, K.H., D. Binson, M. Adelson, and J. Catania. 1998. "Sexual Harassment, Sexual Coercion, and HIV Risk Among U.S. Adults 18–49 Years." *AIDS and Behavior* 2: 33–40.
- Davila, Y. R., and M.H. Brackley. 1999. "Mexican and Mexican American Women in a Battered Women's Shelter: Barriers to Condom Negotiation for HIV/AIDS Prevention." *Issues Mental Health Nursing* 20(4): 333–355.
- Dunkle, K., R. Jewkes, R. Brown, G. Gray, J. McIntyre, and S. Harlow. 2004. "Gender-based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa." *The Lancet* 363: 1415–1421.
- Duvvury, Nata, Karen Grown, and Jennifer Redner. 2004. *Cost of Intimate Partner Violence at the Community and Household Level*. Washington, DC: International Center for Research on Women.
- Farley, Melissa, A. Cotton, J. Lynne, S. Zumbek, F. Spiwak, M.E. Reyes, D. Alvarez, and U. Sezgin. 2003. "Prostitution and Trafficking in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder." *Journal of Trauma Practice* 2: 33–74.
- Gielen, A.C., K.A. McDonnell, J.G. Burke, and P. O'Campo. 2000. "Women's Lives after an HIV-positive Diagnosis: Disclosure and Violence." *Matern. Child Health J.* 4(2): 111–120.

Gilbert, L., N. El-Bassel, V. Rajah, A. Folen, J. Fontdevila, V. Frye, and B. L. Richman. 2000. "The Converging Epidemics of Mood-Altering Drug Use, HIV, HCV, and Partner Violence: A Conundrum for Methadone Maintenance Treatment." *The Mount Sinai Journal of Medicine* 67 (5 and 6): 452–463.

Garcia-Moreno, C., and C. Watts. 2000. "Violence Against Women: Its Importance for HIV/AIDS Prevention." *AIDS* 24(3): S253–S265.

Garcia-Moreno, C. H. Jansen, M. Ellsberg, L. Heise, and C. Watts. 2005. *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. Geneva: World Health Organization.

Greenwood, G. L., M.V. Relf, B. Huang, L.M. Pollack, J.A. Canchola, and J.A. Catania. 2002. "Battering Victimization Among a Probability-Based Sample of Men Who Have Sex With Men (MSM)." *Am.J.Public Health* 92(12): 1964–1969.

Guedes, Alessandra. 2004. *Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*. Washington, DC: Population Technical Assistance Project.

Heise, Lori, M. Ellsberg, and M. Gottemoeller. 1999. "Ending Violence Against Women." *Population Reports*, Volume XXVII, Number 4, Series L, Number 11. Available at: <http://www.infoforhealth.org/pr/111/violence.pdf>.

Heise, L., M. Ellsberg, M. Gottemoeller. 2002. "A Global Overview of Gender-based Violence." *International Journal of Gynecology and Obstetrics* 78 Suppl. 1 S5–S14.

IASC. 2005. *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies*. (Field Test Version). Geneva: Inter-Agency Steering Committee.

Koenig, Michael, Iryna Zablotska, Tom Lutalo, Fred Nalugoda, Jennifer Wagman, and Ron Gray. 2004. "Coerced First Intercourse and Reproductive Health Among Adolescent Women in Rakai, Uganda." *International Family Planning Perspectives* 30(4): 156–63.

Krug, Etienne G., Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi, and Rafael Lozano, eds. 2002. *World Report on Violence and Health*. Geneva: WHO.

Maman, S., J. Campbell, M. Sweat, and A. Gielen. 2000. "The Intersections of HIV and Violence: Directions for Future Research and Interventions." *Social Science and Medicine* 50(4): 459–478.

Maman, S., J. Mbwambo, J.C. Campbell, M. Hogan, G.P. Kilonzo, E. Weiss, and M. Sweat. 2002. "HIV-1 Positive Women Report More Lifetime Experiences with Violence: Findings from a Voluntary HIV-1 Counseling and Testing Clinic in Dar es Salaam, Tanzania." *American Journal of Public Health* 92(8): 1331–1337.

Maman, S., J. Mbwambo, N.M. Hogan, G.P. Kilonzo, and M. Sweat. 2001. "Women's Barriers to HIV-1 Testing and Disclosure: Challenges for HIV-1 Voluntary Counseling and Testing." *AIDS Care* 13(5): 595–603.

Morrison, Andrew, and María Beatriz Orlando. 2005. "The Costs and Impacts of Gender-based Violence in Developing Countries: Methodological Considerations and New Evidence." Working Paper Series. Washington, DC: World Bank.

- National Bureau of Statistics (Tanzania) and ORC Macro. 2005. *Tanzania Demographic and Health Survey*. Calverton, MD: National Bureau of Statistics and ORC Macro.
- Tanzanian Vice President's Office. 2005. National Strategy for Growth and Reduction of Poverty.
- Tanzania Women Lawyers' Association (TAWLA). 2004. *Review of Gender Discriminative Laws in Tanzania*. Dar es Salaam: TAWLA.
- United Nations Children's Fund (UNICEF). 2001. "Early Marriage: Child Spouses." *Innocenti Digest* 7.
- U.S. Department of State, Office to Monitor and Combat Trafficking in Persons. 2008. *Trafficking in Persons Report*. Washington, DC: U.S. Department of State.
- U.S. Department of State, Office to Monitor and Combat Trafficking in Persons. 2008. "Health Consequences of Trafficking in Persons" Fact Sheet.
- U.S. Department of State, Office to Monitor and Combat Trafficking in Persons. 2005. *Trafficking in Persons Report*. Washington, DC: U.S. Department of State.
- United Nations General Assembly. 1993. "Declaration on the Elimination of Violence Against Women." Geneva: UN Special Assembly, resolution 48/104 of 20 December 1993.
- Waters, H., A. Hyder, Y. Rajkotia, S. Basu, J.A. Rehwinkel, and A. Butchart. 2004. *The Economic Dimensions of Interpersonal Violence*. Geneva: Department of Injuries and Violence Prevention, World Health Organization.
- Wingood, G.M., and R.J. DiClemente. 1997. "The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women." *American Journal of Public Health* 87: 1016–1018.
- Woods, A. B., G. Page, P. O'Campo, L. Pugh, D. Ford, and J.C. Campbell. (In review). The Mediation Effect of Post-Traumatic Stress Disorder Symptoms on the Relationship of Intimate Partner Violence and IFN- γ Levels.
- World Health Organization (WHO), Department of Women's Health. 2000. *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth*. Geneva: WHO.
- Wyatt, G. E., H.F. Myers, J.K. Williams, C. Ramirez-Kitchen, T. Loeb, J. Vargas-Carmona, L.E. Wyatt, D. Chin, and N. Presley. 2002. "Does a History of Trauma Contribute to HIV Risk for Women of Color? Implications for Prevention and Policy." *Am.J.Public Health* 92(4): 660–665.

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