THE HEALTH SECTOR'S RESPONSE TO GENDER-BASED VIOLENCE IN TANZANIA: LESSONS FROM ILALA DISTRICT.

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By

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A dissertation submitted in partial fulfillment of the requirements for the degree of Master of Arts in Health Policy and Management (MA.HPM)

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled **"The Health Sector's Response to Gender-Based Violence in Tanzania: Lessons from Ilala District"** in partial fulfillment of the requirement for the degree of Master of Arts in Health Policy and Management at Muhimbili University of Health and Allied Sciences.

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Date

DECLARATION AND COPYRIGHT

I, **Maxmillian Z. Kwangu**, declare that this **dissertation** is my original work and that it has not been and will not be presented to any other university for a similar or other degree award. I confirm that appropriate credit has been given when referring to the work of others.

Signature……. **Date** ……...

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DEDICATION

This study is wholeheartedly dedicated to my lovely mother, brother, sister, friends, relatives, officemates, and my mentors, who have been my source of inspiration, gave me strength, and continually provided their moral, spiritual, and emotional support.

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Finally, may all GBV survivors, whose health, dignity, security, and autonomy are endangered by GBV, have the opportunity to excel.

ABSTRACT

Background: Gender-based violence (GBV) ranks among the most terrible and widely distributed of all human rights violations and is a public health burden. Tanzania's health sector has implemented policies to combat GBV, including the National Policy Guideline (2011) and the National Plan of Actions for the End-Violence Against Women and Children 2017/18-2021/22. Despite the presence of national policy guidelines for anti-GBV, the GBV rate remains high, and little is known about how well policy-level measures have been implemented by the health systems at the district level. This study aimed to explore responses at both facility and community levels.

Objectives: To explore health sector's achievements and challenges in responding to GBV in the Ilala District using the World Health Organization Health Systems Framework components.

Materials and Methods: The study used a qualitative case-study approach, gathering data through document reviews, semi-structured interviews, focus group discussions, and observation. The study used purposive sampling to carefully choose and approach 51 participants suitable for the study. The study involved healthcare workers (HCWs), survivors of GBV at a one-stop center, community members, district/facility leaders, and police desk officers. Thematic analysis was used to analyse using the NVivo 14 trial.

Results: The health sector at district level has responded to GBV through integrated services, para-social groups, exemptions, trained (HCWs), health information systems, and safety plans. However, the response still faces challenges including: limited community awareness, limited space, a shortage of forensic science-trained (HCWs), limited services and funds, and a fear of reporting among community members.

Conclusion and Recommendations: The study highlights the health sector's response to GBV through integrated services, para-social groups, exemptions, and survivors' unification, but acknowledges challenges like limited community awareness, funding, and fear of reporting. Ilala district government should expand One GBV Stop Centers, raise community awareness, allocate percentages to Comprehensive Council Health Planning and Comprehensive Hospital Operational Plan funds for GBV initiatives, and train HCWs in forensic evidence. The Tanzania

Police Medical Examination Form (PF.3) needs revision to facilitate private health facilities' completion, and the Ministry of Health should expedite the finalization process for universal health coverage

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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
CCHP	Comprehensive Council Health Planning
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
CHOP	Comprehensive Hospital Operational Plan
CHWs	Community Healthcare Workers
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HCWs	Healthcare Workers
IRB	Institutional Review Board
MDGs	Millennium Development Goals
MoH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MUHAS	The Muhimbili University of Health and Allied Sciences
NPA	National Plan of Actions for the End
NUPES	New Popular Ecological and Social Union
SDG	Sustainable Development Goals
SV	Sexual Violence
PV	Physical Violence
RRH	Regional Referral Hospital
TAWLA	Tanzania Women's Lawyers Association
TGNP	Tanzania Gender Networking Programme
TDHS	Tanzania Demographic Health Survey
UNFPA	The United Nations Population Fund
USA	United States of America
VAWC	Violence Against Women and Children
WHA	World Health Assembly
WHO	World Health Organization

DEFINITION OF TERMS

Community members are simply the people who live, learn, and work in the street where the One GBV Stop Centers are located.

Female genital mutilation is an internationally acknowledged violation of girls' as well as women's rights as humans, demonstrating a long-standing gender imbalance. FGM is the process of removing and damaging healthy and normal female genital tissue, as well as interfering with the natural processes of girls' and women's bodies (1).

Gender-based violence is an act that causes or is likely to inflict physical, emotional, sexual, or psychological suffering or discomfort on women or men, regardless of whether it's private or public (2). GBV is a slightly more broad phrase than violence against women, and it may also include violence against men if the violence arises from a man's gender identity or presentation.

GBV Response simply means stakeholder reaction and support for launching strategies and activities for GBV survivors (3,4).

Healthcare provider simply refers to anyone who participates in activities with the primary goal of improving health (5). These individuals work towards advocating for, safeguarding, and improving the health of their general community. In this study, healthcare providers include the health facility in charge, the social welfare officer, administrators, and other clinicians.

Intimate partner violence means an intimate relationship or ex-partner's behavior that causes physical, sexual, or psychological harm, such as physical aggression, sexual coercion, psychological abuse, and controlling behaviors (5).

Survivor refers to anyone, whether a child or an adult, male or female, who has been physically, sexually, or mentally assaulted because of their gender (4).

The health sector encompasses all set up both public and private health services (such as promoting health, preventing illnesses, and diagnostics, treatment, as well as care services), in addition to the policies and activities associated with health departments and ministries,

related to health, non-governmental organizations, community groups, and professional associations (5).

The health system includes every activity whose underlying objective is to promote, restore, and sustain health (3,6). The various components of a health system work at multiple levels to provide coherence at the community or national level.

WHO Health Systems Framework means that the framework contains significant features from the areas of coordination, health workforce development, service delivery, health infrastructure, leadership and governance, information, and funding for health system responses to GBV (7).

CHAPTER ONE:

1.0 INTRODUCTION

1.1 Background

Gender-based violence (GBV) ranks among the most terrible and widely distributed of all human rights violations and a public health burden. GBV has multiple dimensions including culture, social, economic, legal, and psychological implications that transcend class, race, religion, and ethnicity (8,9). GBV has no geographical, cultural, or economic boundaries; it affects the lives of millions of men, women, girls, and boys of different ages, with nearly all of them being women and girls, due to unequal power relationships among men and women, marital infidelity, women's poor status, and economic reliance on their male partners (10). Similarly, GBV endangers its survivors' health, dignity, security, and autonomy, and as long as GBV continues, we cannot claim to have made genuine progress towards equality, development, and peace (7,9).

GBV is an international problem, and the health sector is an entrance opportunity for victims to obtain care and address the issue in a multi-sectoral approach through community promotion, awareness, and prevention of GBV, early detection, secrecy, monitoring, and considerate treatment for survivors addressing mental, physical, and reproductive health care requirements, greater long-term counseling, mental health care, and rehabilitation, and referrals to economic, social, and legal guidance (1,8,11–13).

As a result of this recognition, several policies, guidelines, and specialized programs have been taken to respond to GBV since the 1985 Convention to eliminate all forms of discrimination against women (CEDAW). To name a few, the 1995 Beijing Platform for Action (BPA) paragraph 112, the Sustainable Development Goals (SDGs)– mainly SDG 5 and SDG target 5.2, and the global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence against women, girls, and children (2016) endorsed by World Health Organization (WHO) member states parties decisions from

the World Health Assembly (WHA 69.5)(4,14,15). In Tanzania, the National Policy Guidelines for Preventing and Responding to GBV in the Healthcare Sector (2011) and the National Plan of Action to End Violence Against Women and Children (NPA-VAWC) 2017/2018–2021/2022).

Research has shown that globally, one-third of women (35%) have suffered intimate partner violence, whether it was physical, sexual, or non-partner sexual violence, and thirty percent of women in relationships have experienced some kind of GBV. Childhood sexual abuse against males under 18 worldwide is estimated to be 7.6%, with a range of 3-17% depending on the country. 1 out of 4 (24%) of ever-partnered adolescent girls aged 15–19 have experienced sexual violence (SV) or one of two through a male intimate partner by the age of 15 (5). Two hundred million women have suffered from female genital mutilation (FGM) or removal, whereas thirty-eight percent of female murders have been committed by a male intimate partner, and at least 2 million individuals die each year from GBV worldwide. Yet another study reveals that domestic violence among men ranges from 3.4% to 40.3%, with factors like alcoholism, jealousy, mental illness, physical handicap, and short-term relationships contributing to the most violent partners. In addition, it is estimated that, in some countries, GBV imposes large costs on the government, producing a loss of up to 3.7% of the country's gross domestic product (GDP) (12,16).

According to WHO, GBV research from 86 countries in Europe, the Americas, the Eastern Mediterranean, South-East Asia, the Western Pacific, and Africa shows that up to 68% of women have suffered physical and sexual violence from an intimate partner in their lifetime (17). In India, 51.5% of men have experienced violence from their wives or partners at least once in their lives, with 10.5% experiencing such violence in the past year (41). The prevalence of ever-partnered women reporting physical or sexual intimate partner abuse in their lifetimes was highest in Southeast Asia (36.7%), the Eastern Mediterranean and Africa (36.6%), Europe (25.4%), and the Western Pacific region (24.6%). In Sub-Saharan Africa, one-quarter to one-half of women facing spousal abuse have experienced SV; women of reproductive age are more vulnerable to domestic violence (17).

With respect to data collected by the Tanzanian Demographic and Health Survey 2015/16, 40% of women aged 15 to 49 have suffered physical violence (PV), 39% of ever-married women have had spousal PV, 17% have experienced SV, and 36% have experienced spousal emotional abuse (18). This varies equally depending on their husband's or spouse's educational attainment as it does on their own, with the percentage falling dramatically from 53% among women having no schooling to 36% among those possessing some schooling.

In Dar es Salaam, approximately one in every five women aged 15 to 49 has experienced PV from a non-partner; 41% among the women who have additionally ever been in a relationship and endured either sexual or PV from their spouse. 65% are beaten during pregnancy, and 60% of women suffering from PV from their partners have never sought help from any formal service or anybody in a position of authority (19). The number of reported instances of violence against men has increased from 4% in 2022 to 10% in 2023. Despite efforts and previous studies, the GBV rate is high, and this study aimed to explore how the health sector responds to GBV by exploring achievements and challenges both at the health facility and community levels using the WHO Health Systems Framework.

1.2 Statement of the Problem

GBV remains an endless infringement of basic human rights with profound consequences for individuals, communities, and governments. Throughout Tanzania, nearly four out of ten women have experience ed PV, and one out of every five women has experienced SV in her lifetime (from the age of 15). In Dar es Salaam, 65% of women are beaten during pregnancy, and six out of every ten women who suffered from physical relationship violence has never before seek assistance from formal sources. The most prominent perpetrator of SV towards women is the spouse as well as the lover, which accounts for 48.1% of all cases. Similarly, the number of instances reported indicates that violence against men increased from 4% in 2022 to 10% in 2023. Hence, not responding to GBV may increase the rate of death among survivors. Many physical injuries, chronic pain, mental and sexual anxiety, and depression can lead to lethal outcomes like suicide and homicide.

In response to the alarming magnitude of GBV, the health sector in Tanzania has undertaken several policies and programmatic measures. For example, the National Policy Guidelines for the Prevention and Response to GBV in the Health Sector (2011) aim to enhance the health sector's capacity to prevent and respond to GBV effectively. Furthermore, the government and prospective stakeholders in the health sector intend to use this policy guideline to strengthen their response to GBV by encouraging multisectoral collaboration and stakeholder participation. Also, improve the implementation of comprehensive GBV services by including prevention and survivors' services into national health infrastructure, governed by human rights, professional ethics, and compassion in their respective settings. However, despite the fact that national policy guidelines for anti-GBV have been in place from the beginning of implementation, the GBV rate remains high, and little is known about how well policy-level measures have been implemented by the district health system. This study aimed to fil this gap.

1.3 The Conceptual Framework

The study is guided by the WHO's health system framework, a conceptual model that outlines the fundamental components and functions of a well-functioning health system. The study outlined a framework that encompassed service delivery, health infrastructure, health workforce training, leadership and governance, financing, health information systems, coordination, and community engagement. Service delivery for GBV survivors involves accessibility, confidentiality, needs assessment, holistic support, trauma-informed care, coordination, referrals, empowerment, and advocacy to support and empower those affected by violence. Health workforce training in GBV response is crucial for healthcare providers to provide comprehensive, sensitive care, promote prevention, and address the root causes of GBV.

Leadership and governance in response to GBV involve frameworks, accountability, community engagement, legal and ethical standards, and data and research. Health infrastructure in GBV response refers to the systems and facilities that aid survivors in obtaining the necessary care and support. Moreover, GBV financing consists of allocating cash for prevention, intervention, and support measures, such as public awareness campaigns, in order to successfully reduce and address GBV. Health information systems play an important role in

addressing GBV by collecting, maintaining, and utilizing data to enhance services and outcomes. Coordination and community engagement entail effective collaboration across agencies to provide complete support, whereas community engagement educates and engages the community in preventing GBV and assisting survivors.

More importantly, WHO's health system framework does not incorporate health infrastructure, but in this study, it was included in the consulted literature review in order, with other components, to attempt to enhance overall wellness unresponsively and efficiently, and it is feasible to explore the achievements and challenges of how the health sector responds to GBV, both at a healthcare facility and in the community (7).

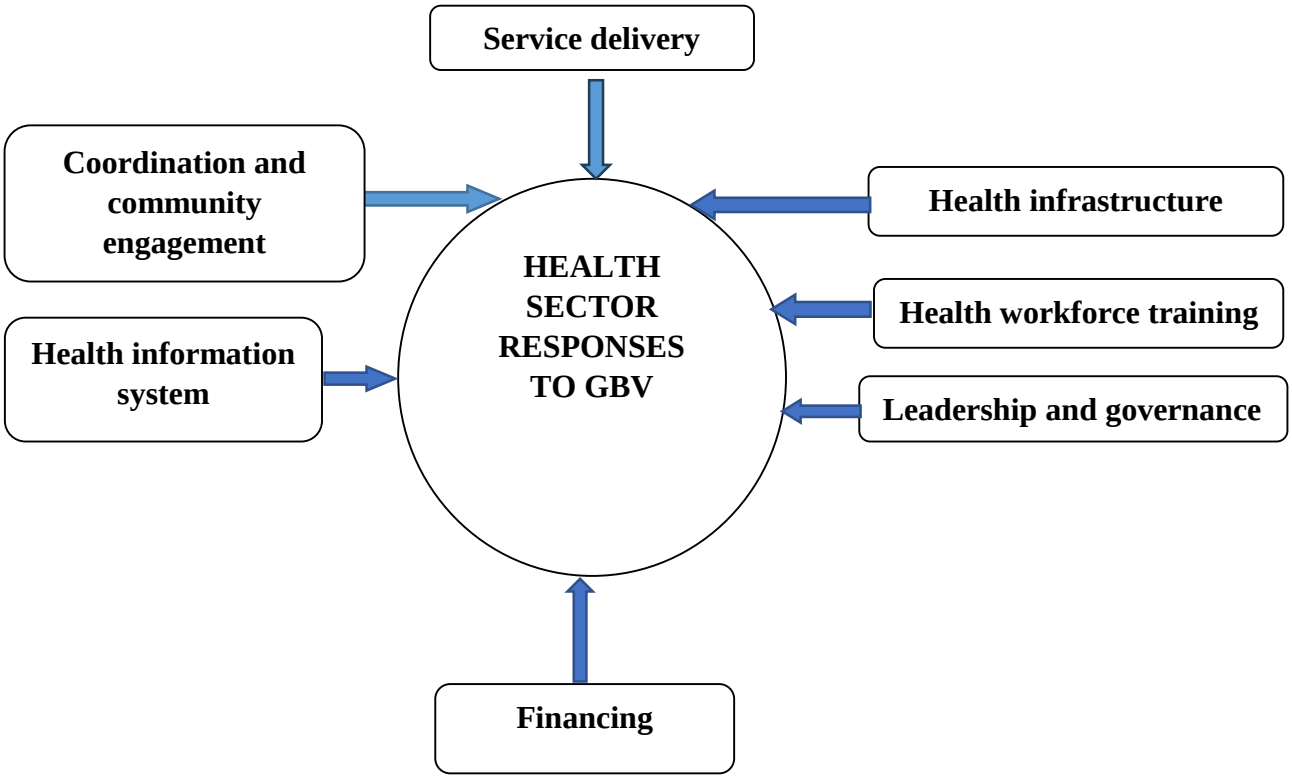


Figure 1. Conceptual framework

Source: Constructed from Literature Review, 2023.

1.4 Rationale of the Study

The results of the study can assist policymakers in making evidence-based decisions when planning interventions and activities meant to enhance the health sector's response to GBV. Not only that, but this study can provide researchers with baseline data for future studies on health sector responses to GBV. Tanzania faces significant costs due to GBV, resulting in a GDP loss. The study's findings can assist policymakers to formulate interventions that can help in achieving SDG 5 and 3 (gender equality and good health and well-being) by addressing GBV, a global public health issue, to improve survivors' health, dignity, security, development, peace, and autonomy. In addition, GBV survivors require stronger health-care responses and more consistent service delivery, and community members' involvement in responding to GBV is crucial, as is the incorporation of service consistency in the services provided to GBV survivors across all facilities. Therefore, it was important to explore how the health sector responds to GBV by exploring achievements and challenges both at the health facility and community levels using the WHO health systems framework.

1.5 Research Questions

1.5.1 Broad research questions

What are the health sector's achievements and challenges in responding to GBV in the Ilala district using WHO Health Systems Framework components?

1.5.2 Specific Research Questions

1. How do the current health sector guidelines impact the GBV response in Ilala district?
2. What are the achievements of the health sector in responding to GBV in the Ilala district using the WHO Health Systems Framework components?

3. What are the challenges that the health sector faces in dealing with GBV in the Ilala district, using the WHO Health Systems Framework components?

1.6 Research Objectives

1.6.1 Broad objectives

Explore the achievements and challenges of the health sector in responding to GBV in the Ilala district using the WHO Health Systems Framework components.

1.6.2 The specific objectives

1. To review the current health sector guidelines that impact GBV responses in Ilala District.

2. To identify the achievements of the health sector in responding to GBV in the Ilala district using the WHO Health Systems Framework components.

3. To examine the challenges the health sector faces in dealing with GBV in the Ilala district using the WHO Health Systems Framework components.

CHAPTER TWO:

2.0 LITERATURE REVIEW

GBV poses a significant threat to the achievement of SDGs No. 3 (good health and well-being) and No. 5 (gender equality), disproportionately affecting women and girls. GBV leads to severe physical, mental, and emotional health consequences, undermining the well-being of individuals and communities and directly contradicting the objectives of SDG 3 (14,15). It perpetuates gender inequalities, restricts opportunities, and limits participation in economic, social, and political life, hindering progress toward SDG 5. The health sector plays a crucial role in responding to GBV through the provision of medical care, psychological support, and referral services. The health sector's efforts to address GBV's health impacts not only aid survivors' recovery but also promote gender equality and public health, advancing SDGs 3 and 5.

GBV is one among a GBV in men is increasing due to factors like civil wars, education, and income increases among women. Men are less likely to report abuse and may not seek support from institutions. Not only does GBV occur most to women, but nowadays, due to women being more economically powerful than husbands, secret relationships, educational differences, and extramarital engagement, this justifies the conduct of this study in both women and men (20).

GBV is a serious issue in the lives of several women and children because it is the product of gender norms and societal and economic imbalances that favor men over women. There is growing recognition of gender discrimination and unfairness in several aspects of life. The awakening acknowledges the widespread impact of GBV on women, girls, men, and boys, as well as the country's growing economic, health, and social welfare systems.

In Tanzania, violence between intimate partners represents a prevalent kind of GBV, which relates to behavior within an intimate relationship that results in any kind of sexual, physical, or psychological suffering, such as physical violence, sexual coercion, psychological abuse, and controlling behavior (21). In summary, forty percent of all women aged 15–49 have experienced physical violence, while seventeen percent have experienced sexual violence. Of women aged

15–49, forty-four percent have experienced either physical or sexual violence by an intimate partner. Spousal violence prevalence is highest in rural areas, averaging fifty-two percent, while the prevalence in urban areas averages forty-five percent. Almost thirty percent of girls experience sexual violence before the age of 18 (22–24).

In keeping with the aforementioned scenario, authorities have been paying greater attention to addressing the problems with GBV within the country as a whole. Both the Mainland and Zanzibar governments have recently adopted National Plans of Action (NPAs) to abolish violence against women and children (23).

The following section explores the health sector's response to GBV in Tanzania, based on the study's specific objectives.

2.1 A desk review of current health sector guidelines influences the GBV response.

Several studies have reported that different steps have been taken to respond to GBV since the 1985 CEDAW, in the 1995 Beijing Platform of Action (BPA) paragraph 112, plus the United Nations Millennium Development Goals (MDGs) in the year 2000, including related SDG 5 and SDG target 5.2. In 2013, the WHO issued its Policy and Clinical Guidelines for Responding to Intimate Partner Violence, WHO WHA67.15.2014 resolution, which aims to reinforce the capacity of the health system in combating violence, especially against women, girls, and children, as well as WHO Member States' acceptance of resolution WHA69.5.2016, a worldwide plan of action to increase the role of the health system within a national multisectoral approach to address interpersonal violence (4,5,7,14,25,26).

According to a French study on the French government's response to GBV, the government has proposed specific initiatives to address violence against women in a variety of areas, including combating sexual abuse, protecting children who are survivors of violence at home, assisting violent offenders, and protecting disabled survivors. The French lawmaker’s arsenal has improved in current times, but it still has flaws. In the year 2019, the Istanbul Convention's supervising body (the Council of Europe Convention on Preventing and Combating Violence

Against Women and Domestic Abuse) singled out France for failing to meet the obligations it bears under the Convention.

The Convention of Istanbul, which was ratified by France on July 4, 2014, provides a wide framework for women's rights; however, even today, all of the actions listed in this treaty have not been put into action in the country with basic human rights. Political parties, such as the new popular ecological and social union (NUPES), an alliance of different left-wing parties contesting 2022 elections for parliamentary representation, have proposed policies to provide equitable treatment and prevent violence against women as a way to close the gap. One of the key projects sponsored by NUPES is the passage of legislation fighting racist behavior and abuse toward women. As a component of this strategy, the alliance promises to commit a million euros to fighting women's abuse, in particular through training and accommodations for violence (27).

Another study conducted in Finland discovered that the government took steps to address issues of violence towards women, particularly abuse in the home, aimed at improving the execution of the Istanbul Convention. The endeavor worked in close connection with the Istanbul Convention's coordination mechanism and all of its stakeholders to ensure the interchange of information on the current state of existing instruments as well as the consolidation of future best practices. For example, the Finnish penal code was updated, primarily involving sexual offenses; other amendments have happened to characterize different kinds of violent behaviors within conformity, considering the possible Istanbul Conventions (28).

The effort to respond to GBV will continue, with the major challenge being the policy's implementation because, according to reports, police are investigating offenses. However, a lack of appropriate or sufficient human resources in the police force has an impact on investigations. The digital preliminary investigation is also under-resourced. Furthermore, despite increased reporting, many types of abuse directed toward women, particularly intimate abuse, are widely considered underreported (28).

In Southeast Asia, the health sector responds to GBV by committing to integrating GBV into national health systems via several government policies and circulars on the implementation of a medical response to GBV. Also in line with the above policies and circulars are potential strategic tools for stimulating greater sensitivity among health providers, such as the establishment of hospital-based integrated service centers at district-level public hospitals and sub district-level public health centers (8). A study conducted in Bhutan (2015–2016) indicated that there are just two referral hospitals throughout the country that designated consultation rooms for health workers when GBV survivors wanted to access health services, while all other health facilities used the usual doctor's chamber (9).

The study done in South Africa on GBV reported that the South African government has signed a variety of international and regional conventions to protect women's and girls' rights, in addition to enacting legislation such as the 1998 Domestic Violence Act, the 2012 Criminal Law (Sexual Offences and Related Matters) Amendment Act, the 1998 Maintenance Act, and the 2011 Protection from Harassment Act. Despite these policies, GBV remains a major problem . It is unambiguous what requires to be accomplished to safeguard survivors of violence done at home; nonetheless, the issue is implementation, even though the Act clearly outlines the responsibilities of the police. According to studies, numerous police personnel refuse to help survivors with GBV; some believe such circumstances to be "secret matters involving two spouses or partners (29).

The Tanzanian government has shown its commitment to tackling GBV concerns by signing international agreements on GBV and gender, particularly how the health sector responds (4,30,31)(4). It is providing guidelines, training HCWs, community outreach programs, one-stop centers, a national recording system, harmonizing GBV indicators, and naming GBV devotees to each healthcare facility, but the proportion of women seeking health care remains low (1.1%) (32). The Ministry of Health (MOH) developed national policy guidelines for the prevention and response to GBV in 2011, which highlighted different levels of support and defined the MoH’s and its key partners' responsibilities and roles.

To some extent a, GBV survivor faces the challenge of obtaining a PF. 3 from a police station in order to qualify for treatment and acquire verification of injuries. This may be a difficult choice between seeking immediate care or dealing with her injuries privately at the earliest feasible moment, foregoing any legal remedies she may have (51). However, guideline implementation remains low, there is a lack of multi-sectoral coordination, and GBV survivors' services must be integrated into the entire health delivery infrastructure.

2.2 Achievements of the health sector in responding to GBV

The study done in Spain about accessibility to equal rights for survivors suffering GBV reported that Spain has succeeded since 2003. Spain has established 106 specialized courts against gender violence in the largest towns and cities, which only hear domestic violence cases, as well as training for judges. These courts make it possible to shorten the processing times for cases as well as the duration of the organization of trials, which must not exceed 15 days. This measure is essential given the urgency of domestic violence situations. It is even possible for the state to file a complaint in place of the victim if the latter does not wish to do so or if she withdraws her complaint (33).

The report in Finland revealed that from 2020 to 2023, the Ministry of Justice financed three intervention and treatment programs for offenders of sexual violence run by CSOs. The projects provide free, low-threshold support services to those who are at high risk of committing sexual offenses against children and young people in particular, as well as approaches for avoiding recidivism among people from migratory backgrounds who have committed sexual offenses. Furthermore, from 2020 to 2023, the Ministry of Justice financed three programs for the treatment of sexual offenders run by NGOs, as well as one for perpetrators of domestic violence. Organizations aggressively communicated about the programs to their stakeholders. Between 2020 and 2023, the programs focused on perpetrators of domestic violence had little over 300 clients, while those directed at sexual offenders had nearly 300 (28).

Another report from Spain revealed that there have been more than 1,100 femicides since 2003. The creation of the anti-reconciliation electronic bracelet took place in 2007 in order to allow

victims and the police to be alerted if the perpetrator of the violence is near the victim. Since its creation, nearly 1,350 women have had this measure, and none have ever been killed. In 2017, the 79th National Pact against Gender Violence was adopted. This reinforces the protection of victims by allocating a budget of one billion euros over five years to the fight against violence against women.

Eighty more than two hundred measures are proposed, in particular the allocation of financial assistance to unemployed victims or the establishment of specific brigades within police stations. In line with the above, since January 1, 2022, all femicide cases have been included in official statistics. Prior to this date, the notion of femicide was limited to killings committed between partners or ex-spouses. From now on, Spain includes "the family," "sexually," "social," and "by proxy" femicides. It is the first country in Europe to count 81 percent of all femicides (27).

The study done in Sri Lanka reported that the health sector has succumbed to addressing GBV through the development of health policies such as Sri Lanka's Demographic and Reproductive Health Policy, 1998; the National Committee on Violence; the Health Master Plan, 2007–2016; the Maternal and Child Health Policy, 2012; and the National HIV and AIDS Strategic Plan for 2007–2011. Furthermore, the health sector has achieved the establishment of **Mithuru Piyasa** (a one-step service center) for survivors of GBV. It is staffed with a medical officer, a nursing officer, and an officer for operational aspects. Basic services provided for the recipients in these centers are: screening for abuse; medical care (surgical and gynecological); befriending services (building up confidence; empathetic listening; and counseling) (34).

Moreover, the study done in Afghanistan reported that the health sector has achieved routine screening to make sure survivors receive the support they need, which involves referrals to other critical services. The same study added that healthcare workers have frequently been the first responders to GBV-related injuries (35).

According to the Moroccan study, the government, through the **"Tamkine"** strategy and program for combating GBV, was successful in adopting a multi-sectoral approach by bringing

together 13 national bodies and more than 50 non-governmental organizations. It sought to prevent and safeguard women and girls from various sorts of violence by addressing the interconnectedness of poverty and vulnerability. Furthermore, the initiative increased access to legal, psychological, social, and economic support for women who had experienced violence. Since 2008, 4,651 women have benefited from program-supported centers for female survivors of violence. The number of centers for counseling increased from 38 in 2008 to 52 in 2010. Morocco's strategy to combat GBV includes institutional, legal, and advocacy activities (36).

One study done in the Republic of South Africa found that the overall health sector successfully integrated full health services to guarantee that all healthcare personnel and associated healthcare workers are upskilled to identify survivors of GBV proactively before circumstances worsen and create a robust support network and seamless referral pathway (37).

With regard to the study conducted in Tanzania, the development of the one-stop GBV facility at Mount Meru Regional Referral Hospital resulted in various benefits, including 1,496 customers serviced over a two-year period. Likewise, survivors are becoming more aware of the resources offered to survivors of GBV and VAC provided by Mount Meru. Justice for survivors in cases where perpetrators are tried and imprisoned (eight suspects were convicted in 2020/21; seven received 30-year jail sentences and four received life sentences). Furthermore, rapid detection and treatment of sexually transmitted illnesses and HIV through comprehensive, integrated healthcare, thereby preventing long-term repercussions, and enhanced collaboration between the center and essential community support services, such as safe houses and other resources (24).

Likewise, campaigns against GBV in Tanzania have been integrated into prevention initiatives for HIV as a multi-sectoral approach to eliminating the practice. However, the most applicable national and international stakeholders, such as the Tanzania Women's Lawyers Association (TAWLA) and the Tanzania Gender Networking Programme (TGNP), have prioritized women's empowerment over male victims; these institutions and initiatives are irrelevant(20). Despite

unequal efforts, GBV remains prevalent, particularly among men. According to (38) GBV is prevalent among men, including in Tanzania.The government and gender stakeholders should consider innovative tactics to promote gender equality and raise awareness about gender issues among Tanzanians.

2.3 The challenges facing health sector in dealing with GBV

GBV towards women and girls cannot be isolated from that of men, since both sexes face the same issues, such as forced rape, sexual abuse, forced enlistment, and sex-selected mass execution, especially in areas with political clashes. The present GBV trend indicates that men are increasingly becoming victims of GBV (20).

According to the study conducted in Germany, NGOs and lawyers working on violence against women informed GREVIO that, in their experience, police frequently hesitate to grant an emergency barring order against a perpetrator of domestic abuse, especially in places that are remote. 331 In some circumstances, they take the victim to a shelter instead. They also encounter a lack of communication among the many parties. While law enforcement agencies should, in principle, notify domestic violence counseling facilities about particular women in domestic abuse situations, this is not usually the case in fact (39).

The study conducted in Finland on GBV survivors in the Finnish asylum system and the opinions from social welfare and healthcare professionals highly skilled in the delivery of services in practice stated that female immigration-seekers are often commonly frightened to talk about what they have experienced with abuse because of an underlying lack of faith in authorities and the thought that talking it up could end up in a poor asylum judgment (40).

In India, fifty-four percent of men in rural Haryana reported experiencing GBV from their female partners due to their low socioeconomic position, in which unemployment and poverty among men led to an increase in GBV perpetrated by female partners (41).

A study conducted in countries across Nepal, Brazil, Bangladesh, Sri Lanka, and Rwanda reported that GBV survivors face challenges in healthcare settings, including insensitivity from providers, re-traumatization of their violent experiences, and victim-blaming. As a result, many survivors have no choice but to go back to the scene of the abuse with no safety strategy or assistance. Cultural beliefs that justify GBV worsen the lack of support for survivors and the difficulty in providing GBV survivors with sufficient health treatment (7).

Some studies conducted in Bangladesh, Iraq, Kenya, and northeast Nigeria found that a lack of essential equipment for comprehensive management, including speculums and rape kits, impeded survivors' care. In addition, there were instances in which HIV-related screening kits were lacking, prompting victims to purchase them. Which might clarify why forty percent of survivor data lacked swab or HIV results. The absence of equipment made it difficult to treat survivors with high-quality care. For example, a lack of samples made it impossible for clinicians to obtain the high-quality samples required for therapeutics and evidence used in forensics (42,43).

In reference to the studies conducted, they show that economic issues contribute to GBV in the Republic of South Africa. Many of the victims of GBV lack both financial and legal support to go after and hold perpetrators responsible. For instance, the police are not always efficient in supporting these survivors (44). The issues related to the deoxyribonucleic acid, also known as DNA, bottleneck are just some of the difficulties that exist and describe the South African police department's inadequate systems. In addition, numerous government departments must collaborate to execute and carry out the law on domestic violence. At present, an Act stipulates the police's duty to give several supports to survivors of GBV; fortunately, these commitments are actually undoubtedly not supported because of other ministries issues like justice, health, and improvement in society. It has a negative impact on the implementation of services as outlined in the Act (44).

Furthermore, a study conducted in Ethiopia discovered that most health care personnel did not receive on-the-job training on GBV, which was one of the biggest challenges they faced during

the screening process for incidents of violence. Researchers indicated that the lack of training hindered their capacity to deliver the necessary level of care to GBV clients. However, just a healthcare provider from a private institution obtained GBV training (45).

Another study conducted in Mozambique found that access to legal and security services for GBV survivors is limited. Only five percent of survivors sought legal assistance, which is understandable given the low number of actors and capacity to provide legal advice and counseling to GBV survivors. Having access to legal services can require reporting, so survivors frequently choose not to seek help, and GBV survivors are also hesitant to seek legal help due to a lack of secure shelter choices and women's financial reliance on intimate relationship perpetrators if they disclose their abuse. The use of legal referrals was made possible by UNHCR-CUAMM's collaboration with local women-led NGO legal professionals, who are demanding further resources. Only one percent of survivors were transferred to security services (police), partly because they did not want to report their cases but also because many survivors believed the service was inaccessible to those living in remote IDP zones (46).

Other studies conducted in Somalia and South Sudan show that women's sexual purity, familial respect for women's safety, and men's capability to punish women and children are all damaging norms of society that support GBV (47). Harmful gender norms, such as inflexible ideals of masculinity, can be detrimental to boys' and men's health, encouraging them to take health risks, abuse alcohol, and delay seeking help or healthcare. They can force survivors to conceal their experiences with abuse, which inhibits health-seeking behavior and limits access to health care. As victims' fear of violence and stigma increases, so does their willingness to use health care (47).

Several studies conducted in Kenya show that the people who provide assistance are uninformed and unwilling to adhere to guidelines and protocols while working with victims. Hospital attendants are unable to provide critical services such as evidence collection and psychiatric counseling because of poor infrastructure, a lack of training, and inadequate budgetary allocations (48,49).

Another study done in Kenya discovered that health care workers in Kenya lack the fundamental skills required to give excellent services to minors, among them gaining and expressing consent, ensuring confidentiality, completing a physical examination that safeguards the dignity of the child, and acquiring specimens (50).

Moreover, the study done by Gatuguta reported on the legal issue that healthcare providers are faced with an ethics and rights dilemma as these survivors might be brought to the hospital against their will and subjected to examination and treatment that they do not wish to receive. It is not clear whether bringing these girls to the hospital and treating them as sexual violence cases actually stops the on-going relationships. More importantly, there are no guidelines for clinicians on what rationale or criteria they should use to make decisions on the type of treatment and additional support to offer (43).

The study done in Tanzania reported that privately owned clinics and health facilities are not permitted or obliged to finalize PF3 forms, and as a result, their capacity to respond to cases of GBV is very limited. This is a substantial hurdle, as almost one-third of Tanzania's health services are obtained outside of the public system. The services provided by NGOs, FBOs, and other private groups that operate health facilities vary depending on the organization's mandate and the specific institution. Tanzania also has several voluntary counseling and testing (VCT) centers that offer services to GBV survivors. However, GBV has yet to be systematically integrated into these facilities (51).

Several research studies indicated that lack of awareness of services among survivors, especially in rural and urban areas, hesitant disclosure, economic considerations, financial barriers, feelings of guilt, fear of stigma, shame, and self-blame, a lack of law enforcement action, and attitudes towards violence as a normal component are among the barriers facing the health sector towards GBV. This makes responding to GBV difficult for the health sector(4,30).

In addition to the study conducted in Dar es Salaam, men seek economic empowerment, yet their economic empowerment is linked to domestic violence. Men need to be aware of the existence and importance of various institutions dealing with GBV; they ought to speak with

the institutions whenever they become victims of GBV; and they ought to participate at gender desks, as many police stations still lack equitable male representation, which could play a role in the health sector's response to GBV, particularly among men (20).

2.4 General Identified Gap

Regardless of the existence of national anti-GBV policy guidelines, the GBV rate remains high, and little is known about how well the policy-level efforts have been implemented by the health system at the district level. This study is intended to fill this gap by exploring the achievements and challenges of the health sector in responding to GBV in the Ilala District using the WHO Health Systems Framework components.

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study Design

The study was a qualitative case study design used to explore the response of the health sector to GBV through interviewing and discussions with community members, GBV survivors, healthcare workers, health facility leaders, and the police gender desk in both the community and health facility. Case study research enabled a thorough exploration of new or ambiguous phenomena while preserving the holistic and significant aspects of GBV-related events (52). This study used a case study approach to explore Tanzania's health-sector response to GBV.

3.2 Study Area

This study was conducted in the Ilala District. The district is one of Tanzania's areas with a high prevalence of GBV cases, with Amana Regional Referral Hospital (RRH) and Chanika Health Centers among the one-stop centers established to provide medical treatment, psychosocial support and counselling, and legal assistance to survivors of GBV (12). Also, being one of the districts with two GBV Stop Centers that provide integrated services to GBV survivors, including a healthcare worker (HCWs), and a police gender desk, is an important indicator in choosing this study area. In addition, data was collected primarily from the Ilala District, where GBV survivors were identified at Amana RRH and Chanika Health Centre, as well as from health care providers, the police gender desk, and community members.

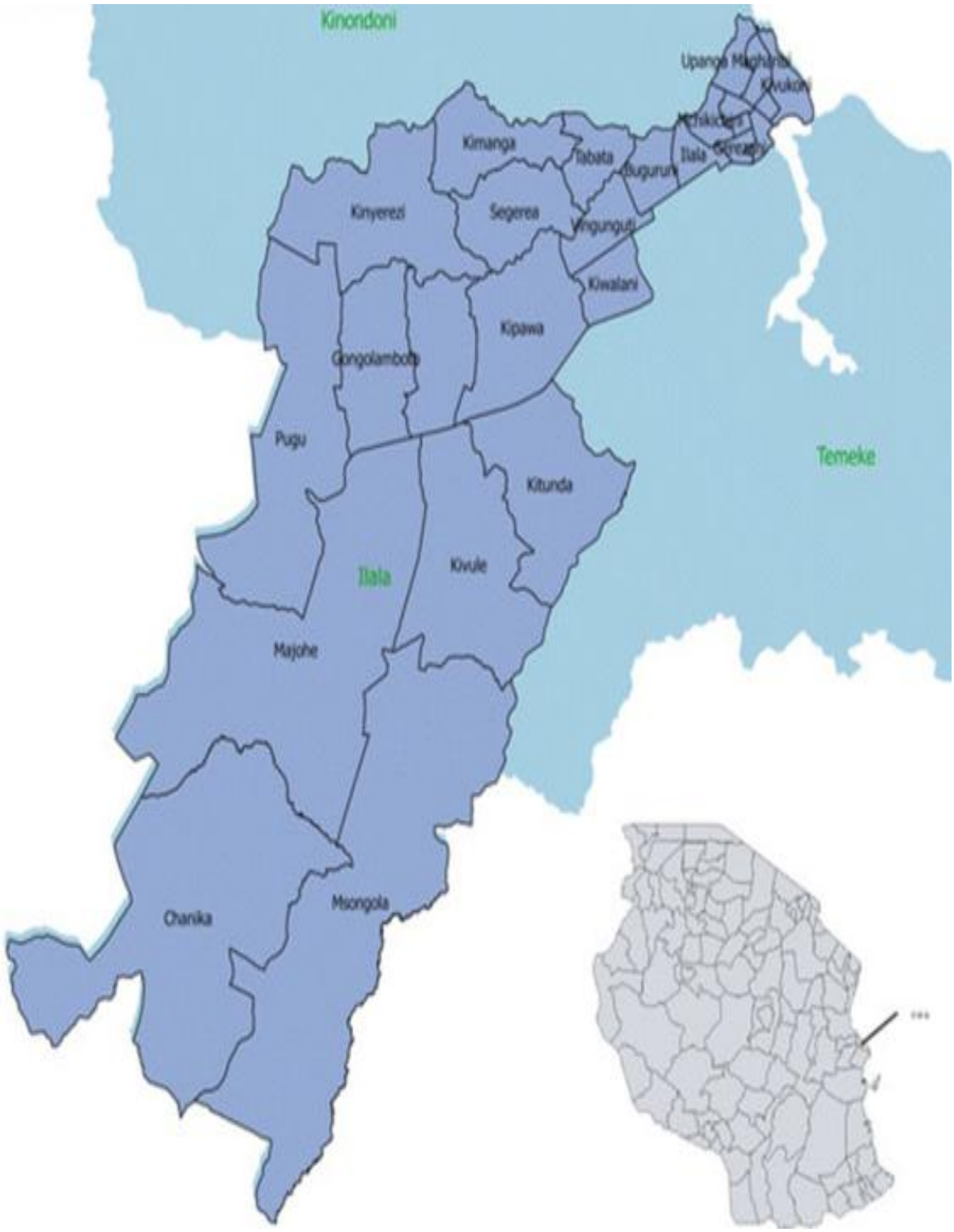


Figure 2: Ilala District Map (53)

3.3 Sample Size

A total sample size of 51 participants was selected for the study, of whom 14 were involved in in-depth interviews and 37 were included in focus group discussions (FGDs). The degree of saturation determined the data collected and the ultimate sample size. The saturation level occurs when no new information or ideas are gathered from repeated interviews or focus group discussions.

3.4 Study Population

The research population included survivors of GBV identified at the GBV one-stop center, HCWs, (such as the health facility in charge, the Council GBV focal person, the social welfare officer, administrators, and other clinicians), police gender desk officers dealing with GBV, and community members in Ilala District.

3.5 Sampling Technique

The research study used purposive sampling. A qualitative method was used since it allowed the researcher to gain insight into only HCWs, survivors of GBV, police desk officers, and community members living near the only GBV stop center who are knowledgeable and responsible for responding to GBV. Furthermore, the strategy facilitated achievements and knowledge of the challenges that HCWs, survivors of GBV, community members, and police desk officers face after responding to GBV.

3.6 Data Collection Techniques

Both primary and secondary data collection methods were used in this study.

3.6.1 Primary Data collection.

Data was collected from GBV survivors, police gender desk officers, health facility leaders, the Council GBV focal person through in-depth interviews, HCWs, dealing with GBV-related cases, and community members through FGDs. The method used to collect data for 2 and 3

objectives of the study on achievements and challenges in the response to GBV by the health sector, respectively.

3.6.1.1 Semi-Structured Interview

Semi-structured interviews were conducted in this study with GBV survivors, police gender desk officers in charge of GBV prevention and management, as well as the implementation of GBV policy and guidelines, health facility leaders, and Council GBV focal persons in charge of GBV intervention implementation.

3.6.1.2 Focus Group Discussion

The data was collected through a FGD among healthcare providers who are daily implementing the policy and guidelines on GBV from Amana RRH, Kivule, and Chanika health centers, as well as community members who are living in the street around one GBV stop center. FGD comprised six groups, each consisting of 6 to 7 participants. In addition, FGD 1 and 2 are HCWs, FGD 3 and 6 are women community members, and FGD 4 and 5 are men community members.

3.6.1.3 Observation

The study utilized observation to explore health sector interventions' responses to GBV, utilizing an observation checklist at community and health facilities for better understanding. An observation checklist was conducted in the community to explore the availability of posters, brochures, and flyers promoting GBV awareness and community preparedness in training. Meanwhile, it is used in health care facilities to check for privacy and confidentiality, safety and security, a comfortable and calming environment, necessary medical and counselling supplies, trained staff, physical accessibility and support (translators or multilingual staff), information and referral systems, documentation and data management, and crisis intervention and support.

3.6.1.4 Secondary data

The study's first objective was to explore the influence of the current Tanzanian health sector guidelines on the response to GBV. The following guidelines were reviewed: National

Management Guidelines for Health Sector Prevention and Response to GBV of 2011, National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011, National Guidelines for Integrating and Management of the One Stop Center Services into Health Care Facilities of 2013, National Plan of Action to End Violence Against Women and Children 2017–2018–2021–22, and Standard Operating Procedures for Prevention and Response to Gender-Based Violence and Child Abuse of 2012.

The study reviewed the guidelines mentioned above with a view to understanding and identifying their effectiveness, challenges, and gaps compared to other countries as part of the health sector's response to GBV. The guidelines were reviewed based on problem identification, policy objectives, design, stakeholder analysis, implementation, cost-benefit analysis, equity and social justice, effectiveness, adaptability, flexibility, monitoring, and ethical considerations. The criteria provided a comprehensive, objective, and effective framework for policy analysis, thereby facilitating thorough and objective decision-making.

3.7 Data research tool/instruments

3.7.1 Interview Guide:

The researcher created an interview guide to help collect data. The interview guide was written in English and administered in Kiswahili before the results were translated back into English. This interview guide contained questions that were open-ended in order to address key theme areas of the study.

3.7.2 FGD guides:

The FGD was administered in Swahili, and the discussion was recorded on a tape recorder and later translated into English. The guide included open-ended questions reflecting study objectives.

3.7.3 Checklist:

The instrument was used to gather secondary information from health facilities, focusing on relevant guidelines, policies, strategic plans, annual plans, and budgets for GBV.

3.7.4 Recruitment of research assistants and training

A research assistant with a bachelor's degree was hired for data collection. The principal researcher provided two-day training sessions to help understand study goals and data collection methods.

3.7.5 Pre-testing of the Tool

Before data collection began, the in-depth interview and FGD tool were developed and tested at Mnazi Mmoja Hospital to ensure accuracy, validity, and compatibility, with any required adjustments made to ensure study participants understood the questions.

3.8 Data Management

Data generated from the in-depth interviews and FGD were transcribed verbatim and translated from Kiswahili to English.

3.9 Data Analysis

The study utilized a thematic analysis approach to analyze the data, focusing on categorizing and examining the opinions of the participants (54, 56). Thematic analysis was employed to comprehend key events in the narrative, while interviews and FGD were translated from Swahili to English using the NVivo 14 trial.

The analysis was divided into three stages: first, line-by-line coding of field notes and transcripts; second, in-depth examination and interpretation of the resulting codes and their categorization into descriptive and analytical themes; and third, formulation of an overarching theme. Coding entailed the creation of concepts; that is, the data was broken down into separate

components in order to reveal underlying ideas and meanings. The technique produced forty codes, which were then interpreted and grouped into sixteen descriptive codes. These later codes were further separated into fourteen analytic themes, and the findings are reported. In addition, descriptive policy analysis was used to analyze findings from the reviews of different guidelines impacting responses to GBV.

Table 1: Example of Data Analysis

S/N	Coding references	Theme	Key Findings
1	10 references across interviews and discussion	Integrated of services	*"There are social welfare officers who provide guidance and direction in office number one; there is office number two, which is for doctors and nurses; and there is a police officer who is in this room where you and I are sitting".*
2	8 references across interviews and discussion	Lack of awareness creation among community members on GBV	*"I became aware of the services accessible to GBV survivors when my relative was subjected to GBV; however, without that case, I would not have noticed the services provided to GBV survivors at our health center"*

3.10 Trustworthiness

Trustworthiness is the key truth gathered from the data that makes the findings worth paying close attention to. This study guaranteed trustworthiness by focusing on four aspects: credibility, transferability, dependability, and confirmability as recommended by (54). In a study on GBV, using observations as a data collection method provided valuable insights into behaviours, interactions, and environments that may not be captured through interviews or surveys alone.

Credibility in research involves accuracy, techniques, and researcher reflexivity in assessing the alignment of the study's findings with reality. In this study, interviews were used because they are an appropriate and well-recognized research method for exploring in-depth information from

the study participants. FGD was used because it is an appropriate and well-recognized research method for exploring information related to the experiences and perceptions of the study topic.

Transferability refers to a study's ability to apply or generalize its findings to different settings, people, or situations. The study required detailed background data to establish its context and be transferrable. The study focused on the setting, contextual factors, findings, and participants' experiences, highlighting the complexity of GBV responses in the health sector by ensuring similarities and differences with a clear rationale and peer review for effective interpretation.

Dependability refers to the consistency of data, even when the work is repeated in the same context, method, and participants. This study guaranteed dependability by providing a clear and detailed explanation for the process.

Confirmability is the process of ensuring that the researcher's interpretations and findings are accurately derived from the data and are supported by evidence. The study achieved confirmability by providing reasons for its conceptual, methodological, and analytical choices, ensuring credibility, transferability, and dependability throughout the study.

3.11 Ethical Consideration

The GBV study is critical because it involves sensitive material. If precautions are not taken, the safety and well-being of participants and the research team may be jeopardized, potentially resulting in a violation of human rights law (55).

The Institutional Review Board (IRB) of Muhimbili University of Health and Allied Sciences (MUHAS) offered ethical approval for this research study (MUHAS-REC-05-2024-22281, Ref. No. DA.282/298/01.C/2281, dated May 31, 2024) and introduction letters to the Regional Administrative Secretary of Dar es Salaam, Amana RRH, and the Chief of Police Force. Clearance for the study was obtained through an introduction letter from the Regional Administrative Secretary of Dar es Salaam (Ref. No. EA.260/307/01B/138 dated June 6, 2024), permission from the City Medical Officer of Dar es Salaam City Council (the local government

authority for the Ilala District) (Ref. DCC/D.F.31/IX/54 dated June 11, 2024), Amana RRH (Ref. No. MoHCDGEC/ARRH/R.1/VOL II/ June 19, 2024), and the Chief of Police Force (Ref. No. GB. 56/897/01/123 dated July 2, 2024).

A commitment was made to respect the participants and safeguard them from being exploited as a result of their involvement in the study. Participants were informed that they might agree or disagree with participating in the study. The dignity of all research participants was upheld. The researcher waited for them to be ready for their interviews and FGD. Permission to record and take notes was secured prior to the interviews and FGD. One of the interview participants asked not to be recorded. Finally, the principal researcher kept all the obtained data secret and did not use identifiers.

3.12 Study Limitations and Mitigation

The study's findings were based on self-report, which may be susceptible to social desirability and recall bias due to underreporting or recall issues among survivors. Others who participated might have overstated the achievements and challenges of the health sector's response to GBV. In addition, using observation as one of the data collection methods may result in an observer influencing participants' actions, potentially leading to altered behaviour known as the Hawthorne effect.

This study mitigated overstated by explaining clearly the objectives of the study to the participants and urging them to be honest. On top of that, there were no wrong or right answers, and nothing would be imposed on the participant. In addition, used natural settings and comfortable environments to minimize the Hawthorne effect and gather accurate data on the health sector's response to GBV.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter summarizes the results, which are organized into subheadings corresponding to the study objectives (4.4, 4.5, and 4.6), and objectives two and three are presented by considering the WHO health systems framework used in this study. These include looking at the health sector's achievements and challenges in responding to GBV, as well as GBV survivors' lived experiences. Quotes were used to elaborate more on the person's experiences in GBV response-related cases.

4.2 Description of the study participants

The interviewed GBV survivors reported that the GBV was committed by their partners, family members, and friends. The majority of GBV survivors included in the study were divorced or abandoned by their partners. The community members who participated in the study had lived on their particular streets for more than ten years. In addition, health facility leaders, GBV council focal persons, and other healthcare workers participated in the study; the majority had worked in the health sector for more than ten years.

4.3 Social demographic characteristics of the participants

The study included 37 (72.5%) participants in six FGDs and 14 (27.5%) interviews. The majority of participants in the FGDs were community members (47.1%), followed by HCWs (25.5%). In addition, female participants were 56.9% and male participants were 43.1%, as shown in Table 2.

Table 2: Social demographic characteristics of the participants

		Frequency(n=51)	Percentage (%)
Age	15-29	7	13.7
	30-49	36	70.6
	50 +	8	15.7
Sex	Male	22	43.1
	Female	29	56.9
Education level	Primary	10	19.6
	Secondary	11	21.6
	Certificate and diploma	10	19.6
	Bachelor degree+	20	39.2
Marital status	Never married	18	35.3
	Widow	1	1.9
	Married	30	58.8
	Separated	2	3.9
Religion	Christian	26	51
	Muslim	25	49
Position	Health facility leaders/Council GBV focal person	9	17.6
	Health care workers	13	25.5
	Police gender desk officer	1	1.9
	Community members	24	47.1
	GBV Survivors	4	7.8

4.4 The review of the health sector guidelines that impact GBV responses

In Tanzania, the health sector responds to GBV through a variety of created and implemented guidelines with a view to understanding and identifying their effectiveness, challenges, gender responsiveness, and gaps compared to other countries as part of the health sector's response to GBV. In this study, two guidelines were reviewed: the National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011 and the National Plan of Action to End Violence Against Women and Children 2017–2018–2021-22.

4.4.1 National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011 in Tanzania

The guideline's review criteria included problem identification and definition, policy objectives and goals, policy design and alternatives, stakeholder analysis, implementation analysis, cost-benefit analysis, equity and social justice, effectiveness and impact, adaptability and flexibility, monitoring and evaluation, and legal and ethical considerations.

Table 3: Analysis of Tanzania National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011

S/N	Criteria	Findings	Achievement	Challenges
1.	Problem Identification and Definition	The policy acknowledges GBV as a significant public health and social issue affecting all ages and genders, especially women and girls	They accept its extensive prevalence and societal consequences	Underreporting due to stigma and a lack of awareness.
2.	Policy Objectives and Goals	Are well stated, and they address the crucial need for accessible, comprehensive care	The introduction of one-stop facilities is a practical solution that has improved service delivery.	Ensuring that these services are offered throughout the country, particularly in rural and neglected areas.
3.	Policy Design and Alternatives	A well-stated and structured framework for responding to GBV	The development of standardized care practices, training, and multi-sector collaboration has been created.	The policy's focus on the health sector may limit its ability to address the broader socio-economic and cultural determinants of GBV.
4.	Stakeholder Analysis	Involvement of different stakeholders with impact on GBV response: MOH, Ministry of Home Affairs, Ministry of Justice and Constitutional	Acknowledge the critical role of various stakeholders in addressing GBV, including	The policy could benefit from clear roles, strengthened partnerships with NGOs, and involving survivors

		Affairs, Ministry of Education, regional and district level, community, and partners	healthcare providers.	in policy-making for effective coordination, resource mobilization, and survivor-centered approaches.
5.	Implementation Analysis	The guide has made progress in recommending integrated services, including one-stop centers for survivors of GBV.	Integration of services to GBV survivors	Uneven implementation across different regions, limited resources, and insufficient training for healthcare providers pose challenges. These issues result in disparities in the quality and accessibility of services.
6.	Cost-Benefit and Cost-Effectiveness Analysis	The policy's implementation could potentially lower healthcare expenses by preventing severe health issues linked to untreated GBV cases.	The analyses show that implementing guidelines outweighs costs, justifying the allocation of resources towards GBV prevention and response initiatives.	The challenge lies in determining the benefits of long-term psychological well-being and societal changes.
7.	Equity and Social Justice	The policy aims to ensure equal access to quality healthcare and support services for all survivors of GBV, regardless of their gender, age, socio-economic status, or location.	The policy emphasizes the importance of providing respectful and non-discriminatory care, acknowledging the	Limited resources in rural locations, as well as inadequate healthcare practitioner training, can result in discrepancies in service delivery. To truly sustain equity and social justice,

			vulnerabilities of marginalized groups.	policies must address these inequalities through equitable resource distribution, focused outreach to marginalized populations, and ongoing education to overcome stigma and discrimination.
8.	Effectiveness and Impact	The health sector has seen a rise in awareness and structured responses to GBV.	The introduction of one-stop centers and standardized care protocols has increased the accessibility and quality of treatment for survivors.	Inconsistent implementation across regions, underreporting of GBV cases, and limited resources.
9.	Adaptability and Flexibility analysis	Provided a foundational framework for addressing GBV.	Exhibit a foundational framework for addressing GBV.	The policy's rigid structure may not fully adapt to emerging challenges and diverse local contexts, such as regional needs, cultural differences, and evolving GBV patterns. Regular reviews and updates of the policy, incorporating feedback from service providers and communities, can improve adaptability, address changing circumstances, integrate new

				evidence-based practices, and ensure culturally sensitive interventions.
10.	Monitoring and Evaluation	Expanded collaboration between the health sector and other stakeholders is also required for a more coordinated response to GBV.	The policy has significantly increased awareness and training, leading to increased reporting and standardized care for survivors.	The policy's effectiveness is hindered by insufficient funding, inadequate data collection, and inconsistent implementation across regions. Strengthening the response requires robust Monitoring and evaluation systems and consistent guidelines.
11.	Legal and Ethical Considerations	The guidelines are legally in line with national and international human rights frameworks, prioritizing the protection of survivors' rights and confidentiality.	The guidelines protect survivors' rights, confidentiality, and privacy, mandate reporting of GBV cases, and prioritize dignity, autonomy, and safety, ensuring respectful care.	Consistent application of ethical principles, particularly in rural areas, requires adequate training for healthcare workers and upholding survivors' rights for effective policy implementation.

On the other hand, on the side of comparing and contrasting the policies of Tanzania and Kenya, it was reported that, the Tanzania National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011 and Kenya's National Policy for Prevention and Response to GBV of 2014 share similarities and differences. Both aim to improve service delivery, survivor protection, and prevention strategies, but Kenya's guidelines have more comprehensive data collection and monitoring, while Tanzania's emphasizes community involvement and

awareness. Both countries face challenges with consistent implementation, especially in rural areas.

4.4.2 NPA-VAWC for 2017-2018 to 2021-2022

NPA-VAWC for 2017-2018 to 2021-2022 is a substantial policy initiative to address the widespread problem of violence against women and children. This analysis takes into account essential policy analysis characteristics such as clear objectives, implementation strategies, resource allocation, stakeholder involvement, and monitoring and evaluation procedures.

NPA-VAWC for 2017-2018 to 2021-2022 is a comprehensive and well-organized policy that targets a crucial social issue. It is distinguished by clear objectives, thorough execution plans, and a commitment to cross-sector collaboration. While issues in resource allocation and data collection remain challenges, the plan's emphasis on stakeholder involvement and thorough monitoring and evaluation frameworks lays a solid foundation for success. Continued commitment from all sectors, proper money, and successful implementation are required to meet the plan's ambitious goals and create a safer environment for Tanzanian women and children.

4.4.3 Review of guideline using WHO's Gender Responsive Assessment Scale

According to the WHO, the Gender Responsive Assessment Scale categorizes programs and policies into five levels based on how they address gender issues**:** gender unequal (level 1), which reinforces gender inequalities; gender blind (level 2)**,** which ignores gender differences; gender sensitive (level 3)**,** which recognizes gender differences but does not fully address them; gender specific (level 4), which considers and addresses gender differences; and gender transformative (level 5), which actively seeks to challenge and change harmful gender norms, roles, and power dynamics to promote gender equity. The goal is to move interventions toward being gender transformative to ensure equitable outcomes.

4.4.3.1 National Policy Guidelines for the Health Sector: Prevention and Response to GBV of 2011 in Tanzania

This review utilized the Gender Responsive Assessment Scale. The policy guideline is rated as level 4 gender-specific, which addresses the unique needs and differences of GBV survivors. Gender-specific health programs provide tailored services for both genders and integrate a GBV stop center. The policy, while a significant step towards a gender-responsive health sector, requires further improvement in addressing GBV underlying causes and transforming mindsets to promote self-awareness and avoid external validation.

4.4.3.2 NPA-VAWC for 2017-2018 to 2021-2022

The plan, classified as gender-responsive (level 4), aims to reduce violence, promote equality, and empower women and children, according to the Gender Responsive Assessment Scale grade used to assess the plan. The highest level of gender responsiveness necessitates mindset transformation, where individuals are aware of their own gender identity and do not require external validation for certain harmful behaviors. Example: GBV is not good, or wife beating is not good.

4.5 The health sector has made significant achievements in responding to GBV.

The health sector has made significant achievements in responding to GBV, with seven themes identified: integrated services, para-social groups, exemptions, trained HCWs, health information systems, and unification and safety plans for survivors, which are presented within the seven components of WHO health system frameworks as used in this study. These themes form sub-headings in the sections that follow.

4.5.1 Service Delivery

The service delivery for GBV survivors includes accessibility, confidentiality, needs assessment, holistic support, trauma-informed care, coordination, referrals, empowerment, and advocacy to empower those affected by violence. These facilities simplify the process for

survivors by decreasing the need to navigate different services while providing complete care in a friendly setting.

4.5.1.1 Integrated services for GBV survivors

The participants indicated that the health sector in Ilala District has successfully provided integrated services to GBV survivors. GBV survivors found it easier to access integrated services at a one-stop GBV center, which included the availability of both HCWs and police gender desks at one facility. This reduced the stress of accessing services for GBV survivors because integrated services provided all services required by survivors at one facility, such as post-exposure prophylaxis, medical treatment, mental health treatment, forensic evidence collection, psychosocial guidance and counseling, referrals, and legal support. One participant demonstrated how the integration of services made them easily accessible and available in one place,

> "*We have succeeded in providing integrated or one-stop services, meaning that when a person dealing with violence comes to the center, they encounter all the available services in one place. There are social welfare officers who provide guidance and direction in office number one; there is office number two, which is for doctors and nurses; and there is a police officer who is in this room where you and I are sitting. So, all the services are together to ensure that the survivor of GBV does not struggle to access the services"* (Interview Participant No. 05).

The participants also found that a steady supply of essential medical equipment and drugs has enhanced the provision of timely, quality care and support to GBV survivors, such as speculums and post-exposure prophylaxis, as part of integrated services. One study participant reported that:

> *"We are grateful to the government for the funding that it provides in the procurement of medicines and medical equipment for our clients, including GBV survivors, because availability is approximately 98% to 99%"*(Interview Participant No. 07).

Similarly, it was observed that the services for GBV survivors were consolidated, making it easier for survivors to access them while minimizing walking distance and bureaucracy. Through the establishment of a one-stop GBV center in the Ilala District, healthcare workers and police gender desks collaborated to provide necessary support and referrals to GBV survivors to access required services.

4.5.1.2 Unification and safety plan provisions for GBV survivors

The participants revealed that unification and safety plan provisions for GBV survivors have significantly aided the health sector in responding to GBV, such as through counseling. The safety plan offered to GBV survivors included relocating to safe camps, such as those for child survivors. One of the survivors' safety plans involved arresting the perpetrators in coordination with the police gender desk, social welfare officials, and parasocial groups. It would be a challenge if GBV was committed by family members and the survivors returned to the site where the GBV was committed, and in such circumstances, there is a loophole for perpetrators to be granted bail. Unification of GBV survivors with their families is one of the responses of the health sector in Ilala district to GBV. Survivors who were violated at the time they visited health facilities executed the function of bringing GBV survivors together with their families in order to remove them from the place where GBV occurred, but this depends upon the assessment done by the officer concerned.

Health education on safety for survivors was provided, ensuring they avoid returning to places where GBV occurred if possible.

> *"I can say that health education on safety for survivors was provided. We create a safety plan for the survivors by ensuring a safe environment upon their return home. We also offered services tailored to the challenges faced, such as rape treatment for the survivors upon their return to the health facility"* (Interview participant No. 13).

The survivor aged 19 reported that the healthcare provider offered hope and tips on how to respond to GBV cases.

> *"After being violated, I had given up hope, but the care provided here at the hospital assisted me maintain my anonymity and prepared me to face any act of GBV"* (Interview participant No. 11).

A young girl reported receiving treatment at a facility and later assisted her family in reunifying to ensure her safety and removal from the area where GBV occurred.

> *"A domestic worker was found to have been sexually violated by the perpetrator, leading to her pregnancy. After she visited our facility, services were provided to help her, and she was then reunited with her family"* (Interview participant No.09).

Furthermore, it was observed that GBV survivors at the facility were provided with a safety plan and unification if they did not have GBV within their family.

4.5.2 Financing

Financing involves healthcare financing mechanisms for the treatment of GBV survivors, distributing funds for prevention, intervention, and support initiatives, such as public awareness campaigns, in order to effectively reduce and combat GBV.

4.5.2.1 GBV survivors were granted healthcare services through an exemption

The participants revealed that the Ilala District health sector has implemented an exemption strategy for GBV survivors, prioritizing their access to integrated services and ensuring that no survivors lack services due to financial difficulties. Also, the study participants reported that no GBV survivors face financial difficulties in accessing services, and nearly 90% of their health services are exempt. Exemption services have increased the chance for survivors to seek and access services without financial barriers.

The study participants, through interviews and FDGs, reported the use of exemptions for GBV survivors to access healthcare services, including registration, tests, and medicines.

> *"It is well known that when a GBV survivor comes here, almost 90% of their services are required to be exempted if they do not have the means"* (Interview participant No.10).
> "*All the people who visit our facility who are subjected to GBV are tested for free; they are given an exemption from registration; all the tests are done for free, as are medicines if required"* (FGD2: Participant No. 3).

It was observed that the provision of health services to GBV survivors was not restricted to exemptions; rather, health insurance and out-of-pocket expenses were used, and if GBV survivors did not have health insurance, an exemption was applied. For the stockout of medicines, the survivor was approached to share the cost, and if he or she did not have it, an officer reported it to management for assistance or mobilization of funds inside the facility to fill the stockout.

4.5.3 Health workforce training

The study participants indicated that health workforce training in GBV response is critical for HCWs to provide thorough, sensitive care, promote prevention, and address GBV's underlying causes.

4.5.3.1 The availability of HCWs who are trained to respond to GBV

The participants found that health facilities are training HCWs to provide integrated services to survivors, managing GBV-related cases through medical, mental health, psychosocial guidance, counselling, referrals, and legal assistance. The health sector in Ilala district's response to GBV is indicated by the presence of trained workers in visited health facilities. There are also some experienced health workers who devote themselves to dealing with GBV cases. FGDs and interviews reveal that HCWs, facility leaders, police gender desk officers, and district GBV focal persons are trained to provide thorough, sensitive care, promote prevention, and address GBV's underlying causes. The study participant mentioned that some individuals are trained and others are on-the-job to provide initial services to GBV survivors,

> *"For us, there are about three or four who have received the training to serve them, but the rest of us continue to receive on-the-job training, and we have a timetable of training every Thursday.... If a survivor of GBV visits the health facility at night, he or she will be given initial services, and if more services are required, a doctor will be called to come and provide services, as well as a social welfare officer to complete the procedures for providing services"* (Interview participant No. 08).

And also, another participant added that healthcare workers were trained before the opening of one GBV Stop Center,

> "*We know that you cannot start a service if the service provider has not received training, so we provided training to one GBV stop center in the Ilala district, where they all received the full package training. Others also continue to do so"* (Interview participant No. 13).

On top of that, it was indicated that the training was conducted for different groups on matters related to GBV,

> "*Every week, we go to different areas to educate people about GBV, such as schools and other groups"* (Interview participant No. 14).

Likewise, the other participant indicated the duration of a previous training was conducted which was a year with different participants,

> *"The last time they received training was a year ago. Doctors, police, and magistrates came here, but after that there was no training. However, those who attended the training provided feedback to the health facility, and in street and ward meetings, the facility sent representatives to deliver health education and promotion in response to GBV"* (FGD1: Participant No. 1).

4.5.4 Health information Systems

Health information systems significantly contribute to responding to GBV by facilitating the collection, preservation, and utilization of data to improve services and outcomes.

4.5.4.1 The presence of a health information system to record GBV-related cases

According to research participants, the Ilala District's health sector has created a digital health information system for reporting and recording survivors' data. The health information systems used by the health facilities visited were GoTHOMIS, HMIS and DHIS2, with GBV and VAC reported using the systems. GBV cases in Ilala were collected by self-reporting and the use of screen tools, which aided in their detection. In addition, the screen tool was used to collect, assess, and evaluate GBV survivors' information, such as their name, age, gender, contact information, residence, and type of violence.

The study utilized a health information system, utilizing both computerized and handwritten methods, to gather data on GBV survivors as reported,

> *"We use GoTHOMIS because we create the report and enter it into the system, but we also record the facts and findings we discover. The system serves as a backup; if the original handwritten document is lost, GoTHOMIS can provide the required facts and information for GBV survivors"* (FGD1: Participant No. 6). "*Our services are fully computerized, and GBV survivors are recorded in the HMIS system*" (Interview participant No. 12).

Furthermore, several of the FGD participants remarked that they could compare the GBV statistics on the dashboard to different types of GBV.

> *"In our hospital system, there is information about GBV on the dashboard. When you open it, it is possible for a registered patient to detect any form of violence, including rape, physical abuse, or emotional abuse"* (FGD2: Participant 1).

It was observed that GBV cases were recorded in both health information management systems and handwriting. Reports and GBV minutes were printed, along with several initiatives designed to address GBV in the Ilala district.

4.5.5 Coordination, and community engagement

The health sector's response to GBV relies heavily on coordination and community engagement. The task involves coordinating efforts across various sectors and involving local communities in prevention and response initiatives. These efforts guarantee that survivors have access to essential services and assistance.

4.5.5.1 The formation of para-social groups was initiated as a response to GBV

The participants revealed that para-social groups have significantly aided the health sector in responding to GBV by serving as referrals, identifying scenarios, promoting health education, and conducting outreach. MTAKUWA and SMAUJATA are parasocial groups and community-owned NGOs formulated to respond to GBV by taking crucial steps. As one participant reported,

> "*We collaborate since **SMAUJATA** operates at the district, regional, and national levels. So, whoever recognizes [a case] at the lower level, possibly **SMAUJATA**, is at the very bottom level. This means that after they have identified those cases, they will work with the proper police to intervene in that case so that it may be acted upon"* (Interview Participant No. 01).

Furthermore, the study discovered that community members took the initiative to respond to GBV alongside other stakeholders (health sector and police) by utilizing existing structures such as street forums and wards. One participant stated,

> *"It is the citizen groups that were formed that are attempting to respond to GBV by raising awareness" (*FGD3: Participant No. 2*).* Also*, "our desk is taking part in commemorating 16 days of GBV activism, participating in community activities, and*

encouraging community members to fully engage in responding to GBV. Then, when GBV occurs, the community should not hide" (Interview participant No. 14).

Likewise, it was observed that there was the presence of a para-social group named MTAKUWA at one of the visited facilities, which is volunteering and prepared to go on outreach and participate in the daily provision of health education and promotion on the subject of GBV.

4.5.6 Leadership and Governance

Leadership and governance play a crucial role in the health sector's response to GBV. Effective leadership and governance ensure that policies and programs addressing GBV are well-designed, implemented, and monitored.

4.5.6.1 Presence of GBV focal persons

It was observed that, GBV focal persons are present in both Council Health Management Teams and Health Facility Management Teams, demonstrating the health sector's response to GBV, including technical and managerial teams. At the Council level, this focal person is both a member of the technical and management teams that designed, implemented, and monitored daily ant GBV interventions within the Council.

At the facility level, a focal person and clinics like HIV/AIDS Care and Treatment Services are available. The GBV facility focal person is a member of the health facility management team but not the board that governs the facility, even though their presence in the management team indicates how the health sector responds to GBV.

4.5.7 Health infrastructure

Health infrastructure, including hospitals, clinics, and specialized centers, is crucial in responding to GBV and providing comprehensive care with adequate medical equipment, trained healthcare providers, and efficient data management systems. In Ilala District's health

sector, it was observed that it effectively responds to GBV through various infrastructure, government-funded HCWs, medical equipment, and systems that support anti-GBV interventions.

4.6 The health sector faced challenges in dealing with GBV.

The health sector is facing challenges in responding to GBV in Ilala District, with seven themes identified: awareness creation among community members; limited space; the shortage of HCWs with forensic science training; the limited choice of health services; limited funds; and a fear among community members of reporting information, which are presented within the seven components of WHO health system frameworks as used in this study. These themes form sub-headings in the sections that follow.

4.6.1 Service Delivery

4.6.1.1 Lack of awareness creation among community members on GBV

Ilala District's health sector responds to GBV, but awareness of One GBV Stop Centers program activities, brochures, and flyers explaining GBV in both communities and health facilities remains lacking.

> *"The first time I was sexually violated by family members, I did not get any help because I was unfamiliar with who to tell, and when my friend sexually violated me, I sought help. That is why I came here for health checks. When I arrived and began the registration process, I was told that I could receive health services with an exemption. "That is why I am here"* (Interview participant No. 04).

A male community member living close to one GBV stop center reported being unaware of the services offered to GBV survivors, and this implies limited awareness creation. As a result, the community may not utilize the services offered and may find responding to GBV difficult.

> *"I became aware of the services accessible to GBV survivors when my relative was subjected to GBV; however, without that case, I would not have noticed the services provided to GBV survivors at our health center"* (FGD5: Participant No. 6).

Also, a female community member living near one GBV stop center reported that she has knowledge of the availability of gender desks but to what extent services offered are limited.

> *"Only gender desks are available in the hospital"* (FGD6: Participant No. 2).

In the FGD and Interview, it was reported that in the community, there were no posters related to awareness creation on GBV education, but it was believed that education was being provided only at hospitals and not in the street. This is also an indication of a lack of awareness creation, which can undermine the efforts of the health sector to respond to GBV.

> *"We are unaware if there is such a center, and we have never seen any kind of poster on the streets. It is also critical that education continue to be taken to the streets rather than only hospitals"* (FGD 4: Participant No. 1). One more participant reported that, *"Another challenge the health sector is facing in Ilala district is a lack of posters, brochures, and flyers explaining GBV at health facilities and within the community*" (Interview participant No. 13).

The interview revealed a lack of guidance for GBV survivors on reporting procedures, potentially causing challenges in responding to such incidents.

> *"As we all know, there is no guide that tells where a survivor of violence should begin. Survivors of violence can seek help from the police, a hospital, or social services, depending on their area"* (Interview participant No. 13).

It was observed that no posters, brochures, or flyers were displayed in community and health facilities to explain GBV, which can cause limited awareness creation among community members as a result of the challenge to respond to GBV.

4.6.1.2 Limited choice of health services for GBV survivors

The study participants reported on the limited choice of services for GBV survivors in Ilala district due to the limited number of one-stop GBV centers confined to only public health facilities, which presents significant challenges in providing integrated services to survivors with only two centers. The study participants revealed that, at present, private health facilities lack GBV stop centers, and only government health facilities fill PF3, which can undermine the response due to limited choices of services.

> *"Ilala district has only two government-owned GBV stop centers out of over 43 more health facilities, making it challenging for survivors to access necessary assistance. There is a need to increase the number of other centers to reach the community, considering that violence is still a major problem in the community and acts of violence continue to increase day by day"* (Interview participant No. 13).

It was also reported how challenging it would be for a place where one GBV stop center is not available to make a bureaucracy walk together with a survivor so as to complete the procedures at government health facilities.

> *"If there is no GBV stop center in the area, police gender desks work with survivors to ensure that they exclusively visit government-owned health facilities, not private-owned ones, to complete the filling of PF3, as indicated in the procedure"* (Interview participant No. 14).

4.6.2 Health infrastructure

4.6.2.1 The dedicated rooms for providing healthcare services to GBV survivors are limited in space.

The study participants noted that all of the GBV stop facilities visited had small rooms and restricted space, which contributed to survivors', to some extent, lack of anonymity and confidentiality.The study participants reported that even when a GBV survivor enters the

dedicated room at one GBV stop center, everyone nearby knows that they have experienced violence.

The study participants also found that survivors are sometimes uncomfortable or feel frightened sharing their experiences in crowded or confined spaces, and that inadequate privacy can lead to increased victimization and stigma for GBV survivors. In addition, survivors may feel exposed, judged, and ashamed, hence discouraging them from disclosing their experience in the future, which undermines the health sector's response to GBV.

It was reported that GBV survivors are mixing with other patients to some extent, which can challenge the health sector to respond to GBV because of privacy and confidentiality concerns.

> *"Our hospital infrastructure is facing difficulties in providing health services to GBV survivors, who often mix with other patients. A special building could provide a space for long-term interaction and better information gathering for GBV survivors. However, waiting in lines for the same patient makes it difficult to communicate and provide better support to the GBV survivor"* (Interview participant No. 03). Also, it was reported that *"in the doctor's room, there is confidentiality. One-GBV Stop Center faces the challenge of maintaining confidentiality due to the limited space as the institution grows. The GBV survivor can be uncomfortable with so much human movement"* (FGD1: Participant 1).

A GBV stop center uses a container office with limited space and dignity, potentially endangering survivor rights and making reporting cases challenging.

> *"Our container-one GBV stop center faces challenges in providing dignity services to survivors due to limited space, especially when dealing with a large number of survivors"* (Interview participant No. 12).

It has been noticed that health facilities with designated rooms for One GBV Stop Centers encounter difficulties in offering integrated services because of the limited space, forcing

survivors to relocate, generating extra stress and communication problems that challenge the health sector's response to GBV.

4.6.3 Health workforce training

4.6.3.1 The shortage of healthcare workers with forensic science training

The study participants indicates that while the Ilala District health sector has made progress in integrating GBV services for survivors, a shortage of specialized forensic science-trained HCWs hinders its provision of the services required. The study participants added that they have gone more than three years without being given any internal or external training. They reported relying solely on their past education and experience to serve GBV survivors.

The health sector faces challenges in obtaining risky evidence for decision-making due to a shortage of trained healthcare workers in collecting forensic evidence.

> "*In our district, there are still gaps in the number of healthcare workers trained to collect forensic evidence, the* other *challenge lies in obtaining risky evidence, which is not feasible due to the limitations of healthcare workers' ability to gather such evidence. Despite relying on PF3 alone, some cases require risk evidence for a person's rights, which may hinder progress*" (Interview participant No. 13). "*We are facing a significant shortage of healthcare workers, with many trained workers moving to other facilities after long periods of training we conducted to handle GBV cases"* (Interview participant No. 12).

Study participants reported the challenge of training health workers to handle forensic science evidence and a shortage of healthcare workers, which undermined the effort to respond to GBV.

> *"Training in forensic evidence science remains challenging. I have found myself liking handling GBV cases, and I am doing better than those who go to seminars, but training is important in handling complex cases like those that require forensic science evidence collection"* (FGD2: Participant 6). Additionally, it was reported in the discussion,

"here at our facility, we have a healthcare worker shortage. About 10 workers received training, but until now, seven of them have gone to different hospitals, so that's a challenge" (FGD1: Participant 1).

4.6.4 Financing

4.6.4.1 Limited funds exist to finance GBV initiatives.

The participants found that there are limited funds available to fund GBV initiatives and challenges in obtaining exemptions for health services for survivors, particularly for continuity of care. Limited funding is causing challenges in the health sector's response to GBV, including inadequate training, limited GBV-stop center services, and data collection. Public awareness campaigns, support services to GBV survivors, including unification and safety plans, and referral systems.

The budget is limited, causing challenges in implementing anti-GBV activities like awareness creation and services for survivors due to the need to respond to GBV.

"If I say we have a special budget for GBV, I will be lying, citing previous NGOs' support but maintaining that management treatment items are available without any challenges" (Interview participant No. 12). On the other hand, from other health facilities, it was reported that:*"In the fiscal year 2023-2024, 1,000,000 Tanzanian shillings were set aside for promotion of anti-GBV and 800,000 shillings for survivor assistance. Despite limited spending on GBV interventions, two incidents allowed for transport to regional areas, with a recent officer transporting a survivor of sexual violence to Mwanza"* (Interview participant No.10).

The study participants discovered that the budget for running a desk was not set but rather based on the concept note submitted to various partners, which undermines the implementation of anti-GBV activities such as awareness creation and unification of survivors and safety plans.

"There is no designated budget for GBV initiatives, but various concept notes are being developed to secure funding for various GBV initiatives, the financial challenge lies in providing coverage to victims who are located far from the center or in poor conditions" (Interview participant No.14). It was also reported that *"I have not seen the budget, but it is part of training in the social welfare unit, which deals with various activities for societal welfare, including GBV"* (FGD2: Participant No. 5).

4.6.4.2 Exemption health financing strategy challenge

The provision of health services through exemption as part of health financing for GBV survivors was reported to have some challenges that undermined their ability to fully utilize services and ensure continuity of care.

"The exemption system does not work properly when initial survivors receive treatment, and then another day is required for cost sharing to ensure continuity of care" (Interview participant No.14).

4.6.5 Coordination, and community engagement

4.6.5.1 The fear among community members of reporting information about GBV

The participants found that there was a fear among community members of reporting information about GBV, which challenges the health sector to respond to GBV through coordination and community engagement, which can be caused by a lack of awareness creation and the fear of the unknown in case the perperuator is one of the family members.

"The first time I was sexually violated by family members, I did not get any help because I was unfamiliar with who to tell, and when my friend sexually violated me, I sought help" (Interview participant No. 04). *"Sometimes not showing up in court to testify and causing the case not to continue, as well as the cruelty committed by a relative, is a challenge to disclosing information"* (Interview participant No.14).

Fear among community members about reporting GBV is causing concern among family, relatives, and the community, making it challenging to respond using an integrated approach.

> *"Society and parents face challenges, including the shame of sharing personal issues in public. Reporting issues can aid survivors, while hiding them can hinder their growth"* (FGD3: Participant No. 2). In addition, *"the fear of exposing those who have experienced GBV and those who do has led to a lack of transparency about the issues the community faces"* (FGD6: Participant No. 3).

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

This chapter presents a discussion of key findings, placing them in a broader context of existing knowledge on GBV and its implications for the public health burden, which calls for tensions. The study has conceptually emphasized the guidelines that have an impact on the GBV response, as well as the achievements and challenges that the health sector encounters in responding. The discussion is centred on these specific areas of study.

5.2 Achievements in responding to GBV

The achievements of the health sector response to GBV resulting from the key findings of the study are presented as per the components of the WHO health system framework used in this study.

5.2.1 Service Delivery

5.2.1.1 Integrated services for GBV survivors

The study found that in Ilala district, GBV survivors received integrated services at a one-GBV stop center, which reduced walking distance and bureaucracy in accessing services by having both healthcare workers and police gender desks at one center. Integrated Services, it comprises post-exposure prophylaxis, medical treatment, mental health treatment, forensic evidence gathering, psychological advice and counselling, referrals, legal assistance, and frequent screenings. The presence of integrated services decreases stress and trauma while also ensuring life-saving safety, well-being, and an overall support system, which speeds up access to crucial services and improves response effectiveness. The study aligns with Sri Lanka's Mithuru Piyasa center for GBV survivors, where survivors are referred to the police desk, while Tanzania's center is staffed by police (34). Three studies in Morocco, South Africa, and Arusha, Tanzania, are in agreement with the study result by effectively utilizing the "Tamkine" strategy and one

GBV-stop center to provide integrated services to GBV survivors, demonstrating the importance of public-private collaboration (36,24).

5.2.1.2 Unification and safety plan provisions for GBV survivors

The study revealed health sector in Ilala achieved to provided unification and safety plan provision for GBV survivors which entail developing a coordinated and secure strategy to safeguard and support people who have experienced GBV. A safety plan is a tailored, practical plan that assists survivors in staying safe while in a violent relationship, intending to leave, or after leaving. It entails procedures such as locating safe areas (camps), establishing a support network, and preparing necessary supplies. These measures attempt to empower survivors, decrease danger, and establish a clear path to safety and healing, which aided the health sector's response to GBV. The study allign with a Bhutanese study from 2015–2016, where survivors of GBV were provided with a safety plan to address the issue (9). The study differs from a similar study in five countries: Nepal, Brazil, Bangladesh, Sri Lanka, and Rwanda, due to healthcare challenges like provider insensitivity, re-traumatization, and victim blaming that result in forced return to abuse locations (7,34).

5.2.2 Financing

5.2.2.1 GBV survivors were granted healthcare services through an exemption

The study found that a significant number of GBV survivors access integrated services through dominant exemption strategy that prioritizes their access to integrated services and ensures that no survivors lack services due to financial difficulties. Exemption strategies included registration, consultation, medical treatment, psychosocial support, counselling tests, and medicines if required, which increased the chance for survivors to seek and access services without financial barriers. The study aligns with Ethiopia's 2022 study and South Africa's 2014 study, which updated circulars to exempt costs for GBV response services, provide job aids, and establish confidential registration and reporting mechanisms (37). A study in five countries,

including Sri Lanka, did not fully align with results in countries where GBV survivors were dominated by the use of universal health coverage in public health facilities (34).

5.2.3 Health workforce training

5.2.3.1 The availability of healthcare workers who are trained to respond to GBV

The availability of healthcare providers educated to respond to GBV is critical for survivors to receive comprehensive and compassionate care and is one of the indicators of the health sector's response to GBV. Healthcare workers identify and treat GBV symptoms, providing medical and psychological care, referring patients to resources, significantly enhancing recovery, preventing injuries, and promoting individual and community well-being. The study, inline with a study in Afghanistan, revealed that healthcare workers are frequently trained and are the first responders to GBV-related injuries (35). Nepal's Health Workers Training programs improve the competence and skills required by the 2016 One Stop Center Operational Guidelines by appointing a minimum of 1 medical doctor and 2–3 staff nurses at one-stop centers to provide 24-hour service availability, identify survivors and doctors, and report medico-legal cases (7). In addition, a study conducted in South Africa is in line with the study that complete health services were successfully integrated, with healthcare workers being trained to identify GBV survivors, build a strong support network, and promote smooth referral pathways (37).

5.2.4 Health information Systems

5.2.4.1 The presence of a health information system to record GBV-related cases which a foundation from the

The Ilala district health sector has implemented a health information system to record GBV-related cases, facilitating easier self-reporting and data assessment, thereby enabling more effective interventions for survivors and facilities. Health information systems allow healthcare providers to routinely document cases of GBV, ensuring that data is reliably captured and securely preserved. This data is critical for monitoring trends, identifying at-risk populations, and assessing the efficacy of treatments. Improved data collection can lead to more effective

resource allocation, policy creation, and assistance for GBV survivors. This study is in line with the study conducted in both Rwanda and Nepal, which are the two countries reporting GBV data through the health information system (7). In addition, Brazil reports on GBV at sub-national levels, Bangladesh plans a nationalized database, and Sri Lanka lacks medico-legal case data or reports through a health management information system (34).

5.2.5 Coordination, and community engagement

5.2.5.1 The formation of para-social groups was initiated as a response to GBV

The health sector's response to GBV is a result of coordinated efforts across sectors and community engagement, ensuring survivors have access to essential services and assistance. MTAKUWA and SMAUJATA, community-owned NGOs, are forming parasocial groups to respond to GBV by serving as referrals, identifying scenarios, promoting health education, and conducting outreach. The study aligns with Finland's and Morocco's strategies for GBV survivors, involving CSOs, NGOs, and Tamkine, offering linkage support to GBV survivors, including support to address poverty, outreach services, and legal, psychological, social, and economic support (28,36).

5.2.6 Leadership and Governance

5.2.6.1 Presence of GBV focal persons

The study found that there is a leadership and governance structure to support the health sector response to GBV, such as policies, guidelines, health facility management committees, and coordination teams that stipulate the roles and responsibilities of each. The presence of the GBV focal persons is a key indicator of the health sector response to GBV because they are the ones who designed, implemented, and monitored daily anti-GBV interventions within their locations. The Tanzanian document, titled National Policy Guideline 2011, Management Guidelines for Health Sector Prevention and Response to GBV 2011, and National Plan of Action 2017–2018–2021–22, outlines the roles of the Ministry of Health, other ministries, agencies, and the community in GBV. The study, in collaboration with five other countries, examines leadership

and governance responses to GBV interventions in Nepal, Brazil, Bangladesh, Sri Lanka, and Rwanda through clear policy roles and responsibilities (7,34).

5.3 Challenges in dealing with GBV

The challenges of the health sector response to GBV resulting from the key findings of the study are presented as per the components of the WHO health system framework used in this study.

5.3.1 Service Delivery

5.3.1.1 Lack of awareness creation among community members on GBV

The study found that while the health sector in Ilala district has made key progress in responding to GBV, community members still lack awareness about GBV services and access mechanisms. This lack of awareness makes it challenging to effectively respond to GBV. The health sector faces challenges in responding to GBV due to a lack of awareness among survivors and community members about integrated services offered at one GBV stop center, which can cause the services to not be fully utilized. This study revealed that a lack of awareness creation among GBV survivors and community members is also documented in the existing Tanzanian guidelines to respond to GBV (4,30). The study differs from a Nepal study where 15% of one-stop centers were allocated for community-level awareness creation campaigns, providing full support services with trained staff nurses (34).

5.2.1.2 Limited choice of health services for GBV survivors

The study found that there is a limited choice of services for GBV survivors in Ilala district due to the limited number of one-stop GBV centers confined to only public health facilities, which presents significant challenges in providing integrated services to survivors with only two centers and only government health facilities filling PF3. The study aligns with a 2015-2016 Bhutan study, which revealed that only two referral hospitals are dedicated to integrating services for survivors, while all other facilities offer services (9). A Tanzanian study revealed

that privately owned clinics and health facilities are limited in their capacity to respond to cases of GBV due to their inability to finalize PF3 forms (51).

5.3.2 Health infrastructure

5.3.2.1 The dedicated rooms for providing healthcare services to GBV survivors are limited in space.

This study found that limited space in dedicated healthcare rooms for GBV survivors poses challenges to quality care, privacy, comfort, and patient capacity, potentially limiting the number of patients who can be seen simultaneously. Also, One GBV Stop Centers hinder integrated services due to limited space, causing survivors to relocate, causing stress, and causing communication issues, challenging the health sector's response. This study is in agreement with the study conducted in Bhutan, Brazil, Bangladesh, Sri Lanka, and Rwanda, which resulted in a health infrastructure challenge with limited space, which jeopardized the privacy of survivors (7,9). According to a similar study conducted in Nepal, more than 80% of the health infrastructure operated with adequate space and equipment or supplies to handle GBV cases.

5.3.2.2 Inadequate forensic kits

This study also found that forensic kits are inadequate, which is one of the challenges of responding to GBV in Ilala District. Forensic kits are essential for medical, legal, and investigative needs. Inadequate recording may jeopardize gathering proof, impede justice, and deter survivors from seeking treatment (42-43).The study, similar to others in Bangladesh, Iraq, Kenya, and northeast Nigeria, suggests that of survivor data lacks swabs or HIV results, hindering high-quality care and evidence (42-43).

5.3.3 Health workforce training

5.3.3.1 The shortage of healthcare workers with forensic science training

The health sector in Ilala district has made progress in integrating GBV services for survivors, but a shortage of specialized forensic science-trained healthcare workers challenges the provision of the services required. This study is in agreement with the study conducted in Kenya and Ethiopia, where a shortage of healthcare workers, inadequate training, challenges their ability to provide necessary care due to inadequate infrastructure and inadequate budgetary allocations (45,48-50). Also, this study is in line with a study done in Dodoma Region in Tanzania in 2021, which found that "*HCWs who were not trained were less likely to adhere to GBV screening practices*"(57).

5.3.4 Financing

5.3.4.1 Limited funds exist to finance GBV initiatives.

The study found that there are limited funds available to fund GBV initiatives for survivors, particularly for continuity of care. Also, limited funds were documented in the reviewed document and primary data, impacting awareness campaign activities and providing necessary services to survivors. This study is in collaboration with the study conducted in Kenya, in which limited funds were provided to challenge anti-GBV initiatives such as training of healthcare workers and other support for GBV survivors (48,49). This study, to some extent, differs from this study in Spain, which allocated one billion euros over five years to combat violence against women, while a study in Nepal allocated 15% of one-stop centers for community-level awareness campaigns (27,34).

5.3.4.2 Exemption health financing strategy challenge

Ilala district's health sector has made significant strides in integrating GBV services for survivors through the use of dominant exemptions. The provision of health services through exemption as part of health financing for GBV survivors was reported to have some challenges

that undermined their ability to fully utilize services and ensure continuity of care, as in line with the study in Ethiopia's 2022 and South Africa's 2014 (37).

5.3.5 Coordination, and community engagement

5.3.5.1 The fear among community members of reporting information about GBV

The study found that community members feared reporting information about GBV, which challenges the health sector to respond to GBV through coordination and community engagement. Fear of reporting GBV impedes efforts to confront and prevent it, frequently due to security concerns, societal judgments, and the possibility of revenge. Cultural norms and silence significantly limit survivors' access to support services and justice attempts Also, fear among community members of reporting information about GBV can be caused by a lack of awareness and a fear of the unknown if the perpetrator is a family member. The study aligns with research in Somalia and South Sudan, revealing heightened fear of reporting violence and stigma among survivors and community members, thereby reducing their healthcare utilization (47).

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In conclusion, the study highlights the health sector's response to GBV in which achieved include integrated services for GBV survivors, unification and safety plan provisions, exemptions for healthcare services, trained HCWs, a health information system, parasocial groups, GBV focal persons, and health infrastructure. The health sector faces challenges in responding to GBV due to the one GBV stop center services not being effectively communicated to the community members, limited services, space, shortage of forensic science-trained HCWs, limited funds, and fear of reporting information. The health sector's response to GBV is critical for attaining SDGs 3 and 5, which promote healthy lives and gender equality, respectively. Effective responses include medical care, mental health assistance, and safe referral networks, which reduce the effects of violence and empower GBV survivors. Not responding to GBV impacts survivors' health, dignity, security, and autonomy, leading to GDP loss and hindering progress towards equality, development, and peace.

6.2 Recommendations

Based on the study results, the following are recommended:

6.2.1 Service delivery

1. The government, through Ilala District, should expand the number of One GBV Stop Centers to ensure full capacity and diverse GBV services, including capacitating the centers with the necessary resources.
2. The government, through Ilala District, should increase awareness creation among community members about the availability of GBV One Stop Centers and their services to survivors by providing health education and promotion through posters, brochures, and flyers.

3. The Ministry of Health and the Police Force should amend police general orders to permit privately owned health facilities to record medical evidence of physical violence, including completing the PF.3.

6.2.2 Financing

4. The government, through Ilala District, should ensure the setting of percentages of funds to finance GBV interventions in the Comprehensive Council Health Planning (CCHP) and Comprehensive Hospital Operational Plan (CHOP), including the provision of health services and other support to GBV survivors.
5. The MOH recommended speeding up the finalization process of universal health coverage, which will help reduce the challenge and inconvenience of getting health services for survivors by using exemptions.

6.2.3 Health workforce training

6. The government, through Ilala District, should ensure the availability of enough trained health workers to deal with forensic evidence and also provide forensic kits, as well as allocate dedicated standard rooms for GBV survivors.

6.2.4 Coordination and community engagement

7. The community should take measures to respond to GBV by ensuring that GBV perpetrators are reported and providing support to GBV survivors in reporting GBV information.

6.2.5 Area for further research

8. The findings call for researchers to conduct detailed quantitative and qualitative research that would assess the health sector's response to GBV, including the impact of community-based interventions in engaging communities to address GBV.

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8.0 APPENDICES

Investigation tools

8.1 Appendix 1: Interview Guide for Survivors of GBV

Interview Setting**.....**……. Interview Number**.....**……

Date…… Start time…… End time…….....

1. Demographics Data about participants

Sex…….…...Age…….……Education level ……...…….....

Marital status……... Occupation……...……Religion.....

2. What do you understand about GBV?

3. What kind of GBV have you ever been subjected to?
4. And after being violated, did you seek any help?

5. Who was the perpertuator?

6. In your experience, what are the achievements attained in the health sector in response to GBV in Tanzania?

    i. Probe on the services delivery
    ii. Probe on referral system
    iii. Probe on the perception of the health care providers
    iv. Probe on the discrimination and fear
    v. Probe on buildings, medicine and equipment
    vi. Probe on the confidentiality
    vii. Probe on provision of education on GBV
    viii. Probe on financial issues
    ix. Involvement of family and neighbors and community engagement

7. What are the challenges facing health sector in response to GBV in Tanzania?
    i. Probe on the services delivery
    ii. Probe on referral system
    iii. Probe on the perception of the health care providers
    iv. Probe on the discrimination and fear
    v. Probe on buildings, medicine and equipment
    vi. Probe on the confidentiality
    vii. Probe on provision of education on GBV
    viii. Probe on financial issues
    ix. Involvement of family and neighbors and community engagement

8.2 Kiambatisho 2: Mwongozo wa Mahojiano kwa Waathirika wa Ukatili wa Kijinsia

Mahali…….……Nambari ya Mahojiano……

Tarehe……Muda wa kuanza……Mwisho…….....

1. Taarifa za mshiriki

Jinsi……...…...Umri……..…Kiwango cha Elimu ……..…Dini: .....Hali ya ndoa……. Kazi…….……

2. Unaelewa nini kuhusiana na ukatili wa kijinsia?
3. Je, umewahi kufanyiwa ukatili wa aina gani wa kijinsia?
4. Na baada ya kufanyiwa ukatili huo ulitafuta msaada wowote?
5. Je ukatili huo ulifanywa na nani?
6. Kwa uzoefu wako**,** Je ni yapi Mafanikio ya mipango ya Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania?
    i. Dadisi juu ya utoaji wa huduma
    ii. ii. Dadisi juu ya upatikanaji wa rufaa
    iii. Dadisi juu ya mitazamo ya watoa huduma
    iv. Dadisi juu ya unyanyapaa na hofu
    v. Dadisi juu ya uwepo wa majengo, vifaa tiba na dawa
    vi. Dadisi juu ya usiri
    vii. Dadisi juu ya utoaji wa elimu kuhusu ukatili wa kijinsia
    viii. Dadisi juu ya rasilimali fedha
    ix. Dadisi juu ya ushiriki wa familia na
7. Je unahisi kuna changamoto zozote zinazoikabili Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania?
    i. Dadisi juu ya utoaji wa huduma
    ii. Dadisi juu ya upatikanaji wa rufaa
    iii. Dadisi juu ya mitazamo ya watoa huduma

iv. Dadisi juu ya unyanyapaa na hofu
v. Dadisi juu ya uwepo wa majengo, vifaa tib ana dawa
vi. Dadisi juu ya usiri
vii. Dadisi juu ya utoaji wa elimu kuhusu ukatili wa kijinsia
viii. Dadisi juu ya rasilimali fedha
ix. Dadisi juu ya ushiriki wa familia na jamii katika kukabili ukatili wa kijinsia

8.3 Appendix 3: Interview guide to district/facility leaders and police desk officers

Interview Setting……..……. Interview No……

Date…… Start time…… End time…….....

1. Demographic information about participants

Sex…...Age……Education level …….....Marital status……... position……..……Religion.....Working experience.....

2. What is the GBV situation in this area?
3. What method is used to identify survivors of GBV?
4. What kind of GBV is leading in this area?
5. What are the safety plans in place?
6. What are the achievements attained in health sector on response GBV in Tanzania?
    i. Probe on the services delivery
    ii. Probe on health infrastructure
    iii. Probe on workforce trainings
    iv. Probe on leadership and governance
    v. Probe on financing
    vi. Probe on coordination and community engagement
    vii. Probe on health information system
    viii. Probe the number of health care providers.

ix. Probe on the discrimination and fear

7. What are the challenges facing health sector in response GBV in Tanzania?

x. Probe on the services delivery

xi. Probe on health infrastructure

xii. Probe on workforce trainings

xiii. Probe on leadership and governance

xiv. Probe on financing

xv. Probe on coordination and community engagement

xvi. Probe on health information system

8.4 Kiambatisho 4: Mwongozo wa Mahojiano Viongozi wa hospitali/vituo na afisa polisi wa dawati la jinsia

Mahali…….……Nambari ya Mahojiano……

Tarehe……Muda wa kuanza……Mwisho…….....

1. Taarifa za mshiriki

Jinsi……...…...Umri……Kiwango cha Elimu ……..…Dini: .....

Hali ya ndoa……. Nafasi…… Uzoefu…….……

2. Hali ya ukatili wa kijinsia ipoje katika eneo hili?
3. Ni njia ipi mnatumia kuwabaini wahanga wa ukatili wa kijinsia?
4. Je ni ukatili wa aina gani unaongoza kwenye eneo hili?
5. Je kuna mpango wa kuhakikisha wahanga wa ukatili wa kijinsia?
6. Je ni yapi Mafanikio ya mipango ya Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania.
   i. Dadisi juu ya utoaji wa huduma
   ii. Dadisi juu ya miundo mbinu
   iii. Dadisi juu ya vifaa tib ana dawa
   iv. Dadisi juu ya utoaji wa mafunzo kwa watoa huduma
   v. Dadisi juu ya idadi ya watoa huduma
   vi. Dadisi juu ya unyanyapaa
   vii. Dadisi juu ya utoaji wa rufaa
   viii. Dadisi juu ya uongozi na utawala
   ix. Dadisi juu ya ushiriki wa jamii
   x. Dadisi juu ya mifumo ya Tehama

7. Changamoto zinazoikabili Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania
   i. Dadisi juu ya utoaji wa huduma
   ii. Dadisi juu ya miundo mbinu
   iii. Dadisi juu ya vifaa tiba na dawa

iv. Dadisi juu ya utoaji wa mafunzo kwa watoa huduma
v. Dadisi juu ya idadi ya watoa huduma
vi. Dadisi juu ya unyanyapaa
vii. Dadisi juu ya utoaji wa rufaa
viii. Dadisi juu ya uongozi na utawala
ix. Dadisi juu ya ushiriki wa jamii
x. Dadisi juu ya mifumo ya Tehama

8.5 Appendix 5: FGD guide for healthcare workers

Location……Date…….… Time discussion started……Time ended: .....Participants total: …… Women: ……Men: …… Education level…….

1. What are the achievements attained in health sector on response to GBV in Tanzania?

   i. Probe on the services delivery

   ii. Probe on health infrastructure

   iii. Probe on workforce trainings

   iv. Probe on leadership and governance

   v. Probe on financing

   vi. Probe on coordination and community engagement

   vii. Probe on health information system

2. What are the challenges facing health sector in response to GBV in Tanzania?

   i. Probe on the services delivery

   ii. Probe on health infrastructure

   iii. Probe on workforce trainings

   iv. Probe on leadership and governance

   v. Probe on financing

   vi. Probe on coordination and community engagement

   vii. Probe on health information system

8.6 Kiambatisho 6: Mwongozo wa Majadiliano kwa Watoa Huduma

Mahali…….……Idadi ya washiriki……Tarehe……...…Muda wa kuanza……Mwisho..... Wanaume.....wanawake..... Kiwango cha Elimu.....

1. Je ni yapi Mafanikio ya mipango ya Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania.
    i. Dadisi juu ya utoaji wa huduma
    ii. Dadisi juu ya miundo mbinu
    iii. Dadisi juu ya vifaa tib ana dawa
    iv. Dadisi juu ya utoaji wa mafunzo kwa watoa huduma
    v. Dadisi juu ya idadi ya watoa huduma
    vi. Dadisi juu ya unyanyapaa
    vii. Dadisi juu ya utoaji wa rufaa
    viii. Dadisi juu ya uongozi na utawala
    ix. Dadisi juu ya mifumo ya Tehama
2. Changamoto zinazoikabili Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania
    i. Dadisi juu ya utoaji wa huduma
    ii. Dadisi juu ya miundo mbinu
    iii. Dadisi juu ya vifaa tiba na dawa
    iv. Dadisi juu ya utoaji wa mafunzo kwa watoa huduma
    v. Dadisi juu ya idadi ya watoa huduma
    vi. Dadisi juu ya unyanyapaa
    vii. Dadisi juu ya utoaji wa rufaa
    viii. Dadisi juu ya uongozi na utawala
    ix. Dadisi juu ya ushiriki wa jamii
    x. Dadisi juu ya mifumo ya Tehama

8.7 Appendix 7: FGD guide for Community members

Interview Setting……..……. Interview No……
Date…… Start time…… End time…….....

1. Demographic information about participants

Sex…...Age……Education level …….....Marital status……...
position……..……Religion.....Working experience.....

2. What do you understand about GBV?
3. What is the GBV situation in this area?
4. What kind of GBV is leading in this area?
5. Do you know about integrated health services centers for GBV survivors?
6. In your experience, do you know the achievements attained in the health sector in response to GBV in Tanzania?
    i. Probe on the services delivery
    ii. Probe on health safety plan
    iii. Probe on community preparedness in training
    iv. Probe on leadership and governance
    v. Probe on financing
    vi. Probe on coordination and community engagement
    vii. Probe on referrals
    viii. Probe on the discrimination and fear
7. What are the challenges facing health sector in response GBV in Tanzania?
    i. Probe on the services delivery
    ii. Probe on health safety plan
    iii. Probe on community preparedness in training
    iv. Probe on leadership and governance
    v. Probe on financing
    vi. Probe on coordination and community engagement
    vii. Probe on referrals
    viii. Probe on the discrimination and fear

8.8 Kiambatisho 8: Mwongozo wa Majadiliano kwa Wanajamii

Mahali…….……Nambari ya Mahojiano……
Tarehe……Muda wa kuanza……Mwisho…….....

1. Taarifa za mshiriki

Jinsi……...…...Umri……..…Kiwango cha Elimu ……..…Dini: .....Hali ya ndoa……. Kazi…….……

2. Unaelewa nini kuhusiana na ukatili wa kijinsia?
3. Hali ya ukatili wa kijinsia ipoje katika eneo hili?
4. Ni aina gani ya ukatili wa kijinsia unaongoza?
5. Je mnafahamu vituo jumuishi kwa ajili ya kutoa huduma za Afya katika eneo lenu?
6. Kwa uzoefu wenu katika eneo hili mnahisi yapi mafanikio ya sekta ya afya katika kukabiliana na ukatili wa kijinsia?
    i. Hali ya utoaji wa huduma za afya
    ii. Mpango wa kuhakikisha usalama wa wahanga
    iii. Jamii ilivyoandaliwa kukabiliana na ukatili wa kijinsia
    iv. Uongozi na utawala
    v. Rasilimali fedha
    vi. Ushiriki wa jamii
    vii. Dadisi juu ya unyanyapaa
    viii. Dadisi juu ya utoaji wa rufaa
7. Changamoto zinazoikabili Sekta ya Afya katika kukabiliana na Ukatili wa Kijinsia nchini Tanzania
    i. Hali ya utoaji wa huduma za afya
    ii. Mpango wa kuhakikisha usalama wa wahanga
    iii. Jamii ilivyoandaliwa kukabiliana na ukatili wa kijinsia
    iv. Uongozi na utawala
    v. Rasilimali fedha
    vi. Ushiriki wa jamii
    vii. Dadisi juu ya unyanyapaa
    viii. Dadisi juu ya utoaji wa rufaa

8.9 Appendix 9: Checklist for Observation

No	Item	Description
1.	Privacy and Confidentiality	The room should be isolated from general patient spaces, soundproofed to prevent overhearing, and staff should follow strict confidentiality protocols to protect the survivor's name and information.
2.	Safety and Security	The room should be secure, accessible to employees but not visible to the public, and provide emergency communication with staff or security personnel if needed.
3.	Comfortable and Calming Environment	Comfortable Seating: chairs or couches that are comfortable for extended conversations.
4.	Essential medical and counseling supplies	Gloves, examination tables, and basic medical devices are all required for the initial assessment and care. Counselling materials include brochures, pamphlets, and publications on accessible services, legal rights, and coping skills.
5.	Trained Staff	Access to trained medical and mental health professionals on-call for handling GBV cases and staff training in trauma-informed care approaches are crucial.
6.	Accessibility	The room should be accessible to individuals with disabilities and provide language support through translators or multilingual staff if necessary.
7.	Information and Referral Systems	The system provides up-to-date information on local resources like shelters and legal aid, and a referral system to refer survivors to external services like long-term counselling or legal assistance.
8.	Documentation and Data Management	Secure documentation systems ensure privacy in records and visits, while data collection improves care and support by securely documenting services and maintaining confidentiality.
9.	Crisis Intervention and Support	The room should be equipped for immediate psychological first aid and crisis intervention, along with systems for scheduling follow-up appointments and providing ongoing support.

8.10 Appendix 10: Checklist for desk review

No	Item	Description
1.	Problem Identification and Definition	✓ Clarity of the Problem ✓ Importance of the Problem
2.	Policy Objectives and Goals	✓ Specificity ✓ Alignment ✓ Feasibility
3.	Policy Design and Alternatives	✓ Policy Instruments ✓ Alternatives Analysis ✓ Innovativeness
4.	Stakeholder Analysis	✓ Identification of Stakeholders ✓ Stakeholder Interests and Influence ✓ Inclusion and Participation.
5.	Implementation Analysis	✓ Implementation Plan ✓ Institutional Capacity
6.	Cost-Benefit and Cost-Effectiveness Analysis	✓ Cost Estimation ✓ Benefit Analysis ✓ Cost-Effectiveness
7.	Equity and Social Justice	✓ Equity Impact ✓ Distributive Effects ✓ Access and Inclusion
8.	Effectiveness and Impact	✓ Outcome Measurement ✓ Impact Evaluation ✓ Sustainability
9.	Adaptability and Flexibility	✓ Adaptability: Determine the policy's ability to respond to changing conditions, such as new evidence, technology advancements, or shifts in public opinion. ✓ Flexibility: Assess the policy's flexibility in resolving developing difficulties or emergencies.

10.	Monitoring and Evaluation	✓ Monitoring Systems ✓ Evaluation Framework ✓ Feedback Mechanisms
11.	Legal and Ethical Considerations	✓ Legal Compliance ✓ Ethical Considerations

8.11 Appendix 11: Informed consent form (English version)

Consent for participation in the study:

Consent form ID Number _____

Introduction

Salutations!

My given name is **Maxmillian Z. Kwangu**, and I am a student at Muhimbili University of Health and Allied Sciences. I would like to have a conversation with you on Tanzania's health sector's response to GBV.

Purpose of the Study: The purpose of this study is to collect information to explore Tanzania's health sector's response to GBV. Your willingness to participate will help collect data that will aid in the planning of various actions required to strengthen the health sector's response to GBV.

The term confidentiality or privacy: Confidentiality is maintained by ensuring that the information you provide in this study is not shared with any unauthorized third parties and remains secret. Any information on you will include a number rather than your name, and only the researcher will know what it is.

Participation: This study will involve your involvement in a detailed interview, and the facts are going to be recorded as well. An interview will last approximately 15 to 45 minutes. The subject may evacuate from the research study at any moment, regardless of the initial consent he or she provided at the outset, without pressure or humiliation.

Benefits: The information you will offer will assist in making evidence-based decisions and planning for the health sector's response to GBV.

Risks: We do not anticipate any risks in this study, but if you are asked some personal or private information by chance or that you are uncomfortable discussing during the interview, you have

the right not to answer any questions or participate in the interview if you believe the question(s) are too personal or make you uncomfortable.

Contact: If you have any inquiries concerning the study, kindly call my supervisor right away, particularly if you are concerned about your participant rights. Then you can also reach the Chair of the Senate's Research and Publications Committee, Dr. Nahya Masoud, Director, Research, Innovation, and Publications: P.O. Box 65001, Dar es Salaam; mobile number: +255 22 2152489/0302-6; email address: drp@muhas.ac.tz ; or Prof. Tumaini Nyamhanga (Supervisor): P.O. Box 65001, Dar es Salaam; phone number: +255713254000/+255620358351 or +255685211158; email address: tnyamhanga69@gmail.com

Agreement

Can I request your approval to proceed with the conversation?

Yes: ☐ No: ☐ Tick appropriate)

I ……. have read and thoroughly understood the contents of this form. My questions have been answered. I agree to participate in this study.

Signature of the participant ……. Date……..……

Researcher signature……... Date……

8.12 Kiambatisho 12: Fomu ya Kublai (Toleo la Kiswahili)

Idhini ya kushiriki katika utafiti:

Nambari ya kitambulisho cha fomu ya idhini_____

Salamu!

Jina langu ni **Maxmillian Z. Kwangu** kutoka Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili ninafanya utafiti unaolenga kutathmini mwitikio wa Sekta ya Afya dhidi ya Ukatili wa Kijinsia nchini Tanzania.

Dhumuni ya utafiti: Utafiti huu una dhumuni ya kukusanya taarifa za kutathmini mwitikio wa Sekta ya Afya dhidi ya Ukatili wa Kijinsia nchini Tanzania. Utayari wako wa kushiriki utasaidia kupata *data* ambayo itasaidia katika kupanga afua mbalimbali zinazohitajika ili kuboresha mwitikio wa Sekta ya Afya dhidi ya Ukatili wa Kijinsia.

Usiri wa taarifa: Usiri unahakikishwa kwa kuhakikisha kuwa maelezo unayotoa katika utafiti huu hayashirikiwi na wahusika wengine ambao hawajaidhinishwa bali yanawekwa faragha. Taarifa zozote kukuhusu zitakuwa na nambari badala ya jina lako, na mtafiti pekee ndiye atakayejua nambari yako ni ipi.

Ushiriki: Utafiti huu utahusisha ushiriki wako katika mahojiano ya kina ambapo utarekodiwa, na mahojiano yatachukua kama dakika 15 hadi 45. Kushiriki katika utafiti huu ni kwa hiari na unaweza kujitoa wakati wowote, bila kujali kibali cha awali ulichotoa mwanzoni na pia bila kushurutishwa au kudhalilishwa.

Faida: Taarifa utakazotoa zitasaidia kufanya maamuzi yenye msingi wa ushahidi na kupanga masuala yanayohusu mwitikio wa Sekta ya Afya dhidi ya Ukatili wa Kijinsia.

Madhara: Hakuna madhara yoyote ambayo tunayategemea katika tafiti hii lakini iwapo unaweza kuulizwa taarifa binafsi kwa bahati mbaya, au kwamba unaweza usijisikie kuongea

wakati wa mahojiano uko huru kutokujibu swali lolote lile au kuhusika katika mahojiano kama utaona kwamba swali au maswali ni binafsi zaidi au kuyaongelea itakufanya usijisikie vizuri.

Gharama za kushiriki katika utafiti huu: Mshiriki hatoingia gharama yoyote ya kushiriki katika utafiti huu.

Mawasiliano

Ikiwa una maswali yoyote yanayohusu utafiti huu, tafadhali unaweza kuwasiliana moja kwa moja na msimamizi wangu ikiwa una maswali kuhusu haki zako kama mshiriki. Unaweza pia kumpigia simu Mwenyekiti wa Kamati ya Seneti ya Utafiti na Machapisho. Dkt. Nahya Masoud, Mkurugenzi wa Utafiti na Machapisho; Chuo cha Afya na Sayansi Shirikishi Muhimbili; S.L.P 65001, Dar es Salaam; Simu ya Ofisi: +255 22 2152489/0302-6; na Barua Pepe: drp@muhas.ac.tz**. Au Prof. Tumaini Nyamhanga (**Msimamizi Mkuu wa Utafiti**),** Mkufunzi Mwandamizi katika Chuo cha Afya na Sayansi Shirikishi Muhimbili; S.L.P 65001, Dar es Salaam; Simu ya Mkononi: +255713254000/+255620358351/+255685211158; na Barua Pepe: tnyamhanga69@gmail.com

Makubaliano:

Je! Unakubali?

Ndio ☐ Hapana ☐ (weka vema kwenye jibu sahihi)

Mimi ……. nimesoma na kuelewa yaliyomo katika fomu hii. Maswali yangu yamejibiwa. Ninakubali kushiriki katika utafiti huu.

Saini ya mshiriki……. Tarehe……

Saini ya mtafiti ……. Tarehe …….

8.13 Appendix 13. Ethical approval forms

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATIONS

Ref. No.DA.282/298/01.C/2281 Date: 31/05/2024

MUHAS-REC-05-2024-2281
MAXMILLIAN Z. KWANGU
SHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: ASSESSMENT OF THE HEALTH SECTOR'S RESPONSE TO GENDER BASED VIOLENCE IN TANZANIA: THE CASE OF ILALA DISTRICT.

Reference is made to the above heading,

I am pleased to inform you that the Chairperson has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

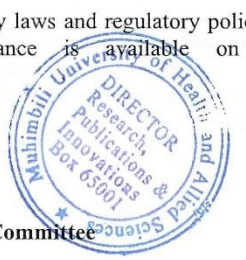
APPROVAL DATE: 31/05/2024
EXPIRATION DATE OF APPROVAL: 31/05/2025

STUDY DESCRIPTION:
Purpose:
To explore health sector achievements and challenges in responding to GBV in the Ilala District using the WHO Health Systems Framework components.

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2015651.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain Data Transfer Agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain Material Transfer Agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country.
8. Apply for and obtain permission to publish the results from National Institute for Medical Research. The application should be before submitting to a publisher and not concurrently through the email publications@nimr.or.tz.
9. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
10. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
11. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.



Dr. Nahya Salim Masoud,
Chairperson, MUHAS Research and Ethics Committee

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.539/2020

03rd June, 2024

The Regional Administrative Secretary
P.O. Box 5429,
DAR ES SALAAM.

Re: INTRODUCTION LETTER MAXMILLIAN Z. KWANGU

We would like to inform you that the bearer of this letter is **Maxmillian Z. Kwangu** with Reg. No. **HD/MUH/T.539/2020** is a student at Muhimbili University of Health and Allied Sciences (MUHAS) "pursuing **MSc. Health Policy and Management.**

As part of his studies, he will be doing an elective research titled. "**Assessment of the Health Sector's Response to Gender Based Violence in Tanzania: The Case of Ilala District."**

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate his data collection process for one month.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c **Maxmillian Z. Kwangu**

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1015;
Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz,Web https://www.muhas.ac.tz

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.539/2020

03rd June, 2024

The Executive Director
Amana Regional Referral Hospital,
P.O. Box 25411,
DAR ES SALAAM.

Re: INTRODUCTION LETTER MAXMILLIAN Z. KWANGU

We would like to inform you that the bearer of this letter is **Maxmillian Z. Kwangu** with *Reg. No. HD/MUH/T.539/2020* is a student at Muhimbili University of Health and Allied Sciences (MUHAS) *pursuing **MSc. Health Policy and Management.**

As part of his studies, he will be doing an elective research titled: ***"Assessment of the Health Sector's Response to Gender Based Violence in Tanzania: The Case of Ilala District."***

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of his research.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c **Maxmillian Z. Kwangu**

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam; Tel. G/Line +255-22-2150302/6, Ext. 1015
Direct Line:+255-22-2151378;Telefax:+255-22-2150465,E-mail:dpgs@muhas.ac.tz;Web: https://www.muhas.ac.tz

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.539/2020

24th June, 2024

IGP,
POLICE HQ
P.O BOX 961,
DODOMA.

RE: INTRODUCTION LETTER OF MAXMILLIAN Z. KWANGU

We would like to inform you that the carrier of this letter is Maxmillian Z. Kwangu with registration number HD/MUH/T.539/2020 a student in the School of Public Health and Social Sciences at Muhimbili University of Health and Allied Science (MUHAS), pursuing MSc. Health Policy and Management

As part of his studies, he will be doing an elective research titled **"Assessment of the Health Sector's Response to Gender Based Violence in Tanzania: The Case of Ilala District".**

The Ethical Clearance for doing the said research has been given by the University.

Kindly request your assistance and cooperation to our student.

Yours Sincerely,

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Maxmillian Z. Kwangu

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1015; Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS

TAWALA ZA MIKOA NA SERIKALI ZA MITAA

MKOA WA DAR ES SALAAM
Anwani ya Simu:
Simu: 2203156/58
Fa: +25522203213
Tovuti: www.dsm.go.tz
Barua Pepe: ras@dsm.go.tz
Unapojibu Tafadhali taja:

OFISI YA MKUU WA MKOA,
3, Barabara ya Rashid Kawawa,
S.L.P 5429,
12880, DAR ES SALAAM.

Kumb. Na. EA.260/307/01B/138

06 Juni, 2024

Mkurugenzi wa Halmashauri ya Jiji,
S. L. P. 5429,
DAR ES SALAAM.

YAH: UTAMBULISHO WA UTAFITI

Tafadhali husika na kichwa cha habari hapo juu.

2. Ofisi ya Mkuu wa Mkoa wa Dar es Salaam inautambulisha utafiti ujulikanao ***"Assessment of the Health Sector's Response to Gender Based Violence in Tanzania: A Case of Ilala District"*** ikiwa ni sehemu ya kukamilisha mafunzo ya shahada ya Uzamili ya **Maxmillian Z. Kwangu** ambaye ni mwanafunzi katika Chuo Kikuu cha Sayansi na Afya Shirikishi Muhimbili.

3. Kibali cha kufanya utafiti huu kimetolewa na Chuo Kikuu cha Muhimbili (MUHAS-REC-05-2024-2281) ambacho kinaanzia tarehe 31 Mei, 2024 hadi 31 Mei, 2025. Utafiti huu umepangwa kufanyika katika Halmashauri ya Jiji ndani ya Mkoa wa Dar es Salaam.

5. Kwa barua hii, namtambulisha kwako **Maxmillian Z. Kwangu** ambaye ndio msimamizi mkuu wa utafiti huo ili aweze kufanya utafiti huu muhimu.

Nashukuru kwa ushirikiano.

Dkt. Ayoub Kibao
Kny: KATIBU TAWALA WA MKOA
DAR ES SALAAM

Nakala: Katibu Tawala wa Mkoa,
DAR ES SALAAM. - Aione katika jalada

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS
TAWALA ZA MIKOA NA SERIKALI ZA MITAA
HALMASHAURI YA JIJI LA DAR ES SALAAM

Ref. DCC/D.F.31/IX/54

11 June, 2024

Mganga Mfawidhi,
Hospitali ya Kivule/Mnazi Mmoja/ Kituo cha Afya Chanika.

YAH: UTAMBULISHO WA UTAFITI KUHUSU 'ASSESSMENT OF THE HEALTH SECTOR'S RESPONSE TO GENDER BASED VIOLENCE IN TANZANIA: CASE OF ILALA DISTRICT"

Tafadhali husika na kichwa cha habari hapo juu.

2. Ofisi ya Mganga Mkuu wa Halmashauri ya Jiji inapenda kumtambulisha **Ndg.Maxmillian Z.Kwangu** wa Shahada ya Uzamili kutoka Chuo kikuu cha Sayansi Shirikishi Muhimbili.

3. Amepewa kibali kufanya tafiti tajwa hapo juu katika Halmashauri ya Jiji la Dar es Salaam. Lengo kuu la tafiti hii ni kutathimini namna gani vituo na halmashauri kwa ujumla inakabiliana na matukio ya unyanyasaji wa kijinsia. Utambuzi wa njia/mikakati hii utasaidia kuboresha ama kuendeleza mikakati na njia zinazotumika.

4. Utafiti huu unatarajiwa kufanyika kuanzia tarehe **12/06/2024** hadi tarehe **31/05/2025**, katika vituo vifuatavyo; **Hospitali ya Kivule, Mnazi mmoja na Kituo cha Afya Chanika.**

5. Kwa barua hii naomba umpokee mtafiti huyu na kumpa ushirikiano kulingana na taratibu na miongozo iliyopo.

Natanguliza shukrani zangu za dhati

Kny: MGANGA MKUU
HALMASHAURI YA JIJI LA DAR-ES-SALAAM

Anence Kamasho
Kny: MGANGA MKUU HALMASHAURI YA JIJI
DAR ES SALAAM

Nakala: Mratibu wa Udhibiti wa Ukatili wa Kijinsia
Halmashauri ya Jiji la Dar es Salaam.

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

AMANA REGIONAL REFERRAL HOSPITAL

Telegram "HEALTH", DODOMA
Phone No.: +255 026 – 2323267
Email: ps@afya.go.tz

P.O. Box 25411
DAR ES SALAAM
Phone: 022—2861903

REF. NO. MoHCDGEC/ARRH/R.1/VOL II/

Date: 19/06/2024

Director, Postgraduate Studies,
MUHAS,
P.O. Box 65001,
DAR ES SALAAM.

Re: PERMISSION FOR DATA COLLECTION

Refer to your letter dated 3rd June, 2024 which requested us to **Maximilian Z. Kwangu** to conduct research and collect data in our institution.

We are here to acknowledge your request with the following conditions, that he must submit the results of his research after completion of analysis in order the hospital to make use of data's to solve hospital problems.

Regards.

For:
MEDICAL OFFICER I/C
AMANA REGIONAL REFERRAL HOSPITAL
P. O. Box 25411
DAR ES SALAAM

Dr. Rose Ntambuto
FOR: MEDICAL OFFICER INCHARGE
AMANA REGIONAL REFERRAL HOSPITAL

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HOME AFFAIRS
TANZANIA POLICE FORCE

Telegram: "MKUU POLISI"
Telephone: 026 2323585
Fax No: 026 2323586
E- mail:info.phq@tpf.go.tz
In Reply Please Quote:

Office of Chief of Police Force,
Police Head Quarters,
4 Posta Street,
P. O. Box 961,
40483 DODOMA.

Ref. No. GB.56/897/01/123

02ND July 2024

Director, Postgraduate Studies,
Muhimbili University of Healthy and Allied Sciences,
9 United Nations Road-Upanga west,
P.O. Box 65001,
DAR ES SALAAM.
E-mail: dpgs@muhas.ac.tz

RE: **INTRODUCTION LETTER OF MAXMILLIAN Z. KWANGU**

Please refer to your letter with Ref: No: HD/MUH/T.539/2020 dated 24TH June 2024 on the above subject matter.

2. Be informed that the Chief of Police Force has received your letter mentioned above.
3. The Chief of Police Force has granted the permission of doing a research programme in the Tanzania Police Force as requested.
4. With best regards.

A. J. Rutashuburugukwa - DCP
For: **CHIEF OF POLICE FORCE**
For: CHIEF OF POLICE FORCE

CC:-

Police Commander,
Ilala Police Region,
P.O. Box 9140,
DAR ES SALAAM. – For your Information and Cooperate accordingly.

Mr. Maxmillian Z. Kwangu.