



**THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE**

**NATIONAL POLICY GUIDELINE FOR THE HEALTH SECTOR PREVENTION
AND RESPONSE TO GENDER-BASED VIOLENCE (GBV)**

SEPTEMBER 2011

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FOREWARD

This National Policy Guideline has been developed to address the critical and largely unrecognized problem of Gender Based Violence (GBV) in Tanzania. The country's recent Demographic and Health Survey (TDHS 2010), revealed unacceptable high prevalence of GBV. Gender based Violence is a gross violation of fundamental human rights and has severe, long-term negative impacts on the physical, sexual and mental wellbeing of the survivors, family and community. The Ministry of Health and social Welfare (MOHSW) initiated the development of this GBV Policy Guidelines to inform the preparation of the National Management guidelines for Health Sector Prevention and Response to Gender-Based Violence. The MOHSW intends to work with other stakeholders, to provide comprehensive services to GBV.

The development of the GBV Policy Guidelines are guided by the Health Policy and key strategic documents in the health sector, namely; the Health Sector Strategic Plan III (HSSP III 2009-2015), Primary Health Services Development Program (MMAM 2007-2017), the Human Resource for Health Strategic Plan (2008-2013), The National Road Map Strategic Plan to Accelerate reduction of Maternal, Newborn and Child deaths in Tanzania "one Plan" (2008-2015), National Family Planning Costed Implementation Program (2010-2015) and the National Plan of Action for Orphans and Vulnerable Children (OVC).

Implementation of GBV related activities in the country and management of survivors of GBV in health facilities and at the community level, have not been comprehensive or effective. National initiative to combat GBV have been launched, but inadequate resources and other causes especially the lack of national policy guidelines, have hindered their effectiveness. A comprehensive prevention and response to GBV, calls for not only the health sector's involvement, but also the inclusion of other sectors that are responsible for psychosocial, police and legal services. The situation demands for a close coordination and collaboration in initiating, planning and implementation of GBV policy guidelines.

The guidelines outline the responsibilities and roles of the MOHSW and its key partners, in planning and implementation of the comprehensive GBV services at all levels. The prevention of GBV and provision of services to survivors, will be integrated into the existing national health delivery infrastructure. The provision of GBV services to survivors at each service delivery point shall be guided by adherence to and respect for human rights, professional ethics and compassion. It is my sincere hope, that all health planners, committees, managers and service providers of the health sector, will find this policy guideline and invaluable tool in planning and implementation of the comprehensive and high quality health services for GBV survivors, and will contribute towards the prevention and elimination of GBV survivors, and will contribute towards the prevention and elimination of GBV in Tanzania.



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BPA	Beijing Platform of Action
CBO	Community-based Organization
CEDAW	Convention on Elimination of Discrimination Against Women
CSO	Civil Society Organization
DP	Development Partner
ECSA	East, Central, and Southern African
FBO	Faith-based Organization
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender Based Violence
GFP	Gender Focal Point
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
MCDGC	Ministry of Community Development Gender and Children
MCH	Maternal and Child Health
MDAs	Ministries, Departments, Agencies
MDG	Millennium Development Goal
MKUKUTA	<i>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini</i> Tanzania
MMAM	<i>Mpango wa Maendeleo ya Afya ya Msingi</i>
MOEVT	Ministry of Education and Vocational Training
MOHA	Ministry of Home Affairs
MOHSW	Ministry of Health and Social Welfare
MOJCA	Ministry of Justice and Constitutional Affairs
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MVC	Most Vulnerable Children
NGO	Non Governmental Organization
NSA	Non State Actor
PEPFAR	President's Emergency Plan for AIDS Relief
PAF	Performance Assessment Framework
PF3	Police Form number 3
PMO-RALG	Prime Ministers' Office Regional Administration and Local Government
RH	Reproductive Health
SOP	Standard Operating Procedure
SOSPA	Sexual Offences Special Provisions Act
SWAp	Sector Wide Approach
TARWOC	Tanzania Rural Women and Children Development Foundation
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Violence Against Children
VAW	Violence Against Women
VICOBA	Village Community Bank
WHO	World Health Organization

GLOSSARY OF TERMS AND CONCEPTS

For the purpose of this document, these terms and concepts shall have the following meanings.

Abuse: Misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inflicting or inciting fear of that harm. Abuse prevents persons from making free decisions and forces them to behave against their will

Adolescent: The transitional stage of development between childhood and full adulthood, representing the period of time during which a person is biologically an adult but emotionally has not achieved full maturity. The time is identified with dramatic changes in the body associated with onset of puberty, along with developments in a person's psychology. In the onset of adolescence, children pursuing an academic career usually complete primary school and enter secondary schools.

Child: According to the Tanzanian constitution and the law of the child act, a child is a person who is less than 18 years of age.

Child abuse: An umbrella term that includes deliberate and intentional words or overt actions that cause harm, potential for harm, or threat of harm to a child. Child abuse can take three broad forms: physical, sexual, and psychological abuse.

Child sexual abuse: The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power—the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity, the exploitative use of child in prostitution or other unlawful sexual practices, and the exploitative use of children in pornographic performances and materials. Child abuse is an umbrella term that includes deliberate and intentional words or overt actions that cause harm, potential for harm, or threat of harm to a child.

Coercion: Forcing, or attempting to force, another person to engage in behavior against her/his will by using threats, verbal insistence, manipulation, deception, cultural expectations, or economic power.

Comprehensive: Covering and involving broadly all relevant aspects and key players at all levels.

Consent: Making an informed choice freely and voluntarily to do something. There is no consent when agreement is obtained through the use of threats, force, or other forms of coercion, abduction, fraud, deception, or misrepresentation. Threatening to withhold or promising to provide a benefit in order to obtain the agreement of a person constitutes an abuse of power. Any agreement obtained in such a way, or from a person who is below the legal (statutory) age of consent, or is defined as a child under applicable laws, is not considered to be consensual.

Domestic violence: A pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation. Domestic violence has many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, throwing objects) or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation, alcohol consumption, and mental illness can be co-morbid with abuse and present additional challenges when present alongside patterns of abuse.

Drop-in center: A place for information, safety, referral, first aid, and other immediate needs of GBV survivors who need a safe and confidential place for a limited period of time.

Fit institution: An approved residential or approved school, retention home, or a home for socially deprived children and street children. This includes a person or institution that has care and control of children.

Fit person: A person of full age who is of high moral character and of sound mind; who is not a relative of the child; who is capable of looking after a child, and has been approved by social welfare as being able to provide a caring home for a child.

Forced widow inheritance: A type of marriage in which a widow marries a kinsman of her late husband, often his brother. It can have various forms and functions in different cultures, serving in relative proportions as a social protection for, and control over, the widow and her children. The custom is sometimes justified on the basis that it ensures that the wealth does not leave the patrilineal family. It is also sometimes justified as a protection for the widow and her children.

Forced prostitution: Forced/coerced sex trade in exchange for material resources, services, and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children.

Gender: The term used to denote the social characteristics assigned to men and women. People are born female or male (sex); they learn how to be girls and boys and then become women and men (gender). Gender is constructed on the basis of different factors, such as age; religion; and national, ethnic, and social origin. Gender differs both within and between cultures and defines identities, status, roles, responsibilities, and power relations among the members of any culture or society. Gender is learned through socialization. It is not static or innate but evolves to respond to changes in the social, political, and cultural environment. Gender refers to what it means to be a boy or a girl, woman or man, in a particular society or culture. Society teaches expected attitudes, behaviors, roles, responsibilities, constraints, opportunities, and privileges of men and women in any context.

Gender-based violence: An umbrella term for any act, omission, or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females. In this context, GBV includes but is not limited to sexual violence, physical violence and harmful traditional practices, and economic and social violence. The term refers to violence that targets individuals or groups on the basis of their being female or male.

GBV Response: The reaction and support of stakeholders in initiating strategies and activities towards GBV survivors.

Harmful traditional practices:

- *Female genital mutilation (FGM)*—Comprises all procedures that involve partial or total removal of the external female genitalia, or other injury inflicted to the female genital organs for non-medical reasons.
- *Early marriage*—Marriage under the age of legal consent—most commonly for girls. Sexual intercourse in such relationships constitutes statutory rape under Tanzania laws, as the girls are not legally competent to agree to such unions. Early marriages are associated with negative health consequences to the mother and the child that include among others, complicated labor, disabilities, and maternal and neonatal deaths.
- *Forced marriage*—An arranged marriage usually against a woman's, a girl's, or a boy's wishes and exposure to violent and/or abusive consequences if she/he refuses to comply.
- *Widow cleansing*—A practice in which a widow has sex with a brother-in-law or other relative or a village cleanser. This is done before she is taken in marriage by the brother-in-law or other relative.

Human rights: Basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion, language, or other status.

Incidence of violence: An act or a series of harmful acts by a perpetrator or a group of perpetrators against a person or a group of individuals. It may involve multiple types of and repeated acts of violence over a period of time, with variable durations. It can take minutes, hours, days, or a lifetime. It may occur at home (domestic) or elsewhere.

Intimate partner violence: A pattern of abusive behavior by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation. Intimate partner violence has many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, throwing objects) or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

Multisectoral stakeholders: Organizations whose roles overlap with that of the MOHSW in GBV-related work, such as the community, relevant government ministries (Ministry of Community Development, Gender, and Children; Ministry of Justice and Constitutional Affairs; Ministry of Home Affairs, Prime Ministers' Office Regional Administration and Local Government), human rights organizations, civil society organizations, and faith-based organizations.

Perpetrator: A person, group, or institution that directly or indirectly inflicts, supports, and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision making, and/or authority and can thus exert control over their survivors.

Physical violence or physical assault: Beating, punching, kicking, biting, burning, maiming, or killing, with or without weapons—often in combination with other forms of gender-based violence.

Power: In the context of GBV, power is directly related to choice; the more power one has, the more choices available. Conversely, with less power, fewer choices are available, with potentially increased vulnerability to abuse. Gender-based violence involves the abuse of power when unequal power relationships are exploited or abused. For example, using any kind of pressure to obtain sexual favors from a weaker person in exchange for benefits or promises constitutes an abuse of power. Gender differentials contribute to men's overall socioeconomic standing. Men are, overall, in more powerful positions than women, and they often control money as well as access to goods, services, and favors. Men often have more physical strength and are bigger than women; more often use weapons; and control access or security. Power is also age-related, and, often, the young and elderly have the least power. Husbands/boyfriends are often older than their wives/girlfriends.

Rape: The invasion of any part of the body of the survivor by the perpetrator with a sexual organ or of the anal or genital opening of the survivor with any object or any other part of the body by force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (1998 Rome Statute of the International Criminal Court (ICC)).

Marital rape: Marital rape is any unwanted sexual acts by a spouse committed without consent and/or against a person's will, obtained by force or threat of force, intimidation, or when a person is unable to consent. These sexual acts include intercourse, anal or oral sex, forced sexual behavior with other individuals, and other sexual activities that are considered by the victim as degrading, humiliating, painful, and unwanted.

Safe house: A place of temporary refuge, suitable for hiding or keeping safe GBV survivors, witnesses, or other persons perceived as being in danger; a place where a trusted adult, family, or a community or charity organization provide a safe haven for GBV survivors.

Sexual abuse: Actual or threatened physical intrusion of a sexual nature, including inappropriate touching by force or under unequal or coercive conditions.

Sexual coercion: Act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations, or economic circumstances to engage in sexual behaviors against her/his will. It includes a wide range of behaviors from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choosing.

Sexual exploitation: Any abuse for sexual purposes of another person in a vulnerable situation. This includes situations where there is unequal power differential; breach of relationships based on trust; or monetary, social, or political profiting from the sexual exploitation of another person. Sexual exploitation is one of the purposes of trafficking in persons. The definition of sexual exploitation also includes a coercive, manipulative, or otherwise exploitative pattern, practice, or scheme of conduct, which may include sexual contact that can be reasonably construed as being for the purposes of sexual arousal or gratification.

Sexual harassment: Any unwelcome, usually repeated, and unreciprocated sexual advance; unsolicited sexual attention; demand for sexual access or favors; sexual innuendo or other verbal or physical conduct of a sexual nature; and display of pornographic material when it interferes with work is made a condition of employment or creates an intimidating, hostile, or offensive work environment.

Sexual violence: Includes sexual exploitation and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that results, or is likely to result, in physical, psychological, and emotional harm.

Socioeconomic violence: Discrimination and/or denial of opportunities and services, including exclusion and denial of access to education, health assistance, or remunerated employment; and denial of property rights, including property grabbing and the associated psychological stress.

Survivor: Someone, a child or an adult male or female, who has been physically, sexually, and/or psychologically violated because of his/her gender.

Violence: Control and oppression that can include emotional, social, or economic force, coercion, or pressure, as well as physical harm. It can be overt, in the form of physical assault or threatening someone with a weapon; it can also be covert, in the form of intimidation, threats, persecution, deception, or other forms of psychological or social pressure. The person targeted by this kind of violence is compelled to behave as expected or to act against her will out of fear.

Violence against women: 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 in private life.

SECTION ONE: INTRODUCTION

I.1 Global Overview

Gender-based violence (GBV) both reflects and reinforces inequities between men and women and compromises the health, dignity, security, and autonomy of survivors. GBV encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls, and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death.¹ While GBV is not widely recognized as a human rights violation in many parts of the world, it is a serious problem that limits the ability of men, women, and children to enjoy their basic human rights and fundamental freedoms. Despite its prevalence in most countries, GBV is often not addressed. It has been described as “perhaps the most shameful human rights violation, and the most pervasive.”² Women's subordinate social, economic, and legal status often makes it difficult for them to get help once violence occurs.³

A study by the World Health Organization (WHO) on women's health and domestic violence in 10 countries reported that ever-partnered women's lifetime prevalence of physical violence by an intimate partner was between 13–61 percent; the range of sexual violence by an intimate partner was between 6–59 percent; and for both sexual and physical violence between 15–71 percent.⁴ In addition, many rural women in the countries studied said that their first sexual experience was not consensual: Peru (24%), Tanzania (17%), Bangladesh (30%), and Ethiopia (17%). Physical violence during pregnancy was reported by 4–12 percent of women. Women and girls face additional types of violence. Trafficking of women and girls for forced labor and sex is widespread and often affects the most vulnerable. Forced and/or child marriages violate the human rights of women and girls, yet they are widely practiced in many countries in Asia, the Middle East, and sub-Saharan Africa. The WHO study indicates that, worldwide, up to one in five women and one in 10 men are reported to have experienced sexual abuse as children.

I.2 Regional Overview

There is limited information, data, and research on GBV in the East African Region. In Kenya, there was no nationally representative data on sexual violence until the 2003 Kenya Demographic and Health Survey (DHS).⁵ In this survey, 29 percent of women reported experiencing sexual violence in

¹ UNFPA. Ending Widespread Violence Against Women. www.unfpa.org/gender/violence.htm

² Annan, K. Remarks on International Women's Day. In: *Interagency videoconference for a World Free of Violence against Women, New York, 8 March 1999*
<http://www.un.org/News/Press/docs/1999/19990308.sgsm6919.html>

³ IGWG of USAID. 2008. Addressing Gender-Based **Violence** Through USAID's Health Programs
www.prb.org/pdf05/GBVReportfinal

⁴ WHO. 2005. WHO Multi-country Study on Women's Health and Domestic Violence Against Women.
www.who.int/gender/violence/who_multicountry

⁵ Central Bureau of Statistics M O H & O M. 2004. Kenya Demographic Health Survey 2003. 2 ed. Carlverton, Maryland

the year preceding the survey, and the highest proportion is among women ages 20–29 years. A survey of domestic violence in Kenya by the Federation of Kenya Women Lawyers showed that 51 percent of women visiting four antenatal clinics in Nairobi reported that they had been victims of violence at some point in their lives; 65 percent from their husbands and 22 percent from strangers.⁶ A study exploring post-election GBV in Kenya focused on the Kibera slums, an area of Nairobi inhabited by about 1 million people and one of the largest slums in the world. The study found that the ages of rape survivors ranged from 25–68 years old and that the majority were in their 30s. GBV affected women of all ages. Interviews revealed that some of the survivors contracted HIV.⁷

In 2008, Amnesty International reported that 40 women are raped every day in Northern Kivu, Democratic Republic of the Congo; in 2007, the United Nations estimated the figure to be around 350 women in a month.⁸

⁶ FIDA. 2002. Domestic Violence in Kenya - Report of a Baseline Survey Among Women in Nairobi. Nairobi, Kenya, Apex Communications.

⁷ Testimony by Millicent Obaso formerly with Care International, currently with Futures Group (Record of evidence-Commission of Inquiry into the Post Election Violence (CIPEV) chapter 6 -15th July 2008 at Kenyatta International Conference Center day 5 published : CIPEV Hansard Day 5.

⁸ Amnesty International. 2008. Report: Human Rights in Democratic Republic of the Congo.

SECTION TWO: SITUATION ANALYSIS OF GBV IN TANZANIA

2.1 The Magnitude of GBV in Tanzania

The WHO study on women's health and domestic violence in 10 countries established that domestic violence in general, and violence against women in particular are prevalent across Tanzania. The study involved 1,820 and 1,450 ever-partnered women in Dar es Salaam and Mbeya, respectively. The result showed that 41 percent and 55 percent of respondents experienced various forms of violence in Dar es Salaam and Mbeya, respectively. In some areas, from 15 to 71 percent of the women reported physical or sexual violence by a husband or partner. The same study indicated that 15 percent of women reported that their first sexual encounter was forced. Four to twelve percent of women reported being physically abused during pregnancy.

According to a national survey in Tanzania, the reported overall prevalence of domestic violence among women ages 15–49 years was 45 percent, including physical violence (25%); sexual violence (7%); and 14 percent for both types of violence.⁹ Nine percent of pregnant women reported physical abuse. The survey showed that 60 percent of women had experienced controlling behavior exhibited by partner/husband. There is considerable regional variation in prevalence of physical violence; it is highest in Dodoma (71%) and lowest in Tanga (16%). In the case of sexual violence, the highest prevalence was in Rukwa (32%) and lowest in Shinyanga (5%). The perpetrators of sexual violence on ever-married women were current husband/partner (48%), former husband/partner (21%), and current/former boyfriend (7%). In the case of never-married women, 27 percent of the perpetrators were current or former boyfriends.

The WHO study referred to above also indicates that trafficking of women and girls for forced labor and sex is widespread and often affects the most vulnerable. Forced marriages and child marriages practiced by some communities violate the human rights of women and girls as they are never asked for their consent. More than 60 percent of Tanzanian GBV survivors have not taken any action to report the violence to any formal or law enforcement authorities. Importantly, GBV can result in HIV infection. Young Tanzanian women ages 18–29 years who have been abused by a partner have been found to be 10 times more likely to be HIV positive than women who have not been abused.¹⁰

A study conducted in Dar es Salaam in 2000 indicated that more than 90 percent of rape survivors knew their attackers¹¹ In another study in Dar es Salaam twenty-five percent (25%) of women respondents agreed with the statement that “violence is a major problem in my life”.¹² Notably, marital rape is not recognized as a crime in Tanzania, except when couples are separated.

GBV in Tanzania is generally directed toward women and girls due to societal norms and practices that discriminate against them and reduce their ability to enjoy and practice their human rights.

⁹ National Bureau of Statistics, Tanzania Demographic and Health Survey Report 2010, ICF Macro, Calverton, Maryland, USA

¹⁰ Gender-Based Violence: Impediment to Reproductive Health. www.prb.org/igwg_media/gbv-impediment-to-RH

¹¹ Maman, S. (2000). The association between HIV-1 and violence among women at a voluntary HIV-1 counseling and testing clinic in Dar Es Salaam, Tanzania. Baltimore, MD: The Johns Hopkins University School of Public Health.

¹² Maman, Suzanne et al. 2001. HIV and Partner Violence Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania Population Council www.popcouncil.org/pdfs/horizons/vctviolence.

Although sexual assaults are more commonly directed at women and girls, men and boys can also be targets of sexual abuse, harassment, and assault. These forms of violence reflect differences in power between the survivor and the perpetrator of sexual violence who are often larger, older, wealthier, or a member of a powerful group or armed with a weapon. In Tanzania, 13.4 percent of adolescent boys have experienced some form of sexual assault.¹³ All forms of GBV—against men and boys as well as against women and girls—are greatly under-reported in Tanzania.

Experience shows that, regardless of the physical health status of the survivor, GBV tends to leave the survivor with long-lasting trauma and limits the survivor's participation in the community and society because of the embarrassment, stigma, and mental and emotional distress it causes.¹⁴ The “culture of silence” among survivors, family members, and the surrounding community compounds the problem. The impact of GBV has direct and negative consequences on the health and socioeconomic well-being of families and communities, especially women and children.¹⁵

2.2 Child and Adolescent Abuse

The national survey on violence against children (VAC) in Tanzania is the first of its kind on the Continent of Africa. Study findings show that Tanzanian children often suffer from abuse, and in many cases, multiple types of abuse including emotional, physical, and sexual violence. The study found that children are most vulnerable to abuse in the home and school settings—the two places where Tanzanian children spend the majority of their time as they mature into young adults. Three quarters of children experience some form of physical violence by a relative, teacher, or other authority figure by the time they are 18 years old. According to the study, nearly 30 percent of females ages 13–24 and nearly 14 percent of males ages 13–24 in Tanzania reported experiencing at least one incident of sexual violence before the age of 18.

In Tanzania, FGC occurs early in childhood. Almost one in three circumcised women, or 32 percent, were cut by the time they were one year old; and 27 percent were cut at age 13 years or older. However, girls are circumcised at increasingly younger ages; the proportion of women who were circumcised by age 5 increased from 34 percent to 39 percent according to the Tanzania DHS 2004–05 and DHS 2010. According to the national VAC survey, five percent of girls ages 13–17 reported being circumcised, while 10 percent of those ages 18–24 years reported being circumcised. As FGC is punishable by law, it is likely that those who are circumcised may be reluctant to report it and that underreporting is taking place.

2.3 Policy Environment

The Tanzanian government has shown its commitment to address GBV issues by being a signatory to several international instruments related to GBV and gender: the Convention on the Elimination of all forms of Discrimination against Women (CEDAW, 1985), which has been instrumental in fighting the effects of discrimination, including violence;¹⁶ the Beijing Platform for Action (BPA, 1995),¹⁷ and

¹³ UNICEF. National Survey on Violence Against Children in Tanzania 2010 (in press)

¹⁴ Child Sexual Abuse in the Eastern Caribbean UNICEF www.actionforchildren.org.uk/.../child_sexual_abuse_in_the_eastern_caribbean

¹⁵ Andrew R. Morrison, Maria Beatriz Orlando; The costs and impacts of gender-based violence in developing countries: Methodological considerations and new evidence. siteresources.worldbank.org/INTGENDER/.../costsandimpactsofgbv.pdf - Cached

¹⁶ Report of the Committee on the Elimination of Discrimination against Women (CEDAW) 1985

the Millennium Development Goals, 2000.¹⁸ Tanzania is also a signatory to the Protocol to the African Charter on Human and People's Rights on the Rights of Women,¹⁹ and the SADC Protocol.²⁰

Tanzania's development priorities are outlined in the National Vision 2022 and the National Strategy for Growth and Development (*Mpango wa Kuondoa Umaskini na Kukuza Uchumi* or MKUKUTA). MKUKUTA II (2011–25) addresses HIV and gender as cross-cutting issues and is the first national strategy to have identified the need to address gender violence as a public policy issue. The Ministry of Community Development, Gender, and Children (MCDGC) is the overall coordinating body for gender-related work. The MCDGC developed the Gender Development Policy (2000) to address gaps and inequalities between men and women, as well as the National Strategy for Gender and Development (2002) to provide a vision to enhance gender equality in the country. In addition, the MCDGC developed the National Plan of Action for the Prevention and Eradication of Violence Against Women and Children 2001–2015 to augment the government's legislative effort to combat GBV and help ensure "equality" and "equity" between women and men in Tanzania.

The National Health Policy of the MOHSW currently provides a framework for the delivery of health services to all in need, including GBV survivors.

2.4 Human Rights, Legal, and Regulatory Environment

Tanzania is a signatory to the Bill of Human Rights and a number of other international and regional instruments that prohibit discrimination on the basis of gender, thus requiring governments to ensure that women are not discriminated against. These instruments include the Convention on the Elimination of all Forms of Discrimination against Women, 1979; the International Covenant on Civil and Political Rights, 1966; the African Charter on Human and People's Rights, 1981; the Protocol to the African Charter on Human and Peoples "Rights on the Rights of Women in Africa," 2000; and the SADC Gender and Development Protocol, 2008.

Tanzania has enacted legislation that supports the prevention of and response to GBV. The Constitution of the United Republic of Tanzania of 1977 explicitly prohibits discrimination on the basis of gender and thus provides for equality (Articles 12-24). The Law of the Child Act facilitates efforts to reduce violence against children. The Sexual Offences Provision Act 1998 (SOSPA) was passed to safeguard "the dignity of women" and discourages GBV by providing extreme punishments for sexual offenses. The Act includes sexual violence (rape), trafficking in persons, sexual harassment, and a prohibition on FGC within a section titled "Cruelty to Children." This was the first time Tanzania took a legislative stance against this practice, which has since been moved to penal code Cap Section 16.

The Penal Act (revised 2002) discourages GVB offenses such as intimidation, Section 89B, 89A; desertion of children, Section 166; neglecting children, Section 167; manslaughter, Section 195,

¹⁷ Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). Also available on www1.umn.edu/humanrts/instree/e5dplw.htm

¹⁸ The United Nations Millennium Development Goals 2000

¹⁹ The Maputo protocol 2005

²⁰ SADC Protocol On Gender and Development 2009

murder, Section, 196; assaults, Sections 240–243; abduction, Section 246; kidnapping, Section 244; forced labor, Section 256; theft by spouse, Section 264; threat to arson, Section 332; arson, Sections 319–322; and concealment of documents, Sections 276–278. The Human Trafficking Act No. 6 of 2008 prohibits human trafficking for any reason and the HIV/AIDS Prevention Act No. 28 of 2008 prohibits stigmatization and criminalizes intentional transmission of HIV.

Despite these international, regional, and national legal instruments guaranteeing women’s rights, the problem of GBV is widespread in Tanzania and is infrequently reported. GBV affects more women and girls than men and boys as a result of the unequal power relationship between men and women in society, which is manifested in several key areas, including the economic, social, political, and legal areas. GBV frequently limits the ability of women and girls to enjoy their basic human rights and fundamental freedoms as stipulated in the Constitution of the United Republic of Tanzania. Identification of GBV offenders in Tanzania is rare in comparison to the number of assaults.²¹ However, it is important to address the legal needs of all GBV survivors: women, girls, men, boys, and children.

2.5 National Health and Social Welfare Services Delivery Infrastructure

The National Health and Social Welfare Services delivery infrastructure under the MOHSW exists at the central, regional/city, and district/municipal levels and supports health promotion, disease prevention, curative, rehabilitation, and social welfare services through health facilities encompassing dispensaries, medical clinics, health centers, and hospitals. There is a two-way national referral system of patient care that starts from the community to dispensaries (4,679), health centers (481), district hospitals (95), regional hospitals (19), and national referral hospitals (8) in the country. There are 5,718 health facilities in Tanzania, comprising dispensaries (86%), health centers (10%), and hospitals (4%) under the ownership of the government (69%), faith-based organizations (14%), parastatals (3%), and private organizations (14%).

The Primary Health Care Service Development Program (2007–2017)—in Kiswahili, *Mpango wa Maendeleo ya Afya ya Msingi* (MMAM)—is to ensure availability of a health center in each of the 2,555 wards and a dispensary in each of the 10,342 villages. A total 8,107 primary health facilities, 62 district hospitals, and 128 training institutions are planned to be established by 2012.

Out of the required number of 82,377 healthcare providers, there are 29,063 (35%) trained healthcare providers; thus a shortage of 65 percent. The total number of social welfare providers required is 3,892. There are only 210 social welfare staff, representing an overall shortage of 95 percent, with acute shortages at the district level (93%), ward level (100%), and centers for people with disabilities and other institutions (85%) (MOHSW statistic 2006). There is an overall shortage of trained health staff at dispensaries (69%), health centers (59%), and referral hospitals (48–67%). There is an overall shortage of trained social welfare workers (95%) at all levels: regional (21%), district (93%), ward (100%), and disability center (95%). The planned MMAM expansion may worsen the current staff shortage.

There is customarily one first referral district/designated hospital under each District Council Authority (DCA). There are 133 DCAs responsible and accountable for service provision in their area. Within each DCA, there is a District Health Board (DHB) that comprises elected councilors who oversee the planning and implementation of healthcare services in the district. The planning and management of healthcare services in the councils is led by the Council Health Management Team

²¹ Sexual and Gender-based Violence in Africa: Literature Review (2008) Population Council www.popcouncil.org/pdfs/AfricaSGBV

(CHMT). The District Medical Officer (DMO) is the leader of the CHMT and provides the secretariat to the DHB. There are district/designated hospital boards (HBs), facility health boards (FHBs) at health centers for the ward population, and dispensaries for the village population, with gender-balanced community representation.

The projected per capital health spending in 2010/11 was USD15.75 against the WHO-recommended figure of USD34.00. The expenditure as a proportion of GDP is about 14 percent, which is below the recommended figure of 15 percent.²²

(a) Central Level

The MOHSW is responsible for the formulation of health-related policies and guidelines; setting of standards; quality assurance; monitoring and evaluation; and regulation of service delivery, including health promotion, prevention, treatment, and rehabilitative and social welfare services. There are eight referral hospitals, with a shortage of trained health personnel (48%).

(b) Regional/City Level

The Regional Health Management Team has the lead role at this level and is primarily responsible for developing and executing the region's five-year health strategic plan and providing technical support to the CHMTs on (1) the correct and timely implementation of national policies, guidelines, and standards for both public and private health service providers within the DCAs and (2) the effective planning, implementation, and monitoring and evaluation of the comprehensive council health plans (CCHPs).

The Hospital Governing Committee oversees the planning and management of the second referral regional hospital. There are 19 regional hospitals, with a shortage of trained health personnel (66%).

(c) District/Municipal Council Authorities

The roles and functions at this level are regulated by the District Council (Council Health Service Board Establishment) Instrument, 2001, under section 86A of Act no. 7 of 1982. The DHB is accountable for delivering comprehensive healthcare services in the district. The CHMT provides the technical support for implementing the board's decisions.

(d) District Level

The CHMT prepares and implements CCHPs and monitors and evaluates health services at hospitals, health centers, dispensaries, medical clinics, and communities, including conducting operational research. The Hospital Governing Committee oversees the planning and management of the first referral district hospital. There are 95 district hospitals, including district designate hospitals, with a shortage of trained health personnel (67%).

(e) Ward Level

The Ward Health Committee oversees the planning, initialization, and coordination of community health plans; supervision and mobilization of resources including the collection and use of the Community Health Fund. Health centers are responsible for delivering comprehensive health and social welfare services within the wards. The Health Center Committee oversees the provision of adequate services and is charged with mobilizing adequate resources for these services. The Health Center Management Team is responsible for the day-to-day management of the health centers. The team plans and manages the community-based health initiatives within its catchment area in the

²² WHO The Abuja Declaration April 2001

context of the Ward Development Plan. There are 2,555 wards in the country—of which 481 (19%) have health centers. There is a shortage of human resources (59%) at the health centers.

(f) Village Level

The Dispensary Committee ensures that the population in its area receives appropriate and affordable health services by overseeing the resource mobilization for and implementation of the dispensary plan. The Dispensary Management Team plans and manages the community-based health initiatives within its catchment area in the context of the Ward Development Plan. There are 10,342 villages in the country—of which 4,679 (45%) have dispensaries. There is a shortage of human resources at dispensaries (69%). The Village Social Services Committee mobilizes and sensitizes the population to participate and be involved in health promotion and protection.

(g) Household Level

There are about 7 million households in Tanzania, with, on average, 4.7 members per household (of which 70% are headed by males and 30% by females). Under the national health policy, it is the responsibility of each citizen to promote and protect one's health and that of one's family. In addition, every citizen must avoid behavior that is hazardous to his/her health or to that of others and contribute resources for his/her own health and the care of health facilities.

2.6 GBV Response and Prevention

The Government of Tanzania and its key partners have implemented various GBV-related prevention and response activities. Ministries that help implement GBV activities include the MCDGC, MOJCA, MOHA, and MOHSW. Collaboration occurs among ministry departments and agencies, CSOs, and development partners. At the national level, the government implements the National Strategy for Gender Development (2005) to promote gender equality and equity for women. It also implements the SOSPA, 1998, which is now a part of the Penal Code, Cap 16, Revised Edition, 2002. The government also executes the National Plan of Action to Prevent and Eradicate Violence against Women and Children (2001–2015), which aims to eliminate related legal, social, economic, cultural, and political discrimination and exploitation. Above all, through the Constitution of United Republic of Tanzania, 1977, the government stipulates the fundamental principles of equality, respect, and individual rights.

In collaboration with other stakeholders, the government facilitates the establishment of gender desks in various ministry departments (e.g., MOHA police departments). CSOs provide advocacy, legal aid, and healthcare services and organize media campaigns; and a few CSOs have taken steps to provide GBV shelters and drop-in centers. There are national policies, laws, strategies, and action plans in place to address gender equality. Furthermore, the government, in collaboration with CSOs, works to create an enabling environment for survivors to access services such as legal aid. The MOHSW has been delivering services to GBV survivors despite the lack of GBV policy guidelines that would guide providers' actions when a survivor visits a health facility.

2.7 Challenges

In Tanzania, the current legal and policy framework and interventions to promote and protect human rights face numerous challenges that hamper GBV prevention, response, and mitigation efforts. The challenges include, but are not limited to, inadequate funding, gaps in laws and policies, inadequate multisectoral coordination, and lack of well-established referral mechanisms for GBV prevention and response services. Knowledge/information on the magnitude of the problem is limited. The MOHSW has therefore initiated the development of specific GBV policy and management guidelines.

(a) National Policies

The Government of Tanzania is striving to create an enabling environment for preventing and responding to GBV. Although the National Health Policy aims to provide adequate health services to every Tanzanian, it does not adequately address GBV issues. Lack of GBV policy and management guidelines has presented a major barrier to effective GBV prevention and response efforts, including the treatment and care of GBV survivors. The health sector should use this policy guideline to improve its response to GBV and the multisectoral collaboration and involvement of all stakeholders.

(b) National Laws

Despite the existence of many laws passed to protect women and children, many challenges exist. Some laws are ambiguous; some contradict each other, thus decreasing their effectiveness in discouraging GBV; and some deter reporting of cases, prosecution, and application of the laws because of severe punishment and the potential for losing the breadwinner. Moreover, the existing Law of Marriage Act Revised Edition, 2002, does not specify actions to be taken in domestic violence cases. When enacted, the SOSPA was silent on domestic violence and did not recognize marital rape unless the husband and wife were separated. SOSPA further qualifies rape if a girl is below age 18. However, if the survivor is married and experiences forced sex from her husband, this is not considered rape. By providing extreme punishment for sexual offenses, SOSPA discourages GBV.

The Local Customary Law (Declaration) Order G.N 436 of 1963—used by all Tanzanians (who are indigenous)—has gathered customs and traditions of different tribes in Tanzania. However, it is discriminatory and creates challenges for women and for children who are born out of wedlock, especially in regard to the inheritance of property. For example, the distribution of the deceased's property falls into three degrees: (1) the first male child, (2) the other remaining male children, and (3) the female children regardless of their age, sex, or status in the family. According to this law, a widow has no right to inherit any property from her deceased husband. She can only benefit through her children.

The laws that support mitigation of GBV are powerful acts that contain rules and regulations that encourage sectors to develop policies and procedural frameworks in GBV prevention and response. Relevant GBV actors in different sectors are encouraged to review current laws related to GBV and recommend enactment of other laws to mitigate GBV. There is also need to clarify roles and responsibilities of different sectors in the prevention and response to GBV. This includes child abuse and violence. Clarifying and strengthening these roles will help ensure adherence to both policy and practice in the following sectors:

- **Social welfare:** Develop a system for performing risk assessments of a referral system involving a range of sectors and services to determine and respond to the immediate and longer term protection needs of children.
- **Education:** Integrate sexual violence prevention messages as well as safe places into school-based programs addressing sexuality, reproductive health, and social development. Ensure education is linked into a multisectoral referral and response system for child protection.
- **Police and legal:** Strengthen and expand appropriate legal protection for children and legal consequences for perpetrators; continue to build on current gender and children's desk efforts among the Tanzania Police Force nationally. Continue to educate police and other public safety officials about violence against children. Develop joint investigation procedures with social welfare, the medical subsector, and other relevant authorities and subsectors.
- **Health:** Work within a multisectoral framework to assure clear and simple guidelines for the prevention, treatment, care, and follow-up of violence against children. Build a clear and appropriate platform for the integration of child-sensitive and friendly services into existing GBV-related structures.

(c) Police and the Judiciary

Reforms in the police, particularly in establishing community policing and gender desks at police stations, show progress in addressing GBV issues and handling survivors. However, the survivors still find it difficult to access the police and justice system. The few cases that have been to court have been thrown out mostly due to lack of sufficient evidence. This, in turn, de-motivates survivors to report GBV incidences and move forward to seek legal justice.

Court cases have been unsuccessful in part due to inadequate training within the police, legal, and judicial systems on GBV issues and how to apply existing laws. Police Form 3 (PF3) is generally based on reporting cases of assault and does not have enough focus on GBV. The form is inadequate in capturing the forensic evidence required to ensure justice for GBV survivors. Although some relevant legal frameworks do exist, these laws/policies are often not known or implemented. In addition, strong customary and religious traditions deter survivors from reporting GBV incidences.

SOSPA advocates for severe punishment for sexual offenses, but in some cases, perpetrators are not brought to justice for fear that many years of imprisonment will rob the family of breadwinners. For these reasons, reporting by survivors and their families, as well as the application of laws and prosecution present a challenge even if laws such as SOSPA exist.

(d) Traditional and Cultural Practices

At the societal, community, and individual levels, numerous factors contribute to high rates and severe cases of GBV. Many studies identify the following risk factors.²³

- Traditional gender norms that support male superiority and entitlement
- Some cultural practices that encourage tolerance to GBV and restrain survivors from reporting and seeking help
- Female empowerment threatening patriarchal norms, which, in turn, provokes men to violence in an attempt to regain control
- Application of customary laws unsupportive of survivors
- Fear of reprisal, stigma, and discrimination and lack of access to supportive services prevent survivors from reporting and seeking help.

(e) Power and Authority

Power and authority are necessary to prevent and respond to GBV. Sometimes people with power and authority perpetrate acts of GBV. For example, there is sufficient evidence that abuse of power and authority takes place in schools and workplaces.

(f) Community Involvement

The community is the first to learn of an incidence of GBV and provide the survivor security and protection. Thirty-seven percent of women in the WHO multi-country study sought help from the community. Given the level of stigma, discrimination, and social exclusion; sensitized community leaders in this situation, provide response in this hostile environment. The community can assist the survivor by creating an enabling environment (e.g., a safe house or drop-in center). The community is involved in mobilizing survivors; providing security, basic needs, psychosocial support, and referral to other services; preventing GBV; reducing stigma; and providing basic counseling and awareness

²³ Krug Etienne et al. 2002. World Report on Violence and Health. Geneva: WHO.
http://www.who.int/violence_injury_prevention/violence/world_report

among local leaders and community members. The community is a bridge between the survivor and health facility.

The community can be involved in primary and secondary GBV prevention. In primary prevention, the community strives to reduce tolerance to GBV and thus decrease GBV incidences. In secondary prevention, the community identifies and protects those at increased risk of GBV, such as women and children. The community also identifies service delivery barriers—in the health, police, and legal systems—and helps community members mitigate these barriers.

Community involvement is necessary for implementing comprehensive GBV prevention and response efforts, including the medical management of survivors. The community has great potential in mobilizing survivors to seek healthcare and other services related to GBV, as well as in combating GBV. The community also plays a role in integrating the survivor back into the community.

Nevertheless, challenges in community involvement include

- Inadequate engagement of men and boys in addressing GBV issues;
- Community actors who stigmatize rather than support GBV survivors and sometimes are perpetrators;
- Community and religious leaders who are not proactive; and
- Communities that have high levels of tolerance toward GBV.

(g) Socioeconomic Status

Addressing GBV solely as a medical challenge is like treating the symptoms but not the cause. It is necessary to address the drivers of GBV, including poverty among women, forcing them to depend on other people. The government has devised strategies for poverty reduction in MKUKUTA II, which stipulates promoting and protecting human rights for all, particularly for poor women, children, men, and the vulnerable (MKUKUTA II cluster III, goal 3) and creating productive and decent employment opportunities, especially for women and youth (MKUKUTA II cluster I, goal 3). The challenge is to prioritize implementation of these commitments to women and youth through allocating adequate resources and implementing strategies to change the social and economic status of women, thus reducing their vulnerabilities to GBV.

2.8 Gaps in the GBV Response

The health sector has initiated the development of GBV policy and management guidelines. However, to provide effective and comprehensive, high-quality GBV services, the following key gaps must be addressed within the relevant services of various sectors.

(a) Healthcare Services

- Lack of guidelines for GBV service provision
 - No GBV-related SOPs for MOHSW healthcare providers exist at any level; this limits access to and the provision of comprehensive, high-quality GBV services.
- Inadequate financial resources
 - Funding in the national and local government budgets is insufficient.
- Shortage of trained human resources in GBV

- Existing service providers in health facilities and in the community lack the knowledge and skills necessary to address the needs of GBV survivors of all age groups.
- Inadequate integration of GBV services into other health services
 - GBV services are not integrated into other health services, such as reproductive health and HIV/AIDS services (e.g., voluntary counseling and testing).
- Inadequate healthcare referral system
 - The healthcare referral system for other services is well established, but with regard to GBV, health workers are not well informed of the procedures for two-way referral of patients within a facility and from one level to another or of the related services provided by the community, police, legal system, and so on. In these situations, the referral needs and demands of GBV survivors are not adequately met. GBV survivors lack information on where to obtain services and are therefore unable to make informed decisions or seek further care and treatment.
- Inadequate information and data
 - GBV in Tanzania is under-reported for many reasons: survivors are reluctant to report incidents due to stigma and discrimination, social exclusion, shame, and taboos associated with GBV. As a result, limited data are available for evidence-based planning, systematic service provision, policy and advocacy development, monitoring and evaluation, and management decisionmaking.

(b) Social Welfare Services

The provision of social welfare services is constrained by limited integration with healthcare services and an inadequate number of social workers, especially below the district level. This negatively affects the scope of psychosocial services, especially in councils and the community. Another constraint is that most social workers—along with community health workers and multisectoral stakeholders—have received limited, systematic training on GBV.

The role of social workers is critical because they operate at the community level, where most GBV incidents occur. They play an important role as frontline actors to prevent and provide a response to GBV. The link between the community and service delivery points determines the extent to which GBV survivors seek medical services and integrate themselves back into the community.

(c) Community Services

Some gaps observed in the linkage between the community and health facilities include

- Limited awareness of GBV issues and empowerment of the community to prevent and respond to GBV;
- Limited awareness of where services can be obtained; and
- Inadequate community services for survivors, including community-owned structures to provide security and protection (e.g., drop-in centers/shelters) and referrals to health, police, and legal services.

(d) Legal (Police and Judiciary) Services

Critical constraints lie with law enforcement, including

- Limited access of GBV survivors to the police and legal systems;
- Lack of specific legislation on GBV;

- Inadequately trained (on GBV) law enforcement agents;
- Ambiguous and contradictory GBV-related laws that hinder the administration of justice;
- Limited human resources and funding for legal and police services; and
- Few legal aid services or paralegal centers—which tend to be run by small NGOs, have limited budgets, and operate in mostly cities.

(e) Education Services

The Ministry of Education and Vocational Training has incorporated a curriculum on GBV into the teacher training curriculum and in primary and secondary schools. However, many challenges exist in involving schools in the prevention of and response to GBV:

- Inadequately trained teachers to provide GBV-related education;
- Lack of safe places for school-based programs addressing GBV and violence against children;
- Inadequate linkages between the education system and the response system for child protection.

SECTION THREE: RATIONALE AND OBJECTIVES

3.1 Rationale

Many studies conducted in Tanzania indicate unacceptably high levels of GBV, ranging from 30–50 percent, that lead to physical, sexual, and psychological injury and trauma in all age groups, particularly among children and women. GBV can have fatal outcomes, including suicide, HIV infection, and maternal morbidity and mortality; as well as non-fatal outcomes, such as acute and chronic physical, sexual, and psychological injuries. The negative effects of GBV go beyond the health consequences and wounds that are difficult to heal. GBV violates the survivors' human rights and negatively affects family stability, structure, and livelihoods, which ultimately has a negative impact on overall socioeconomic development.

Although the Government of Tanzania and CSOs have made considerable efforts to prevent and respond to GBV, the problem still remains a major challenge. The MOHSW is expected to address this challenge in collaboration with other stakeholders, requiring effective linkages to overcome existing barriers—including shortages in financial and human resources; inadequate referrals and mechanisms for integrating GBV services into existing services; and insufficient advocacy and data for evidence-based planning, decisionmaking, and monitoring and evaluation. However, the government has laid a strong foundation for GBV prevention and response efforts, as evidenced by existing policies, strategies, and action plans for supporting gender and the reduction of GBV and violence against adults and children.

Given the magnitude of the problems, consequences, and challenges related to GBV, the MOHSW developed this GBV policy guideline under the national health policy to strengthen its response to GBV and ensure the provision of comprehensive, high-quality services at all levels. The policy guideline shall provide direction to health facilities at all levels regarding their role and responsibility in GBV service provision. In addition, the policy guideline shall inform the development of GBV management guidelines for healthcare providers delivering care to survivors. Because of the complex nature of GBV prevention and response efforts, drafting of this guideline involved a comprehensive consultative process within the MOHSW and with many multisectoral stakeholders.

3.2 Overall Objective

Strengthen the MOHSW's capacity to prevent and respond to GBV through providing a policy guideline to direct the health sector and establish effective linkages with the community and multisectoral actors.

3.3 Specific Objectives

The policy guideline shall

1. Provide a framework to inform development of GBV management guidelines and protocols for service provision to GBV survivors;
2. Guide the MOHSW's well-coordinated implementation of GBV prevention and response efforts;
3. Guide the establishment of comprehensive systems for monitoring, evaluating, and documenting GBV interventions under the MOHSW; and
4. Guide linkages among the MOHSW, community, and other multisectoral stakeholders in GBV-related service provision.

SECTION FOUR: POLICY DIRECTIONS

Healthcare providers shall work together with other sector providers, particularly at the community level, to strengthen linkages with local networks in support of GBV survivors and to engage in health promotion and GBV prevention.

The MOHSW, in collaboration with other key stakeholders, has developed this GBV policy guideline to provide the health sector with information, objectives, and directives for GBV prevention, mitigation, and response efforts. Key stakeholders include leaders in the community, police, and legal system. Any of these stakeholders could be the first point of contact for GBV survivors. All are responsible for providing an effective immediate response to GBV survivors.

4.1 Medical Management of GBV Survivors

Providers must deliver GBV services to survivors with compassion and strict adherence to medical ethics. This mandate includes ensuring the safety, confidentiality, respect and dignity, non-discrimination, and consent of the survivor or caretaker of a child (below 18 years old). Healthcare providers at all levels shall adhere to the following guiding principles of working with survivors and shall use a survivor-centered approach.

(a) Guiding Principles: Human Rights, Ethics, and Compassion

- **Safety:** All actions taken for a survivor shall aim to restore or maintain safety.
- **Confidentiality:** At all times, confidentiality of the affected person(s) and their families must be respected. This means only sharing necessary information with other providers as requested and agreed by the survivor.
- **Respect and dignity:** Providers must listen to survivors' opinions, thoughts, and ideas and treat survivors with respect.
- **Non-discrimination:** All survivors are equal and must be treated as such according to their needs; they must have equal access to services.
- **Informed consent:** Consent shall be obtained for specific procedures and services—(1) physical examination and treatment only; (2) 1 + forensic evidence; (3) 1 + 2 + police investigation and legal justice.

In the case of children:

- Promote the child's best interest at all times
- Comfort the child
- Involve the child in decisionmaking
- Treat every child fairly and equally
- Support and nurture the child's resilience

(b) Rights of the Survivor

All actors shall use a survivor-centered approach, respecting the rights of the survivor, which are to be

- Treated with respect and not encounter stigma, discrimination, and "blame the victim" attitudes;
- Given correct and understandable information to ensure informed consent and not to be told what to do, which contributes to feelings of powerlessness;
- Given privacy and confidentiality and not be subject to gossiping and shaming;

- Protected from discrimination, including differential treatment based on gender, ethnicity, or other factors.
- Given a choice in being attended by a male or female service provider.
- Given a choice in being accompanied by a relative or caretaker.

(c) Obligations of the Service Provider

- Show empathy and be sensitive, discreet, friendly, and compassionate when dealing with the survivor.
- Provide correct information to the survivor and handle evidence according to guidelines to safeguard the chain of evidence; ensure informed consent for different services.
- Focus on the best interest of the survivor and respect her/his wishes in all instances.
- Ensure the physical protection and safety of the survivor and prevent any further suffering.
- Keep written information about the survivor in a safe place and maintain confidentiality at all times.
- Refer the survivor for further services as appropriate, depending on the nature and extent of physical, emotional, and psychological trauma. The service provider, if trained, shall provide counseling to the survivor prior to referral for further medical care and other services that the survivor needs or requests.

In the case of children:

- Ensure that a parent/guardian is present at all times (while also ensuring that the parent/guardian does not present a threat to the child).
- Always prepare the child on what to expect and ensure that the child understands what is going to happen.
- For children below age 18, obtain the parent/guardian’s written consent on their behalf.

Criteria for obtaining contributions from children²⁴

- Children age 16 years and older are generally sufficiently mature to make decisions.
- Children ages 14–16 are presumed to be mature enough to make a major contribution.
- Children ages 9–14 can meaningfully participate in the decisionmaking procedure, but maturity must be assessed on an individual basis.
- Children younger than age nine have the right to give their informed opinion and be heard. They may be able to participate in the decision making procedure to a certain degree, but caution is needed to avoid burdening them with being decision makers.
- Ultimately, the recommendation is that the views of the child must be considered on a case-by-case basis, depending on his/her age; maturity level; developmental stage; and cultural, traditional, and environmental factors.

(d) Role of MOHSW at the Central Level

The MOHSW formulates policy, issues guidelines and regulations, controls quality, monitors and evaluates implementation, and ensures adequate financial and human resources for health programs,

²⁴ UNHCR. 2006. Best Interests Determination Guidelines.

including the prevention of and response to GBV, at all levels. The MOHSW shall foster collaboration and links with key stakeholders at national and international levels. The MOHSW shall

- i. Provide medical guidelines to manage comprehensive, high-quality GBV services for children and adults;
- ii. Mobilize adequate financial resources for GBV interventions;
- iii. Provide guidelines for training related to GBV prevention and response efforts;
- iv. Train healthcare and social welfare providers on GVB prevention and care for children and adults;
- v. Integrate GBV services and referrals into the healthcare and social welfare delivery systems;
- vi. Integrate GBV data into the monitoring and evaluation system of the MOHSW;
- vii. Promote information and data sharing and collaboration with key stakeholders on GBV; and
- viii. Provide supportive supervision to ensure adherence to guiding principles, human rights, and ethics and to promote compassion.

(e) Role of Health Facilities

Health facilities under the MOHSW include dispensaries, medical clinics, health centres, and hospitals owned by the government, private sector, voluntary agencies, and parastatals. A Facility Governing Committee and Facility Management Team exist at each health facility and for all levels. Health facilities shall

- i. Ensure that facility management teams allocate adequate resources in their strategic and annual plans for high-quality GBV services; establish GBV services for both children and adults; and ensure adherence to minimum standards of care in GBV services;
- ii. Integrate GBV into existing services in health facilities and ensure referrals (horizontal and vertical) to meet the demands and needs of children and adults;
- iii. Ensure the availability of medical and social welfare staff who are trained in providing comprehensive GBV services for children and adults;
- iv. Establish effective collection of data and information on GBV services and proper record keeping and reporting for use at the facility and for sharing with stakeholders; and
- v. Work in close collaboration with the Facility Health Committee, police, judiciary, and educational institutions to foster linkages for the prevention of and adequate response to GBV in the community.

(f) Role of Healthcare Providers

Healthcare providers include medical recorders; clinicians (Clinical Officers, Assistant Medical Officers, Medical Officers and specialists), nurses (nurse B, nurse A, and graduate nurses); and laboratory, pharmacy, and social welfare staff. Healthcare providers shall

- i. Be well-informed of and adhere to the guiding principles of human rights and ethical practices and show compassion in delivering GBV services to survivors (adults and children);
- ii. Ensure the availability of minimum requirements and standards for comprehensive management of GBV survivors at the service delivery point and in the community;
- iii. Identify GBV survivors in the outpatients and ensure prompt treatment and referral
- iv. Ensure the provision of comprehensive GBV services for adults and children, including medical care, forensic evidence, psychosocial counseling, and appropriate referral within the health system and to other sector service providers;

- v. Ensure that forensic material is properly collected and appropriately stored to safeguard evidence;
- vi. Obtain comprehensive information and data on the GBV survivor and ensure the confidentiality and safe custody of records; and
- vii. Establish linkages with the community and other stakeholders.

4.2 Role of the Community

Relevant key players in the community include the Social Services Committee; Security Committee; Dispensary Committee; Community Own Resource Persons (Community Health Workers, Community-Based Distributors, TBAs, Community-Based Organizations, Faith-Based Organizations, Traditional Healers, Community Leaders, Village Health Committees, Women’s Groups); and heads of households. The community shall:

- i. Plan and allocate adequate resources for prevention and the provision of high-quality GBV services in annual dispensary plans—ensured by the Dispensary Committee through the Dispensary Management Team;
- ii. Ensure comprehensive care of GBV survivors—including security, provision of basic needs, psychosocial support, access to health facilities, and referral to police, legal, and other providers—testify in the court of law when summoned, and assist with reintegration of the survivor into the community;
- iii. Ensure the availability and adequacy of safe houses and drop-in centers in the community; and
- iv. Create awareness among and empower the community to prevent and respond to GBV by advocating adherence to basic human rights principles, gender equality, rights of women and children, justice, and intolerance of GBV.

4.3 Legal Support for GBV Survivors

The MOHSW shall refer survivors (with their consent) to other key ministries and stakeholders, such as the police and legal aid, for appropriate specialized services. Medical service providers are responsible for providing adequate information on legal requirements for reporting GBV incidents and in a timely manner. Service providers are also responsible for advising GBV survivors (both children and adults), on forensic procedures, legal protection and support, and police procedures, as indicated below.

(a) Forensic Chain of Evidence

Services for GBV survivors shall be client-centered, respecting their right to confidentiality as well as sufficient, understandable, and correct information, thus assuring informed consent to a series of actions. With the consent of the survivor, the

- i. MOHSW shall ensure availability and adherence to minimal standards at all levels for taking a complete medical history, conducting a complete investigation and medical examination, and obtaining forensic evidence and documentation using government-approved forms, which are admissible as evidence in court;
- ii. Health facility management teams shall, with the survivor’s consent, plan, allocate, and release adequate resources to ensure the proper documentation, storage, and transportation of forensic specimens and follow up on results; and

- iii. Healthcare providers at all levels shall ensure the proper collection of forensic evidence and documentation, including completeness in filling out the PF3, to guarantee that the survivor is well-informed and understands the process.

(b) Protection and Support for the Survivor

The survivor is entitled to protection from the perpetrator, as well as basic needs (e.g., transport and food), access to the police (e.g., escort); and access to legal action.

- i. The MOHSW shall ensure that health facilities and healthcare providers at all levels are well-informed about the rights of GBV survivors to protection and support.
- ii. Health facility management teams at all levels shall plan for and allocate adequate resources for protection and support of GBV survivors. If the survivor is a child, s/he shall be escorted by a social worker and a parent(s) or guardian(s), assuming they are not the perpetrators.
- iii. Healthcare providers shall give the survivor information on available support in healthcare facilities and the police and legal systems and on their rights of protection under the Tanzanian constitution and the law. Service providers shall refer the survivor to police and legal services.

(c) Healthcare Providers' Role in Legal Proceedings

Health providers at all levels need to ensure that GBV survivors (adults and children) and caretakers have basic information about medical-related legal issues beyond the health facility.

- i. The MOHSW shall ensure that health facilities and health providers have adequate information on their roles in witness corroboration in support of GBV survivors.
- ii. The Health Facility Management at all levels shall ensure that health providers are well-informed of the necessary documentation, court proceedings, and standards of proof.
- iii. Healthcare providers at all levels shall ensure that survivors are adequately informed about the likely timeframe for investigations and the importance of legal action.

4.4 Psychosocial Support for GBV Survivors

Psychosocial support, with compassion, shall be provided to GBV survivors (adults and children) from the time of incidence to successful reintegration into the family and the community. Social workers under the MOHSW and community development workers under the MOCDCG, and if trained, CSOs, FBOs, community health workers, and community-based distributors shall provide psychosocial support services to GBV survivors.

- i. The MOHSW shall ensure provision of adequate psychosocial support to GBV survivors at all levels, including ensuring the availability of safety and protection facilities (i.e., drop-in centers and safe houses).
- ii. Health facility management teams at all levels shall plan for and allocate adequate resources, including staffing, for psychosocial support, drop-in centers and safe houses, referrals, and linkages with other stakeholders to foster reintegration of GBV survivors into their family and community.
- iii. Healthcare providers shall ensure adequate counseling of GBV survivors, child-friendly services, and two-way referrals to medical facilities and drop-in centers and safe houses and facilitate reintegration into the family and community.

4.5 Supervision, Coordination, and Linkage Mechanisms

Provision of comprehensive high-quality GBV services requires regular supportive supervision of healthcare providers of different cadres at all levels; coordination of key players at the central level (MOHSW); and coordination of activities and effective referrals between different types of healthcare facilities at national, regional, council, and community levels. Also required are effective mechanisms to create linkages within the health sector and among stakeholders in other sectors.

(a) Supervision of GBV Services

- i. Supervision of GBV services shall be part of the strategic and annual plans of health facilities at all levels.
- ii. Supervisors at all levels shall conduct supportive supervision to ensure high-quality GBV services.

(b) Coordination of GBV Services

- i. Health managers at all levels shall identify interventions and activities to be coordinated by key players for an effective GBV response.
- ii. Health managers at all levels shall ensure the planning, implementation, and effective coordination of GBV services and activities.

(c) Linkage Mechanisms for GBV Services

The linkage mechanisms will involve different levels of healthcare delivery, varying in size and complexity and involving different health cadres in different organizations, including public, private, and voluntary agencies, as well as parastatals.

- i. Health managers shall identify and establish effective linkages for the provision of comprehensive, high-quality GBV services.
- ii. Health managers will plan for and allocate adequate resources for maintaining linkages with other key players, including establishment of an effective two-way referral service.
- iii. The MOHSW shall ensure the compilation and dissemination of a directory of local referral facilities by type of GBV services offered.

4.6 Advocacy and Behavior Change Communication (BCC)

Advocacy and behavior change communication related to GBV issues shall be part of strategic and annual plans at all levels. All levels shall mobilize, allocate, and release adequate resources for implementing strategic and annual plans. Health managers shall identify and support community initiatives on GBV, ensure their participation, and mobilize community resources for GBV interventions. Health managers shall plan and allocate adequate resources for health education aimed at behavior change communication.

(a) Advocacy for GBV Prevention and the Response in Collaboration with Stakeholders

Health managers and their respective committees at all levels of the MOHSW shall

- i. Plan awareness-raising activities on the scope and causes of GBV, its prevention, and the response;
- ii. Advocate for increased resource mobilization and allocation and budget line items in Medium-Term Expenditure Framework and in the CCHP for GBV prevention and services;

- iii. Advocate for policies and laws that support comprehensive GBV prevention and response efforts; and
- iv. Involve the media in implementing advocacy activities.

(b) BCC for GBV Prevention and the Response in Collaboration with Stakeholders

Health Managers and their respective committees at all levels shall

- i. Identify needs and plan for BCC in support of comprehensive GBV prevention and response efforts; and
- ii. Involve the media in planning, implementing, and following up BCC activities.

4.7 Monitoring and Evaluation (M&E) of GBV Services

Monitoring and evaluation of GBV services is necessary to measure the effectiveness of GBV-related activities. M&E requires the selection of indicators for GBV prevention and services, data collection, analysis, interpretation, reporting, and dissemination to key stakeholders. M&E helps identify areas of research.

- i. Health managers at all levels shall use the M&E selected indicators for GBV prevention and response services.
- ii. GBV data shall be harmonized and integrated into the existing MOHSW Health Management Information System.
- iii. Health managers and healthcare providers at all levels shall ensure the collection of GBV information and data (using standardized forms) for M&E, supervision, and dissemination of performance reports to other stakeholders—based on agreed information-sharing protocols.
- iv. Health managers and healthcare providers at all levels shall conduct research to help improve GBV-related services.

SECTION FIVE: INSTITUTIONAL FRAMEWORK FOR THE PREVENTION OF AND RESPONSE TO GBV

The role of the MOHSW is to develop, supervise, and coordinate the implementation of this GBV policy guideline, laws, regulations, and guidelines and standards for GBV services at all levels of service delivery in Tanzania. The institutional framework for the prevention of and response to GBV under the MOHSW is organized under three levels: central, regional, and council.

5.1 Central Level

At the central level, the Chief Medical Officer (CMO) has the lead technical role in implementing GBV prevention and response efforts. Under the CMO are five divisions: Preventive Health Services, Curative Health Services, Social Welfare Services, Health Policy and Planning, and Human Resource Development. The Reproductive and Child Health (RCH) Section under Preventive Health Services shall provide leadership in the implementation of the GBV policy guidelines. The roles of the office of CMO, divisions, and RCH section are as follows:

(a) Office of the CMO

The office of the CMO is, overall, in charge of health-related policies and services under the MOHSW. In addition, the office oversees the Nursing Services, Health Services Inspectorate, and Primary Health Care units.

- i. The Nursing Services Unit shall develop and ensure adherence to standards of nursing and midwifery services and practices related to GBV.
- ii. The Health Services Inspectorate Unit shall ensure the inspection of GBV-related services in the country.
- iii. The Primary Health Care Unit shall ensure that GBV prevention and response efforts are implemented in line with the Primary Health Strategy and the health sector reform process.

(b) Reproductive and Child Health Section

This section shall

- i. Formulate policy guidelines for comprehensive GBV prevention and response services and develop appropriate manuals for managers and providers at all levels;
- ii. Coordinate, monitor, and evaluate GBV prevention and response services at all levels;
- iii. Liaise with other ministries and relevant organizations dealing with GBV-related activities at the national and international levels;
- iv. Review the list of standard essential equipment and supplies for high-quality GBV service provision at all levels; and
- v. Provide leadership to the National GBV Technical Working Group and oversee Sub-Technical Working Groups that support Sector Wide Approaches (SWAp) in Health and Task Forces that oversee implementation of GBV prevention and support.

(c) Preventive Health Services Division

This division oversees four sections: Reproductive and Child Health, Epidemiology and Diseases Control, Environmental Health and Sanitation, and Health Education. There are 14 programs and projects under the division—some of which are closely related to preventing and responding to GBV. These include the National AIDS Control Program (addressing HIV and other sexually transmitted infections), Community-Based Health Care Program, School Health Project, Safe Motherhood Project, and Family Planning Program. The division and its sections shall

- i. Ensure GBV prevention and response services are integrated into the division's programs and projects and sections; and
- ii. Ensure that GBV prevention and response activities, including advocacy and BCC, are incorporated into health education guidelines.

(d) Curative Health Services Division

This division oversees National Hospital Services; Regional, District, and Private Health Services; Pharmaceutical Services and Diagnostic Services; and the Traditional Medicine Section. The division and its sections shall

- i. Ensure that health facilities at all levels allocate adequate resources for high-quality and comprehensive medical services for GBV survivors, including support and two-way referral;
- ii. Ensure that health facilities at all levels are provided with adequate supplies and stationeries necessary for medical examination, diagnosis, laboratory tests, forensic procedures, treatment, recording, referral, and reporting.
- iii. Ensure that health providers adhere to professional standards and ethics and show compassion to GBV survivors.

(e) Social Welfare Services Division

Social Welfare Services oversees five sections: Family and Children Welfare; Juvenile Justice; Disability, Elderly Persons, and Human Resource Development for Social Welfare staff. The division and its sections shall:

- i. Ensure the provision of high-quality social welfare services to GBV survivors at health facilities at all levels, drop-in centers and safe houses, and the community;
- ii. Ensure the training and deployment of adequate social welfare staff for GBV-related services at all levels; and
- iii. Advocate for the revision or repeal of existing non-supportive social welfare laws or the enactment of new ones.

(f) Health Policy and Planning Division

This division oversees the Budget, Policy, and Planning Section and Health Information and Research Section. The division and its sections shall

- i. Ensure the inclusion of GBV prevention and response services in the MOHSW annual and medium-term plans and ensure adequate funding in the budget; and
- ii. Ensure the inclusion of GBV prevention and response services into health systems research and health management information systems.

(g) Human Resource Development Division

The Division of Human Resource Development oversees Health Human Resource Planning, Allied Health Sciences Training including Social Welfare, Nursing Training and Continuing Education. The division and its sections shall:

- i. Identify national health training needs for formal and continuing education of key staff involved in GBV service provision at all levels in the country; and
- ii. Conduct short- and long-term human resource planning for training a mix of adequate staff at all levels for GBV service provision.

(h) MOHSW Collaboration with Key Stakeholders in “Elimination of GBV”

- i. The MOHSW, through the RCH Section and in collaboration with other stakeholders, shall advocate for the protection of the rights of GBV survivors and for the elimination of abuse against women, men, and children.
- ii. The MOHSW, in collaboration with other responsible ministries, CSOs, private and voluntary agencies, shall strengthen and develop strategies to ensure that all forms of discrimination, exploitation, and abuse against women, men, and children are eliminated.
- iii. The MOHSW shall collaborate with the MOHA, CSOs, and private and voluntary agencies to review laws, policies, and regulations that oppose or pose barriers to GBV prevention and response efforts. They shall advocate for sexual and reproductive health rights, including the protection of women and children against GBV, domestic violence, and violence against children; and advocate for inclusion of these aspects in the proposed Tanzanian constitution.
- iv. The MOHSW shall review laws related to GBV and advocate for the revision of laws and legislation that perpetuate GBV.
- v. The MOHSW shall collaborate with relevant key ministries to advocate for the revision and amendment of laws that undermine the rights of GBV survivors.

5.2 The Regional/City Councils

Implementation of the GBV response at regional/city councils will be managed under Regional Health Management Teams (RHMTs) and Regional Referral Hospital Management Teams (RRHMTs), which are overseen by the Regional Secretariat and Regional Referral Hospital Board, respectively. RHMTs and RRHMTs shall

- i. Ensure the inclusion and allocation of adequate resources for comprehensive GBV prevention and response services in the five-year strategic and annual regional/hospital plans;
- ii. Ensure the integration of GBV prevention and response services into existing services; adequate staffing; and training of managers and providers at all levels in the region;
- iii. Ensure the provision of high-quality services through monitoring, evaluation, supportive supervision, and dissemination of reports on the performance of GBV prevention and response efforts at all levels in the region;
- iv. Provide technical support to DCAs and CHMTs in the planning and implementation of GBV prevention and response services;
- v. Ensure the allocation of adequate funds in CCHPs toward community initiatives for GBV prevention and the response; and
- vi. Identify and conduct research to improve understanding around and the implementation of GBV prevention and response services.

5.3 District/Municipal Council

The Council Health Service Board is an instrument of DCAs and is responsible and accountable for the delivery of comprehensive healthcare services, including GBV services at health facilities within its area, to the communities served. The planning and implementation of health services in the districts is under CHMTs. The health facilities in the district council include hospitals, health centers, dispensaries, and clinics under council, private, voluntary, and parastatal ownership. The first referral district/designated hospital and any other hospital in the district have a Hospital Governing Committee and are operated by Hospital Management Teams. The health facilities have Facility Health Committees and are run by Health Facility Management Teams.

(a) District Level

CHMTs shall

- i. Ensure the planning and adequate allocation of resources and effective implementation of comprehensive GBV services and prevention activities under the annual CCHPs, including the establishment of drop-in centers and safe houses;
- ii. Ensure the integration of GBV prevention and response services at all levels in the district;
- iii. Ensure adequate staffing; and continue training of providers involved in GBV prevention and service provision at all levels;
- iv. Advocate for, mobilize, and allocate adequate resources for community initiatives to ensure their participation in GBV prevention and response efforts under annual CCHPs; and
- v. Ensure the provision of high-quality services through monitoring, evaluation, regular supportive supervision, and preparation of performance reports on GBV prevention and the response, including dissemination at all levels.

(b) Ward Level

The Ward Health Committee, Health Center Committee, and Health Center Management Team provide health services in the catchment area, which includes wards and villages. The committees and team shall

- i. Ensure planning for and adequate allocation of resources and effective implementation of comprehensive GBV services and prevention activities under the annual Comprehensive Ward Health Plans, including the establishment of drop-in centers and safe houses;
- ii. Ensure the integration of GBV services and prevention efforts in health centers and dispensaries;
- iii. Ensure adequate staffing and continue to train providers involved in GBV prevention and service provision at the health centers and dispensaries;
- iv. Advocate, mobilize, and allocate adequate resources for community initiatives to participate in GBV prevention and response efforts under the ward health plans; and
- v. Ensure the provision of high-quality GBV-related services through monitoring, evaluation, regular supportive supervision, reporting, and information dissemination at health centers and dispensaries.

(c) Village Level

Dispensary Committees and Dispensary Management Teams are responsible for health service delivery in their catchment village(s). The committees and teams shall

- i. Ensure the planning for and adequate allocation of resources and effective implementation of comprehensive GBV services and prevention activities under the CCHPs, including the establishment of drop-in centers and safe houses;
- ii. Ensure the integration of GBV-related services at dispensaries;
- iii. Ensure adequate staffing and continue to train providers involved in GBV-related service provision at dispensaries;
- iv. Advocate, mobilize, and allocate adequate funds for community initiatives to participate in GBV prevention and response efforts under dispensary plans; and

- v. Ensure the provision of high-quality services through monitoring, evaluation, regular supportive supervision, reporting, and information dissemination at households level in the catchment area.

(d) Household Level

All individuals in households shall support GBV prevention and response efforts by working to change attitudes and practices that encourage and perpetuate GBV and reporting GBV incidences to relevant authorities.

SECTION SIX: MONITORING, EVALUATION, AND RESEARCH

Monitoring and evaluation of GBV prevention and response efforts shall be implemented at the central, regional, district, and facility levels. The proposed monitoring indicators at these levels are included in Annex 1.

6.1 Central Level

The RCH Section coordinates the monitoring and evaluation of GBV prevention and response services at all levels in the country and shall

- i. Receive, compile, and disseminate to stakeholders relevant information and data on GBV prevention and the response from the RHMTs;
- ii. Analyze gathered information and data to evaluate the performance of GBV-related service providers; and
- iii. Identify areas for improvement and research.

6.2 Regional Level

The RHMTs coordinate, monitor, and evaluate GBV prevention and response services at all levels in the region and shall

- i. Receive, compile, and disseminate to stakeholders relevant information and data on GBV prevention and response efforts from the regional referral hospital and CHMTs;
- ii. Analyse gathered information and data to evaluate the performance of GBV-related service providers; and
- iii. Identify areas for improvement and research.

6.3 District Level

The CHMTs coordinate, monitor, and evaluate GBV prevention and response services in the district and shall

- i. Receive, compile, and disseminate to stakeholders relevant information and data on GBV prevention and response efforts from health facilities;
- ii. Analyze gathered information and data to evaluate the performance of GBV-related service providers; and
- iii. Identify areas for improvement and research.

6.4 Facility Level

The Facility Management Teams coordinate, monitor, and evaluate GBV prevention and response services at health facilities and shall

- i. Collect, compile, and disseminate to stakeholders relevant information and data on GBV prevention and response efforts at health facilities.
- ii. Analyze gathered information and data to evaluate the performance of GBV-related service providers at facilities; and
- iii. Identify areas for improvement and research in the wards, villages, and communities.

ANNEX I: GBV INDICATORS FOR THE HEALTH SECTOR

(a) Ministry Level

- i. Number of persons provided with GBV services at the regional level by type of services, age, and sex
- ii. Proportion of health facilities with service providers trained to provide GBV services by region
- iii. Proportion of health facilities with service providers oriented on the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence by region
- iv. Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence by region
- v. Proportion of health facilities that have essential supplies and equipment for the management of GBV by region

(b) Regional Level

- i. Number of persons provided with GBV services at the district level by type of services, age, and sex
- ii. Proportion of health facilities with service providers trained to provide GBV services by district
- iii. Proportion of health facilities with service providers oriented on the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence by district
- iv. Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence by district
- v. Proportion of health facilities that have essential supplies and equipment for the management of GBV by district

(c) District Level

- i. Number of persons provided with GBV services at a health facility by type of services, age, and sex
- ii. Proportion of health facilities with service providers trained to provide GBV services
- iii. Proportion of health facilities with service providers oriented on the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence
- iv. Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence
- v. Proportion of health facilities that have essential supplies and equipment for the management of GBV

(d) Facility Level

- i. Number of persons provided with GBV services at a health facility by type of services, age, and sex
- ii. Number of service providers trained to provide GBV services

- iii. Number of service providers oriented on the National Management Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence

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